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The Integration of Peer Recovery Supports within Philadelphia's Crisis Response Centers: An In-progress Report from the Field

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Abstract

The provision of peer recovery support services are being integrated into recovery-focused behavioral health systems transformation efforts throughout the U.S. and in other countries, but little information exists regarding such integration within crisis services. This paper describes efforts underway to integrate peer recovery support services within the City of Philadelphia's network of Crisis Response Centers, including the history of this initiative, the stages and current status of service implications, obstacles to peer integration and some of the key issues addressed through the implementation process. Peer services may have a unique role to play within behavioral health crisis interventions services, but many questions remain unanswered as to the best implementation processes and their short- and long-term effects on recovery outcomes.

Introduction

Recovery has recently emerged as a new organizing paradigm for behavioral health care in the U.S. (Davidson, et, al, 2005, 2007; El-Guebaly, 2012; White, 2005, 2008) and the U.K. (Berridge, 2012; Humphreys & Lembke, 2012; Wardle, 2012). Calls to shift acute and palliative care models of treatment to models of sustained recovery management have increased (Davidson, et al, 2007; Kelly & White, 2011), as have calls to wrap the latter models within larger recovery-oriented systems of care (Anthony, 2000; Clark, 2007; White, 2008;). Recovery is becoming a conceptual and practice bridge in the integration of mental health and addiction treatment services (Davidson & White, 2007, 2010, Gagne, White & Anthony, 2007; White & Davidson, 2006; White, Boyle & Loveland, 2004). In both service systems, the call for increased recovery orientation has been accompanied by the growing involvement of people with lived experience of recovery in the planning, delivery and evaluation of services, as well

as in the expansion of peer-based recovery support services (Kaplan, 2008; Laudet & Humphreys, 2013; Valentine, 2011; White, 2009; White, W., Humphreys, K., Bourgeois, et al, 2013).

Peer-based support services are being delivered in numerous contexts, including recovery mutual aid groups, recovery community organizations, behavioral health service organizations and allied health and human service organizations (Davidson, Chinman, Kloos, et al, 1999; White, 2009). Peers are being used within service roles that span outreach and early engagement, case management, support during hospitalization, promotion of a peer recovery support culture within the treatment milieu, facilitation of education or support groups, ongoing recovery coaching, assertive linkage to indigenous recovery community institutions, post-treatment monitoring, advocacy and support and within treatment outcome research (Galanter, Castaneda & Salamon, 1987; Ryan, Choi, Hong, et al, 2008; White, 2009, 2010). The Veterans Health Administration, through Vet2Vet and other peer support programs, has recently hired more than 800 peer specialists (Barber, Rosenheck, Armstrong, et al, 2009; Resnick, Armstrong, Serrazza, et al, 2004; Rosenheck, Resnick, Herbert, et al, 2009), and an increasing number of states are developing certified peer specialist roles and reimbursing such services through Medicaid. Such expansions are exerting pressure to develop national standards and ethical guidelines for the delivery of peer-based recovery support services (Salzer, Schwenk & Brusilovskiy, 2010).

Evaluations of peer support within behavioral health services suggest that such models can serve as a catalyst of recovery initiation, enhance service engagement, reduce symptom severity, reduce emergency room utilization, decreased hospital readmissions and increase participants' sense of hope, self-care, connection to community and quality of life (Blondell, Behrens, Smith, et al, 2008; Blondell, Looney, Northington, et al, 2001; Davidson, Bellamy & Miller, 2012; Cook, Copeland, Corey, et al, 2011; Landers & Zhou, 2011; Repper & Carter, 2011). Recent reviews of existing research have reported no evidence of harm resulting from peer recovery support services (Pitt, Lowe, Hill, et al, 2013), and suggest that the delivery of such services has positive effects on those in the delivery role, including reductions in services needed and enhanced quality of personal recovery (Salzer, Darr, Calhoun, et al, 2013). Multiple stakeholders have collaborated on the development of general guidelines to address the structure and process of delivering peer-based recovery support services (Grant, Daniels, Powell, et al, 2012). Studies of implementation of peer recovery support services have noted challenges related to selection, training and supervision of peers; integration of peers within professional care teams; role transitions from service recipient to service provider; continued problems of role ambiguity and inadequate support for peer service providers (Cabral, Strother, Muhr, et al, 2013; Gates & Akabas, 2007; Mancini & Lawson, 2009; Walker & Bryant, 2013).

Although the literature on peer-based recovery support services is growing, few studies have focused on the process of implementing peer supports within crisis intervention services. The purpose of this paper is to review the status of efforts to incorporate peer recovery support services within the City of Philadelphia's network of Crisis Response Centers.

Philadelphia's Behavioral Health Transformation Process

Recovery-focused systems transformation efforts in the City of Philadelphia begin with the creation of the Department of Behavioral Health and Intellectual disAbilities Services (DBHIDS) in 2004 and the recruitment of Dr. Arthur Evans, Jr. to lead behavioral healthcare systems innovations. The creation of the DBHIDS within Philadelphia City Government combined the Office of Intellectual disAbility Services (IDS) with the

three elements of Philadelphia's behavioral health system: Office of Mental Health (OMH), Office of Addiction Services (OAS) and Community Behavioral Health (CBH), Philadelphia's Medicaid Managed Care entity. The resulting efforts involved substantial changes in the core systems values and concepts, constituency relationships, service practices, and funding and regulatory policies. These changes have been described elsewhere (Achara-Abrahams, Evans, & King, 2011) in considerable detail and are briefly summarized below.

The behavioral health system transformation in Philadelphia began by involving all community stakeholders in the process—particularly recovering people and their families. The resulting vision was to create an integrated behavioral health care system for the citizens of Philadelphia that promotes long-term recovery, resiliency, self-determination, and a meaningful life in the community. A Recovery Advisory Committee developed a consensus definition of recovery and nine core recovery values: hope; choice; empowerment; peer culture, support, and leadership; partnership; community inclusion/opportunities; spirituality; family inclusion and leadership; and a holistic/wellness approach. The recovery definition and recovery core values were then used to guide the system transformation process in both mental health and addiction service settings.

Sustained efforts have aimed at restructuring system's relationship based on a partnership model. Relationships between service practitioners and service consumers and between DBHIDS and its local service providers have transitioned from authority-based relationships to relationships based on mutual respect and collaboration. Recovery representation has been promoted at all levels of system decision making. The focus on recovery has also resulted in expansion of the availability, quality, and sustainability of recovery support services and expansion of the settings in which such services are available. New relationships, such as the linkage between treatment agencies, the faith community, and other indigenous recovery support institutions are also a visible part of the system transformation process.

Changes in service practices have focused on the following areas:

1. Engagement: Greater focus on early identification via outreach and community education; emphasis on removing personal and environmental obstacles to recovery; shift in responsibility for motivation to change from the client to service provider; loosening of admission criteria; and focus on the quality of the service relationship.

2. Assessment: Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery.

3. Retention: Increased focus on service retention and decreasing premature service disengagement.

4. Role of Client: Shift toward philosophy of choice rather than prescription of pathways and styles of recovery; greater client authority and decision-making within the service relationship; emphasis on empowering clients to self-manage their own recoveries.

5. Service Relationship: Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."

6. Clinical Care: Greater accountability for delivery of services that are evidence-based, gender-sensitive, culturally competent, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying each client's recovery environment.

7. Service Dose/Duration: Increased dose and duration of total services with accompanying decline in number and

duration of acute care episodes; emphasis has shifted from crisis stabilization to ongoing recovery coaching.

8. Service Delivery Sites: Emphasis on transfer of learning from institutional to natural environments; greater emphasis on home-based and neighborhood-based service delivery; greater emphasis on building and revitalizing indigenous recovery supports in neighborhoods where they are absent or weak.

9. Post-treatment Checkups and Support: Emphasis on recovery resource development (e.g., supporting alumni groups and expansion/diversification of local recovery support groups); assertive linkage to communities of recovery; face-to-face, telephone-based, or Internet-based post-treatment monitoring and support; stage-appropriate recovery education; and, when needed, early re-intervention. (For additional detail, see Abrahams, Ali, Davidson, Evans, et al, 2012).

The conceptual, relationship, and practice changes described above necessitated accompanying changes in funding and regulatory policies. The focus to date has been on providing regulatory relief (reducing duplicative and excessive regulatory requirements), generating more recovery-focused regulatory standards, shifting the focus of program monitoring from one of policing to one of consultation and support, generating new RFPs for recovery-focused service initiatives, and exploring models for long-term funding of recovery support services.

Peer Recovery Support Services within the Philadelphia Systems Transformation Process

DBHIDS' expansion of peer recovery support services (PRSS) within its Crisis Response Centers is part of a larger effort to expand peer recovery support services within the whole system of care. Critical steps and achievements in this process include:

- a sustained partnership between DBHIDS and the Pennsylvania Recovery Organization - Achieving Community Together (PRO-ACT)
- the opening of Philadelphia's first recovery community center and its subsequent delivery of PRSS to more than 5,400 individuals
- findings based on an evaluation of 39,000 hours of PRSS that PRSS enhanced abstinence outcomes as well as increases in employment, educational involvement income, housing stability and parental custody of children.
- Expansion of peer roles to provide system-wide and program-level guidance on service design, street outreach, support during treatment, solicitation of feedback from clients on the quality of their treatment experience, and providing sustained post-treatment monitoring and support.

These specific achievements were part of a larger effort to culturally mobilize local communities of recovery for recovery support and recovery advocacy. Mobilization activities over the past eight years included hosting national speakers to address local communities of recovery about recovery advocacy and peer recovery support initiatives, a 12-week peer leadership academy (averaging 60 graduate a year), 34 Certified Peer Specialist trainings (611 trainees to date), 92 recovery storytelling workshops (1,532 participants to date), 31 peer group facilitator trainings (519 trainees to date), and 285 Taking Recovery to the Streets presentations to individuals in treatment provided by more than 50 trained peers. DBHIDS has used a federal Access to Recovery grant to deliver PRSS through a

network of 52 community and faith-based service providers that collectively employ 22 Peer Recovery Specialists. More than 8,500 individuals were served through this initiative between 2011 and 2013. Since 2005 DBHIDS has also sponsored two major professional/peer recovery conferences, co-sponsored Amends in Action events (involvement of people in recovery in community service projects), and co-hosted an annual public recovery celebration event (with more than 18,000 participants in 2012) (White & Evans, in press).

The History of Philadelphia's Crisis Response Center (CRC) Network

The City of Philadelphia opened a small Crisis Intervention Unit within the Health Department in 1953 to address a wide spectrum of acute mental health concerns; such crises had become a serious public health challenge that had not received adequate attention. This original unit provided counseling, consultation, guidance, technical advice, information and referrals to individuals who exhibited an acute episode of disturbed thought, behavior, mood or social relationships. The unit also routinely accepted calls from individuals who had suicidal thoughts or intentions as well as calls from persons seeking assistance for family members or friends who were in crisis.

This unit also provided mental health evaluations and some brief psychotherapy conducted by psychiatrists, clinical social workers and psychologists. Home visits were frequently made by the staff, particularly when a mental health application needed to be made to the court for an involuntary inpatient treatment order for a person who was dangerous to themselves and/or others. In the absence of any other public patient evaluation center, persons involuntarily committed were further assessed for treatment options by the State Reception Center located on the grounds of the now defunct Philadelphia General Hospital.

The 1966 Pennsylvania State Mental Health and Mental Retardation Act provided funding to the counties for a wide range of mandated services. Psychiatric Emergency Services (PES) were established on an around the clock basis and grew to seven PES centers dispersed throughout the City of Philadelphia. The PES centers were located in or in close proximity to hospitals. They significantly expanded the capacity of the county to perform in-depth comprehensive mental health crisis evaluations, to develop treatment plans and to implement the plans. The PESs were operated by contractual providers that functioned as clinical extensions of the county's Acute Services Unit. This transferred and expanded key aspects of the clinical functions of the Acute Services Unit to the PESs. The Acute Services Unit began operating around the clock providing telephone crisis intervention and some clinical management functions. The unit was also charged with maintaining ongoing communication, collaboration and problem solving within the now expanded Crisis Services Delivery System. In 1966, the County Mental Health Administrator was assigned authority to issue warrants for Involuntary Emergency Examination and Treatment with those duties then delegated to staff in the Acute Services Unit and no longer performed by the court.

The Psychiatric Emergency Services were mandated in DPW-MH & MR Manual 5223.1 as follows:

- Psychiatric emergency services need to be provided, consisting of observation, treatment and close supervision to be available any hour of the day or night to persons with a mental disability in need of immediate care.
- Psychiatric emergency services must not be denied to any person needing such care.
- Psychiatric emergency care may be required to prevent aggressive behavior by the patient toward himself or others.

- Psychiatric emergency Services must be made available on a voluntary basis to those persons where prompt treatment increases the likelihood of recovery from emotional disturbance.
- Psychiatric inpatient hospital care must be available to the psychiatric emergency service.
- When it becomes necessary to make an involuntary commitment for emergency detention, Section 405 of the Act becomes applicable(the Mental Health Procedures Act of 1976—revised in 1978 contains Section 302 which is the present day commitment procedure and supplants Section 405).

In the late 1990s, Psychiatric Emergency Services and the City's larger crisis response system underwent evaluation. This resulted in implementation of a comprehensive plan to restructure crisis intervention services. Some of the main features emerging from this restructuring included the following:

- The new crisis centers, called "Crisis Response Centers (CRC)," are designed to meet the needs of persons with serious behavioral health challenges, including mental illness, drug- and alcohol-related problems and co-occurring mental illness and substance use disorders as well as other special populations.
- Numerous regulations, directives and procedures were written to clearly specify structural and functional standards of the CRCs, including standards related to space requirements and accessibility, staffing levels, staff credentials and training, continuity of care, client evaluations and documentation, and laboratory services.
- The CRCs provide triage and assessment; acute psychiatric drug and alcohol evaluation and intervention; crisis counseling and support; and referral and linkage.
- CRCs perform important functions in the processing of 302 Applications for the Behavioral Health System. The Pennsylvania Mental Health Procedures ACT of 1976 (amended 1978): Section 302 provides a procedure for involuntarily committing a person who has a mental disability, is considered to be dangerous to self or others and refuses to seek help voluntarily for an examination at a Crisis Response Center and subsequent treatment if deemed necessary by the examining psychiatrist for a period of up to five days. The CRCs also have other related responsibilities pertaining to this process, including assisting families and other concerned persons to file 302 Applications when necessary and appropriate, as well as calling 302 Applications into the staff of the Acute Services Unit for possible approval and issuance of a warrant for involuntary examination and treatment.
- CRCs establish linkages and move persons in crisis quickly to such services and do follow-up to assure that clients get enrolled and engaged in these various programs.
- No CRC, under any circumstances, is allowed to close its doors or turn away a person in need of emergency services.

A monitoring team was established and made up of professional staff from the Acute Services Unit, CBH and the Behavioral Health System. This team conducts site visits to the CRCs on a regular basis to review all aspects of the program to determine if the centers are in compliance with regulations and performance standards, and to provide technical assistance as needed. One aspect of this monitoring is to assure that services are trauma-informed and recovery-based, individualized, comprehensive, flexible, person-first

(culturally responsive), and designed to support health and wellness.

Five CRCs have served the City of Philadelphia since this restructuring of crisis services in 1998: Einstein Crisis Response Center at Germantown Hospital (North/Northwest); Friends Crisis Response Center at Friends Hospital (Northeast); Hall Mercer Crisis Response Center at Pennsylvania Hospital (Center City/South); Temple/Episcopal Crisis Response Center at Temple/Episcopal Hospital (North Central /East); and Mercy Crisis Response Center at Mercy Hospital (West /Southwest). In addition to the five CRCs, the John F. Kennedy (JFK) Behavioral Health Center is contracted to provide 24/7 Mobile Crisis Services available to all residents of Philadelphia. Known as the Mobile Emergency Team (MET), they are dispatched by the DBHIDS Acute Services Unit (The Delegates) to intervene where a crisis has developed, to help people petition to have someone committed involuntarily, and to provide other mental health-related interventions.

The Crisis Intervention System continues to evolve concurrently within the larger systems transformation process underway in Philadelphia. A key area in which the transformation has influenced the CRCs is in the emerging plan to integrate peer recovery support services within the CRCs. This planning process included development of a set of core values for the CRCs (Appendix A) and development of organizational readiness criteria for implementation of CPRS within the CRCs (Appendix B). The remainder of this paper will explore aspects of this early integration process.

Early Vision for Peer inclusion within CRCs

The staffing requirements for the five CRC's include a CRC Director who meets the State requirements for a Mental Health Professional, a Medical Director who is a Board Certified Psychiatrist, adequate number of licensed physicians who have completed at least a PG1 level in Psychiatry, Certified Registered Nurse Practitioners (CRNP) who may be deployed in roles otherwise filled by a physician, Behavioral Health Associates who meet the State requirements for a Mental Health Crisis Intervention (MHCI) service medical assistant, and medical personnel who can immediately assess and treat emergent medical conditions on a 24/7 basis. The CRCs must have one physician at least at the attending level (board eligible) on site or available on an on-call basis at all times both for consultation with on-site staff and with CBH. The staff of the CRC also includes personnel to meet the special needs of persons receiving services. These personnel include addiction specialists, staff who are responsible for referrals and follow up of persons who use the CRC and staff to offer services to family members.

As the recovery transformation process evolved, interest grew in the integration of peers within the staff of each CRC. The original push for peer inclusion in the CRCs came from CBHISA leadership (Dr. Evans and Sade Ali) with discussions beginning at the CRC Director's meetings in 2009. Early discussions at the CRC level included hopes that peers might increase quality of services by bringing experiential knowledge, styles of engagement and dimensions of support not previously available within the CRCs. Various concerns and uncertainty related to peer integration were also expressed regarding issues of recruitment and selection, orientation and training, team relationships, and legal/professional liability.

Implementation Status

Two of the five CRCs—Einstein/Germantown and Friends Hospital--have begun providing peer services within their units. Einstein/Germantown hired a Certified Peer Specialist in 2011 to provide services five days a week. This role has been filled since then, but the plan to add a second has not materialized due to lack of funding for this second position. Friends

Hospital now has two Certified Peer Specialists, one full time in the CRC and the other primarily assigned to the inpatient units, but occasionally consulting in the CRC. JFK hired three peers in 2012 and presently has two CPSs working within their Mobile Emergency Team. Their primary role is engaging participants, sharing their stories where applicable and doing telephone follow ups. They provide education, information and act as community liaisons. They also record the information they collect on a log called Certified Peer Specialist Participant Engagement Log. It includes the participant's demographics, presenting situation, the engagement and follow up and or recommendations. The CPSs are dispatched by the MET to participants, family members in crisis or to assist other community service providers responding to a crisis.

Although two CRCs and JFK have integrated peers within their respective service operations, integration of peers within the other CRCs has been held up for more than two years because of lack of funding for these roles. All sites report being internally ready (e.g., policies developed, job descriptions, etc.) for greater peer integration pending approval of funding for these services.

Major Obstacles to Implementation

The use of peers in crisis services in Philadelphia has been championed at multiple levels of the system since discussions of their potential value began. The delay in wider implementation of peer recovery support services within these venues has been administrative and fiscal rather than one of any attitudinal resistance. The ability of the Crisis Response Centers (CRCs) in Philadelphia to hire peers seemed initially to be relatively straightforward (i.e. negotiate a payment rate that covers the cost of peer specialists with those organizations operating the CRCs). However, this has turned out to be much more complicated than expected. In Philadelphia, the Crisis Response Centers (CRCs) were all recently required to become licensed by the State as Crisis Walk-in Centers and then to become enrolled as Medicaid providers. This turned out to be a much slower process than anticipated with only two CRCs enrolled and a third in the process of being enrolled. The remaining two CRCs have been licensed as Crisis Walk-in Centers but they have yet to be enrolled by the State as Medicaid providers. What will continue to present as a challenge is how the CRCs have been functioning to date financially. Each year they report costs that well exceed their allocations, forcing them to continue to carry a large "agency contribution" line to balance their budgets. This issue comes up when they are asked to change or enhance their services but are not offered additional funding for new personnel and thus supervisory costs. Facilitating resolution of these challenges was impeded by staff changes within DBHIDS. At present, the Medicaid Managed Care entity, Community Behavioral Health (CBH) is working with providers to achieve the presence of certified peer specialists within every unit of the CRC network.

Experience to Date with Key Issues

Job Descriptions and Duties Sample job descriptions for peers working within Philadelphia's Crisis Response Centers are included in Appendices C and D. The general requirements for working as a peer in these settings include a high school education (with preference for post-secondary education), successful completion of the DBHIDS Certified Peer Specialist Training Program, prior experience working in a health or mental health service setting, skills in verbal and written communication, and skills and comfort sharing one's personal recovery experience. CRC supervisors also note that it is beneficial if the Peer Specialist has worked as a peer in another level of care before working within the crisis response setting.

The duties required of the peer specialists within the CRCs generally include:

- contributing to the development of a strong culture of recovery within the CRC treatment milieu (See sample CPS Schedule in Appendix E)
- helping orient patients and their family members to the facility and its treatment program
- observing, monitoring and reporting status of each patient
- providing emotional support to patients and families
- facilitating group activities within the treatment milieu
- assisting patients with development of plans for continued recovery stabilization and maintenance in the community
- assertively linking patients to recovery support resources within the community, and
- conducting ongoing telephone or face-to-face recovery check-ups on each discharged patient (See sample post-discharge follow-up consent form in Appendix F and sample follow-up call documentation form in Appendix G).

Recruitment and Selection The recruitment of peer specialists was achieved through newspaper advertisements, online postings, and reaching out to peers already working within other units of the CRC organizations. CRC leaders also expressed plans for future recruitment that would be expanded to postings through the mental health association, local recovery advocacy organizations and other organizations in the community who utilize peers to deliver recovery support services. Recruitment responsibilities were generally shared by the human resource departments of the hospitals in which the CRCs were located and CRC administrators and supervisors.

Beyond the requirements noted for the peer specialist positions, CRC supervisors noted other characteristics they were seeking within the screening of candidates. These characteristics included:

- Insight: understanding of the potential necessity and potential therapeutic benefits of involuntary commitment
- Empathy: capacity to be with and remain with people on what may well be the worst day of their lives
- Initiative: ability to self-initiate contact and respond to patient needs as they arise without direct supervision
- Assertiveness: ability to speak out on issues of import to quality of patient care
- Mutual respect: willingness to collaborate within the larger care team
- Self-care: capacity to handle the emotional distress/drama/unpredictability of the crisis setting via capacity for self-monitoring their own emotional responses to crisis situations (See later discussion)
- Acceptance of Limitation: Recognition/acceptance of limits on one's role and ability to practice within those limitations; ability to work within the context of crisis without being involved in the long-term outcome.

Orientation, Training and Supervision The initial orientation of peers working within the CRCs generally combines a 2-3 hour one-on-one orientation with progressive integration into the care-giving process. Training activities that have supported CPS integration within the CRCs include a 2-day CRC workshop (See Appendix H for sample Agenda) and a Certified Peer Specialist training course that is completed prior to CPSs entering their roles (See Appendix I for Training Manual).

The Certified Peer Specialist (CPS) initiative was developed to assist people with behavioral health challenges become re-acclimated to the community in which they live as well as empower them to cope with

their challenges. This 2-week training culminates with a graduation and job fair with prospective employers. College credits are also awarded upon successful completion of the training. CPS training candidates must have a high school diploma or GED and one year of relevant volunteer or paid work experience. Upon employment, a CPS is a paid staff person who is willing to self-identify as a person with a serious behavioral health disorder (mental illness, substance use disorder, or co-occurring disorder) with lived experiences.

To date, most of the selections for peer specialists to work within the CRCs have worked out very well, but supervisors were insistent on providing each peer a guilt free exit from this role if there was evidence of role-person mismatch within the CRC. Discussions with the supervisors elicited numerous references to the fact that not everyone (regardless of personal/professional background) was suited for the crisis response role. To wit, some very well-qualified CPSs who could work very effectively in other settings may not be a good fit with the fast paced and high acuity environment of a CRC.

The structure of peer supervision within the CRCs generally included brief daily check-in, an open door policy regarding any issue arising within the service process, and more formal supervisor-supervisee meetings (ranging from monthly to quarterly across the CRC sites). The supervision structure is also individualized based on each peer's level of functioning and comfort and generally proceeds from a high to lower frequency and intensity of contact. At Einstein, each CPS submits a monthly report that is reviewed in supervisory meetings. The report format elicits monthly activities, challenges and successes.

Some supervisors noted having participating in a specialized training event on supervision of peer specialists that was sponsored by the local mental health association The Certified Peer Specialist Supervisor's Training is a 2-day training for staff who will be responsible for hiring and supervising Certified Peer Specialists (See Appendix J). This training is designed to increase knowledge about operating a peer support service as well as the supervisory techniques needed to support CPS in the workplace. This training is approved by the NASW for 13.5 Social Work continuing education contract hours. It is set up for a maximum capacity of 20 participants.

When asked about lessons learned in the supervision of peers within the CRCs, supervisors noted the following lessons:

1. Good supervision applies to all roles: there are not substantial differences between supervision of peer specialists and other roles within the team.

2. Due to the newness of the peer specialist position, it is important to clearly define this role, address any areas of role ambiguity or role conflict and identify and respond to concerns about role-person mismatch as early as possible.

3. Maintaining openness and continuity of contact and support within the supervisory relationship is critical to successful adjustment to and performance within the crisis context.

<u>Importance of Clarity of the Peer Specialist Role and Team Integration</u> If there was a single concern most often expressed by CRC supervisors about the peer specialist role, it was the linked issue of role clarity and team integration. Supervisors first noted that ambivalence towards the peer specialist role by traditional professionals was normal. Such ambivalence or defensiveness is common when experiential models of knowing are integrated with professional/scientific/clinical models of knowing. Professional staff trained to rigorously maintain boundaries between themselves and their clients are also unsure of the ethics and etiquette of interacting with peer specialists. It often takes 3-4 months for professional members to recognize peer specialists as full team member with this timing depending on the individual and their fit with the team. Our experience is that early ambivalence or even outright resistance to peers specialists gave way to growing respect for the value of peer specialist working within the crisis response setting.

This occurred through processes of communication and relationship building between the peer specialists and professional team members and observing peer specialist making exemplary contribution within the service process. It also helped to continually clarify roles through the integration process and to assure existing staff that their professional duties were not being turned over to peer specialists.

An unanticipated side-effect of integrating peer specialists within the CRCs was that it increased the visibility and unacceptability of some of the "MASH humor" used as an adaptive response to the distress of working within the crisis settings and staff views ("My way or the highway") couched within the rubric of "tough love" that could at times migrate into disrespectful communications. It is the view of the CRC supervisors that the presence of peer specialists helped shape much more respectful and recovery-oriented service milieus within the CRCs. Furthermore, having clinicians working alongside peer specialists has affected a realignment of staff members' understanding of life with a mental illness and expectations of patient outcomes. As is often the case in acute-care settings, staff members will often focus on the high-utilizing patients when constructing mental schema about what it means to be a mental health consumer, as opposed to the many patients who move on to the next stage of their recovery. This availability heuristic (i.e. basing assumptions on the most readily available information) often leads to inaccurately high estimates of hospital readmission, and low expectations for recovery following discharge. Having peer specialists interacting with clinicians on a regular basis is invaluable on-the-job training for what recovery can look like.

Vulnerability of Peers in Crisis Services Conversations with the CRC supervisors continually elicited references to the uniqueness of crisis services and that integration of peer specialists needed to be understood within the context of such uniqueness. Crisis services have a "battle front" atmosphere and a level of unpredictability, intensity, and exposure to trauma rarely seen elsewhere in behavioral healthcare. They are characterized by clinical complexity, service volumes, and a speed of required decision-making which often exceed other levels of care. Not everyone is as well-suited to confront such life and death intensity, patient threats of harm to self and others (including to staff), legal and physical constraints and interaction with police and other community members whose attitudes may be less than ideal toward people in crisis who suffer from a psychiatric or substance use disorder. Responding to such intensities may be particularly difficult for peer specialists who may have had similar experiences in their journey to achieve stable recovery. Extra care is needed in these environments to prevent and minimize the effects of vicarious traumatization. Although this is a noteworthy point for *any* staff member working in such a setting, the importance is specifically heightened for CPSs, who may intermix these experiences with their own.

Supports for Peer Specialists All of this suggests the need for careful selection and special supports for those working within crisis services. CRC supervisors noted a number of strategies that they believed would be of benefit to peers working within crisis services. These strategies included the following (of note is the fact that each suggestion is similar to supports already in place for other mental health professions):

- Defining potential career ladders for peer specialists
- Local networking (mutual support) of peers working within crisis, treatment and recovery support settings
- Exploring the potential for a local association of peer specialists
- Regular training conferences for peer specialists
- Workshops for peer specialists on compassion fatigue and self-care
- Consciously creating frameworks of support for both patients and staff

(e.g., JFK defines this framework as CREST: Commonsense, Respect, Empathy, Support and Trust)

Ethical Concerns or Dilemmas for Peers A wide range of ethical issues can arise within the context of peer-based recovery support services. These issues, according to the earlier work of White and the PRO-ACT Ethics Workgroup (2007), span the arenas of:

1. *Peer personal conduct* arising in such areas as self-care, personal impairment, personal bias, pre-existing relationships, personal/professional role conflicts, personal advocacy activities, and personal/professional conflicts of interest.
2. *Conduct within the Peer-Organization Relationship* arising in such areas as exploitation of the peer and representation of personal history and credentials at point of hiring.
3. *Peer Conduct within Service Relationships* arising in such areas as autonomy/choice versus paternalism, relationship boundaries—including emotional/sexual/financial exploitation of service consumers, boundaries of competence, confidentiality and discretion and duty to report.
4. *Peer Relationships with other Service Providers* arising in such areas as representation of credentials and responding to unethical conduct of other service providers.

When CRC supervisors in Philadelphia were polled as to ethical issues that had arisen within the context of peer recovery support services, there was a consensus that experience to date with peer specialists was too limited to accurately identify ethical issues unique to these roles. No organizational liability issues have yet risen related to the integration of peer recovery support services within Philadelphia's crisis response system. There was awareness of the potential of ethical/legal issues arising within the conduct of peer specialists and the need to address this potential within the context of orientation, training and supervision.

Perceived Outcomes It is far too early in the implementation of peer recovery support services within Philadelphia's CRCs to report specific outcomes related to the integration of peer recovery support services. No systematic evaluation has been conducted of the impact of peer services within the CRCs on key outcome measures. Persons served by the CRCs do complete evaluations of their CRC experiences (See Appendix K for sample evaluation form) and do sometimes note the helpful role of peers. The following comments drawn from those forms convey typical responses.

"Having someone who has been where I am, and who has been through what I am going through come and approach me was such a relief. At first I was surprised because they had this guy actually working here, and I wasn't sure I could believe him. Talking to Alex gave me a little hope that things can get better and that I might actually be able to do something once I get better."

"It was real nice having a person who really knew a little bit about what I was going through. He treated me real nice. You couldn't even tell he ever had issues."

"Places like this need to have more people like him."

"It's very good that you all hire people who can relate to patient's personal struggles. Sometimes when you talk to doctors, you feel like they don't get it, but Alex really did get it. It was like having a friend there who was on your side."

"He didn't tell me what I need to do. He just listened and shared a personal story of his own. I didn't feel alone and I didn't feel like I had to impress him. I could just talk and be me and knew he couldn't judge me because the same thing happened to him."

"He offered to keep in touch with me since I was going to [Facility]and told me about peer support in the community. I didn't know there

was such a thing. I hope I get to see him again. Maybe I can do something like this too if I can get it together."

Peer specialists also regularly express what this form of service work has meant to them personally. As one CPS recently communicated:

Working with MET and learning about crisis situations has improved the quality of my life. It is comforting/educational to us to observe your interactions with participants and their families. We [CPSs] didn't realize the danger and or the stressful situations. We appreciate the opportunity to share our stories with other participants.

There is a consensus among the administrators and supervisors of the CRCs that future evaluations of peer services within the CRCs should include at least four discrete dimensions: 1) the effects of peer recovery support services on the recovery outcomes (recovery initiation, stabilization, maintenance and quality of life) of the individuals and families served by the CRCs, 2) the effects of working as a peer specialist on recovery and quality of life measures of the peer specialists, 3) the effects of integrating peer specialists on the recovery orientation of each CRC, and 4) the effects of CRC integration on key recovery-focused systems performance measures (e.g., costs of care, lengths of stay, re-hospitalization rates)

Summary and Next Steps in Peer Integration

The City of Philadelphia is in the process of integrating peer specialists within its behavioral health crisis response system. This paper has reviewed the history of this process and our experience to date with key issues related to the implementation process. The next steps in this process include:

1) adding peer specialists within those CRCs not presently providing peer services via completion of enrollment of the remaining CRCs as Medicaid providers and completing the hiring, orientation and training of certified peer specialists within all CRCs ,

2) exploring systems-level supports for the peer specialists via mechanisms of mutual support, training and explorations of career ladders for peer specialists, and

3) promoting research on the effects of peer recovery support services within the CRCs.

We would be very interested in hearing how other communities have integrated peer recovery support services within their crisis response systems. Correspondence can be sent to Dr. Margaret Minehart (Margaret.Minehart@phila.gov).

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Appendix A

Core Values of CRC's as set forth in DBHIDS Request for Proposals

1. **Strength-based Approaches that Promote Hope:** A strengths perspective is woven throughout system-transformation efforts. Services are focused on identifying and building strengths, assets, resources and protective factors within the individual, family, peer group and community, rather than focusing solely on identifying and addressing problems or challenges in the individual's or family's life. These strengths are mobilized to support the individual's and the family's journey to wellness. A focus on hope is equally essential—the message that people can and do show resilience in the face of adversity, and can and do recover from behavioral health conditions. Change is always possible, and the extent to which people's lives can change is often beyond what we can imagine. We learn hope by seeing others lead meaningful lives in their communities, listening to their stories and having opportunities to give to others. Hope-inducing environments can help people of all ages in their recovery processes.

2. **Community Inclusion, Partnership and Collaboration:** The focus of care is on integrating individuals and families into the larger life of their communities, connecting with the support and hospitality of the community, developing community resources that support recovery and resilience and encouraging service contributions to and from the larger community. Resilience, recovery and wellness can be tapped, initiated, catalyzed and promoted in care settings, but can be maintained only in the context of people's natural environments. Connecting services, individuals and families with the community is no longer considered optional, but is understood as an integral factor in sustaining wellness.

3. **Person and Family-Directed Approaches:** In recovery and resilience-oriented systems, service designs shift from an expert model to a partnership/consultation model, in which everyone's perspective, experience and expertise is welcomed and considered. Each person's and each family's values, needs and preferences are respected and considered central to any decision-making process. Services and supports are individualized, built with and around each person and family. All parties in the system recognize that there are many pathways to recovery and that people have a right to choose their own paths. People have the opportunity to choose from a diverse menu of services and supports and to participate in all decisions that affect their lives and those of their children. Multidisciplinary teams that include participants and family members reduce fragmentation and ensure the delivery of comprehensive, effective services.

4. **Family Inclusion and Leadership:** Family members are actively engaged and involved at all levels of the service process. Families - and particularly parents of children and youth - are seen as an integral part of policy development, planning, service delivery and service evaluation. Assessment and service planning are family focused. The system and its providers recognize that families come in many varieties. Families of birth, foster and adoptive families and families of choice are respected, valued and involved in meaningful ways. When multiple family members are involved in care in different programs and agencies, providers take steps to ensure that services are integrated.

5. **Peer Culture, Support and Leadership:** Service systems and providers recognize the power of peer support and affirm that recognition by: a) creating environments in which peers can support one another in formal and informal ways and providing opportunities for that support; b) hiring people to provide peer support to individuals and/or families; c) ensuring representation of youth and people in recovery at all levels of the system; d) developing respectful, collaborative relationships between behavioral health agencies and the service structures of local recovery mutual-aid societies and assertively linking people to peer-based support services (e.g., mutual/self-help groups, other recovery community support institutions and informal peer support); e) acknowledging the role that sharing stories of lived experience can play in helping others initiate and sustain the recovery process; and f) developing opportunities for people in recovery and youth to engage in active leadership roles at all levels of the system.

6. **Person-First (Culturally Competent) Approaches:** The title of this core value reflects the fact that services that are appropriate to and respectful of culture - often referred to as culturally competent - must also respect the individuality and centrality of each unique individual. In a person-first (culturally competent) service system, all staff and volunteers are able to work effectively with individuals and families from different cultures. They possess knowledge of the values, worldviews and practices of the major cultural groups they serve - and, equally important, the humility to know the limits of their knowledge. They address culture broadly, not forgetting the importance of ethnicity, nation of birth and primary language, but also acknowledging the implications of gender, age, sexual orientation, religion, socioeconomic factors and other key characteristics. Rather than merely developing a generic understanding of the people they serve, however, they are also skilled at using cultural knowledge to develop an accurate and individualized understanding of each person they serve, each family and each community. Providers also possess an understanding of their own cultural worldview, the ways in which it enriches their work and the ways in which it may constrain their work.

7. **Trauma-Informed Approaches:** All components of the service system are designed with an understanding of the role that serious adverse events can play in the lives of individuals and families. Services are delivered in safe and trustworthy environments and through respectful, nurturing relationships to promote healing and avoid inadvertent re-traumatization. Individuals and families are always assessed for the extent to which the spectrum of traumatic experiences may have affected their lives and their ability to participate in care and establish recovery. They are offered services and supports that will help them reduce the destructive effects of traumatic experiences and maximize the growth that can emerge from the healing process.

8. **Holistic Approaches toward Care:** Services and supports are designed to enhance the development of the whole person. Care transcends a narrow focus on symptom reduction and promotes wellness as a key component of all care. In attending to the whole person, there is an emphasis on exploring and addressing primary care needs in an integrated manner. Providers and peers also explore, mobilize and address spirituality, sexuality and other dimensions of wellness in service settings.

9. **Care for the Needs and Safety of Children and Adolescents:** Service systems and providers recognize the incredible resilience of children and adolescents, along with their unique vulnerabilities and the complexities that attend their need for services and support. As a result, providers employ a developmental approach in the delivery of services. Like adults, children and their families are shown respect and given a partnership role in services and supports. Screening and assessment processes are informed by knowledge of the ways in which children and adolescents' strengths, symptoms, needs and progress tend to differ from those of adults and of the ways of honoring those differences. Providers also recognize that attention to the safety,

needs and well being of children and adolescents includes attention to the safety, needs and well-being of their families—and back up that recognition with concrete action.

10. **Partnership and Transparency:** This system transformation effort is built upon the values of partnership and transparency at all levels of the system. This applies to the ways in which system administrators strive to work with providers, as well as the ways in which providers aim to collaborate with the individuals and families receiving services.

Appendix B:

READINESS CRITERIA FOR IMPLEMENTATION OF CPRs WITHIN THE CRCs:

These Readiness Criteria have been developed to assist DBH in determining the degree to which providers are prepared to implement recovery oriented services and supports including the addition of Certified Peer Specialists to the CRC staff. Meeting these criteria can set the stage for the implementation of high quality recovery focused programs, but will not guarantee success. Establishing a recovery culture of services and supports is more complicated than these criteria indicate, but the criteria are a step in the right direction. These criteria have been developed based upon the experience gained to date in various levels of care and provider specific programs. They are intended to assist in clarifying expectations. Assisting people in recovery (PIR) and program personnel to understand and embrace the recovery philosophy and orientation will require a concerted effort by all stakeholders.

Program readiness will be determined by:

1. Creation and submission of a "Readiness Plan"
2. A DBH site visit and/or kickoff meeting have proven beneficial in the effort to confirm "Readiness."
3. A meeting between program staff, PIRs, (Provider's Change Management Team) and the DBH CRC Transformation Team

Once providers have submitted the Readiness Plan the DBH will develop their plan to provide any needed supports to the CRC's.

Readiness Plan Criteria: Plans must be formatted using the headings provided below.

1. Establishment of an internal change management team who must be formed at the outset of this process that includes top level management (or easy access to this level), program leadership staff, psychiatric leaders, direct staff, people in recovery and family members. This team must be empowered to envision the change, direct the change and plan for the change. It is their responsibility to track the pace of the change, to solicit continuous feedback from all stakeholders regarding the change and to be nimble enough to alter plans and processes on the basis of this feedback. As programs mature, the structure of Change Management Teams maybe modified, but they remain an essential mechanism to track change, explore innovations and energize the vision for transformation.

2. Program Description: All programs must submit or amend and submit their program description to be completed in partnership with peer representation and the Change Management Team. The following must be included in the description:

    a. Vision: Describe your vision of the transformed service. Please use this is an opportunity to "re-think" the role and purpose(s) of CRC to move beyond what is offered today. The peer leadership group and/or a stakeholder group are required to play a tangible role in the formation of this vision. The vision should reflect the desires, aspirations and hopes of PIRs regarding recovery as well as reflecting the vision of the change management team. From its inception, the process of developing the vision should utilize the core principles of PIR self-direction and choice.
    b. Recovery Approaches: The plan should describe the recovery approach(es) the organization intends to employ; how this differs from current practice; how will the fundamental pillars of the recovery transformation will be addressed (assertive outreach and initial engagement, screening, assessment, service planning and delivery, continuing support and early intervention, and community connection and mobilization). It is expected that the narrative to this "recovery approaches" section will provide a comprehensive picture of your intended program which will ultimately lead to a "repurposing" of the CRC. Additional assistance in addressing this question is contained in the Practice Guidelines.

c. Roles: Identify all staff roles and how they will change to accomplish your vision and support your approach(s);
d. Voices: Explain how you will ensure inclusion of all voices (psychiatric staff, recovery coaches, CPSs, other non-medical staff, PIR & families) in the ongoing transformation of your program and in developing new roles and supporting collaborative relationships consistent with your recovery approach.
e. Leadership Support and Staff Supervision: Present your approach for providing staff and peer leaders with support as well as sustaining motivation as this complex and at times unsettling change process moves forward**.** Outline the methods and frequency of staff supervision (including specifying who will have direct responsibility for the supervision of CPSs).

3. Job Descriptions: The Readiness Plan will include completed job descriptions appropriate to the program approach and a strategy for orienting and training staff to perform their new roles. The orientation of staff should include an overview of changing roles, and strategies for supporting connections to other providers and community resources.

4. Certified Peer Specialist: Pending DBH authorization, at least one FTE Certified Peer Specialist (CPS) needs to be hired in conjunction with the development of the Readiness Plan. In addition, appropriate staff need to complete CPS orientation and supervisor training provided by the Mental Health Association of Southeastern Pennsylvania, prior to hiring CPS staff.

5. Screening and Assessment Process: In a recovery- and resilience-oriented organization or system, assessment is conducted in a strength-based fashion, giving priority to the identification of assets, interests and resources as well as difficulties. A person-first assessment is based on strengths and embraces the principles of cultural competence, weaving clinical knowledge and its application within the cultural context of the individual and family seeking services and the community in which they live. Evidence that the current practice around screening and assessment has been evaluated and any gaps in accomplishing the above have been planned for.

6. Peer Run Groups: The Readiness Plan should indicate progress made concerning

7. Walk-In Crisis License: All required material will have been submitted to OMHSAS in pursuit of a new Crisis license.

8. Evaluation: Initial development of a plan to evaluate the development of a recovery and resilience based Crisis Center will be created.

Appendix C

SAMPLE Peer Specialist Job Description

Certified Peer Specialist
Principle Duties and Responsibilities

FRIENDS HOSPITAL

JOB DESCRIPTION / EVALUATION

POSITION TITLE: Certified Peer Specialist

DEPARTMENT: Spiritual Care/Clinical Services

SERVICE: Adult or Geriatric

POPULATION SERVED: Adult, Older Adult

TIME: Full Time

REPORTS TO: Director of Spiritual Care

JOB SUMMARY:

Performs duties and responsibilities as required in the delivery of patient care services on a patient unit under the supervision of the professional nurse; provides peer support services; serves as an advocate; provides information and peer support for patients in an inpatient setting; contributes to the development and implementation of treatment plans as determined by the treatment team; participates in Performance Improvement and in-service education; supports development, customer service and community relations activities.

JOB SPECIFICATIONS:

Graduate of accredited High School or successful completion of GED

Current credentialing as a Certified Peer Specialist through the Department of Behavioral Health and Intellectual Disability Services

Ability to clearly communicate, both verbally and in writing

Computer literacy required

Demonstrates potential and skill to be trained in delivery of patient care

1-2 years experience in health care or mental health care setting preferred

%	Task	Evaluation
20%	1.0 Observes and monitors the patient's status and safety; delivers physiologic and interpersonal care according to standards which is consistent with multidisciplinary treatment and discharge plan, care directives, and expected discharge outcomes; observes and maintains safety, comfort and aesthetics of the unit milieu. (1,2,3,5,6,7) 1.1 Observes, intervenes and reports relevant patient behavior, including patient response to interpersonal, intrapersonal and extrapersonal events and awareness of / ability to meet basic needs. 1.2 Participates in and contributes to the establishment of a consistent therapeutic environment in keeping with the unit philosophy and the needs, treatment goals and care directives of each individual. 1.2.1 Works within the larger context of the unit milieu. 1.2.2 Intervenes to reduce the level of anxiety in the interpersonal environment. 1.2.3 Implements nursing care directives and physician's orders under the supervision of the professional nurse. 1.2.4 Assists in the preparation of patients for evaluative and diagnostic studies. 1.2.5 Leads patients in group activities focusing on patient education outcomes. 1.2.6 Leads patients in group activities which are not insight-oriented in purpose or scope. 1.2.7 Communicates in a therapeutic manner with families / significant others. 1.2.8 Participates in treatment groups in keeping with the goals and practices of the service unit. 1.2.9 Provides or assists with patients' basic physical needs, including food, fluid, air, rest/exercise, protection from temperature extremes; assists the professional nurse with basic nursing treatments and with preparation, treatment and aftercare of persons receiving electroconvulsive therapy (ECT). 1.2.10 Assists the patient to maintain integrity of personal and physical environment, such as hygiene, room and belongings. 1.2.11 Provides support services as needed to facilitate patient care, such as unit errands, escorting, and timely delivery of specimens and request slips. 1.2.12 Demonstrates working knowledge of the discharge planning process.	☐ **Exceptional** ☐ **Competent** ☐ **Needs Development**

	1.3 Responds appropriately to physical, psychological and environmental crises, in order to maintain safety. 1.3.1 Verbally de-escalates patients with potential for violence. 1.3.2 When necessary, using the least restrictive measures, may intervene physically to prevent patients from harming themselves and/or others. 1.3.3 Demonstrates safe care according to standards for the patient whose care requires the use of restraints. 1.4 Performs direct patient care utilizing Universal Precautions, in order to maintain safety and infection control. 1.4.1 Performs or assists in safe and appropriate collection, storage and transport of specimens, including body fluids.	
60%	2 Provides direct services to patients to aide in their recovery 2.0 Assists patients transitioning from an inpatient setting to an outpatient setting by offering hope, assisting the patient in navigating through the process of starting in services, and providing on-going peer support. 2.1 Promotes an emphasis on the strengths, skills, talents, and abilities of the patient and to increase the patient's independence and self-sufficiency in the community. 2.2 Works collaboratively with the treatment team in identifying program and service environments conducive to recovery, which will lead to effective and efficient patient care. 2.2.1 Records accurate and complete documentation of patient information on traditional and computerized records, according to standards. 2.2.2 Works cooperatively to promote an atmosphere conducive to teamwork and mutual accountability. 2.2.3 Attends and participates in unit meetings 2.2.4 Participates in the implementation and evaluation of unit goals. 2.3 Educate and role model the value of every individual's recovery experience. 2.4 Assists patients in articulating personal goals for recovery and determining the objectives the patient needs to take in order to teach his or her recovery goals. 2.5 Assists patients in creating a Wellness Recovery Action Plan (WRAP). 2.6 Helps patients develop and/or maintain relationships with family, friends, neighbors, and other social supports in the community.	**☐Exceptional** **☐Competent** **☐ Needs Development**

	2.7 Aides in the acquisition, development and maintenance of vocational skills by providing linkage to vocational opportunities in the community as appropriate. 2.8 Facilitates group activities on the unit such as recovery-oriented topics and themes 2.9 Documents interactions and groups in a timely manner through progress notes, treatment plans, and follow-up contacts according to agency policy and procedure. 2.10 Conducts post-discharge aftercare follow-up through phone contacts with patients 1 week, 1 month, and 3 months post-discharge.	
5%	3.0 Accepts flexible arrangement of assignments when necessary, for optimal distribution and utilization of staff to assure quality patient care. (2,5,6) 3.1 Performs clerical duties as needed, as part of the Clinical Services team. 3.1.1 Maintains a quiet, organized work area with easily accessible materials and logical work flow. 3.1.2 Contributes to the implementation of the individualized Treatment Plan, and the timely accomplishment of patient care goals and directives. 3.1.3 Contributes to the integrity and completeness of the Medical Record. 3.1.3.1 Follows procedures and standards for facsimile (FAX) transmission and receipt of all electronic patient information. 3.1.3.2 Facilitates availability of sufficient blank chart pages for documentation by each clinical discipline. 3.1.3.3 Stamps each page with patient identifying information on both sides according to standards. 3.1.3.4 Organizes chart in standard order post discharge.	☐ **Exceptional** ☐ **Competent** ☐ **Needs Development**
10%	4.0 Demonstrates leadership through role modeling, accountability and attainment of individualized performance goals. (1,2,4,5,6) 4.1 Participates in service- and unit-based inservice programs, including workshops, and incorporates content into performance. 4.2 Offers recommendations for educational programs and identifies both general and situation-specific learning needs. 4.3 Safeguards the confidentiality of patient-related information, documents and work materials.	☐ **Exceptional** ☐ **Competent** ☐ **Needs Development**

	4.4 Demonstrates responsible use of work time and benefit time, including punctuality and adequate notice of absence for emergency or illness. 4.5 Follows hospital policies and unit protocols. Meets Criteria for Age-Specific Patient Care as relevant to practice area. ADULT 4.6 Immediately reports possible signs / symptoms of domestic abuse to professional nurse or supervisor, for appropriate and timely assessment and follow-up. GERIATRIC 4.6 Immediately reports possible signs / symptoms of abuse or neglect to professional nurse or supervisor, for appropriate and timely assessment and follow-up.	
5%	5.0 Participates in centralized Clinical Services department activities, including education, performance improvement, and committee work, in order to maintain department standards.(2,5,6) 5.1 Participates in department in-service programs and Workshops, and incorporates content into performance. 5.2 Serves on committee as appointed. 5.3 Demonstrates knowledge and support of Performance Improvement initiatives. 5.3.1 Assists in the collection of data; participates in its interpretation and use.	☐ **Exceptional** ☐ **Competent** ☐ **Needs Development**
5%	6.0 Performs other duties as assigned, in order to support the smooth functioning of the service team and the Clinical Services department, the timely attainment of their objectives, and their effective relationship with the larger hospital system. (1,2,4,5,6,7) 6.1 Participates in hospital, medical staff, departmental, or unit team committees and task forces as assigned. 6.2 Supports development, community relations, customer service and human resources activities. 7.0 Performs other duties as needed, requested or assigned.	☐ **Exceptional** ☐ **Competent** ☐ **Needs Development**

RATIONALE FOR ESSENTIAL FUNCTIONS:

1. The performance of this function is the reason the job exists.

2. There are limited employees among whom the performance of this function can be distributed.
3. This function occupies a great deal of the employee's time.
4. This function is highly specialized. Employees are hired for the skill/ability to perform this.
5. Failure to perform this function may have serious consequences.
6. The function was performed by past employees, and is performed by current employees.
7. Exposure to blood borne pathogens that requires use of personal protective equipment.

WORKING CONDITIONS:

1. Work with potentially aggressive individuals; physically intervene in aggressive behaviors.
2. Care for patients with infectious diseases.
3. Occasional exposure to unpleasant patient elements.
4. Contact with patients under a wide variety of circumstances.
5. Handle emergency or crisis situations; may perform emergency care.
6. Exposure to wetness in patient areas (tub, shower room).
7. Requires judgment/action which could result in death of a patient.
8. Participate in manpower pool.
9. On occasion, escort patient off the grounds.
10. Requires sufficient stamina to be able to rotate shifts and remain alert on the night shift.
11. Requires reporting to work in spite of inclement weather and other external events.
12. Requires remaining with assignment until relieved.
13. Use computer to enter and retrieve information.
14. Requires reaching, stooping, bending, kneeling.
15. Occasionally subjected to irregular hours.
16. Occasionally asked to transport patients or accomplish errands in the hospital vehicle, after receiving Approved Driver status.
17. Must agree to record searches in accord with Pennsylvania statute.

The above statements are intended to describe the general nature and level of work being performed. They are not intended to be construed as an exhaustive list of all responsibilities, duties and skills required of personnel so classified.

_____Date_____

Director, Human Resources

_____Date_____

Director of Spiritual Care

I have reviewed this job description with the employee and provided a copy to the employee.

_____ _____ _____

Supervisor Signature Job Title Date

I have received and reviewed a copy of this job description. I understand that my performance evaluation is based upon the content of this job description.

_____ _____

Employee Signature Date

Director of Spiritual Care –Internship-Externship Programs 12/2012,

Appendix D

Peer Specialist Position Description, JFK

Title: Certified Peer Specialist, MET Team

Reports To: Division Director

Location: JFK Behavioral Health Center

112 North Broad Street

Job Purpose: To promote and contribute to a culture of recovery within and outside JFK by creating hope and optimism for their peers.

Duties and Responsibilities

1. Assist in the development of a culture of recovery and self-determination through building peer relationships, sharing personal achievements, and exposure to successful experiences.

2. Engage with persons in recovery, by identifying their strengths and existing supports and linking them with community resources.

3. Create a partnership with peers and family members by sharing information about support services and resources available through the community.

4. Provide education for persons in recovery, staff, and family members.

5. Serve as a community liaison.

6. Complete all required program documentation.

7. Attends staff meetings to contribute to case conferences.

8. Attend other required meetings, trainings, and continuing education courses as recommended by direct supervisor.

9. Adhere to all JFK polices and procedures including confidentiality, HIPAA, compliance, etc.

10. Assist in handling peer crisis situations at JFK and in the community.

11. Perform outreach activities to re-engage peers in program activities, in person or by telephone.

12. Perform other duties and responsibilities as directed by the Division Director, and/or designee.

Appendix E

Certified Peer Specialist, MET Team – page 2

Position Qualifications Required:

I. Education, Training and Experience:

- Peer Specialist Certification. Must take CEU credits to maintain certification.
- Current or former recipient of mental health, and/or co-occurring services with a willingness to share personal recovery experiences.
- High school diploma or GED.
- 12 months paid or volunteer experience over the past three years, or one-year post secondary education totaling 24 credit hours.

II. Other Requirements:

- Proficient in verbal and written communication
- Ability to share recovery experiences and support others in their recovery process.
- Ability to establish relationships with peers.
- Strong interpersonal and problem solving skills.
- Ability to work a flexible schedule, including nights and weekends.

<u>Physical Requirements/Working Conditions:</u>

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. Travel is required for this position.

1. Frequent stair climbing, walking within the community even under inclement weather conditions such as heat, cold, ice, etc..
2. Ability to sit, stand, bend and walk for extended periods of time.
3. Must be able to lift and/or move up to 10 lbs.
4. Must be proficient in English with ability to read, write and speak.

_____ _____

Employee Signature Date

_____ _____

Manager Signature Date

Append	Monday	Tuesday	Wednesday	Thursday	Friday
8:30	Preparation	Preparation	Preparation	Preparation	Preparation
8:45					
9:00		Community Meeting – TE1	Community Meeting - TW1	Community Meeting – TE2	Community Meeting – TW2
9:15					
9:30					
9:45	Community Meeting – BN2				
10:00			Hillside Group		
10:15					Orientation for TW2 New Clients
10:30					
10:45	*Break*	*Break*	*Break*	*Break*	*Break*
11:00			Follow-Up Calls (CRC)	Orientation for TE2 New Clients	Follow-Up Calls (CRC)
11:15		Recovery Road Show – TE1			
11:30					
11:45					
12:00					
12:15	*Lunch*	*Lunch*	*Lunch*	*Lunch*	*Lunch*
12:30					
12:45	Unit Introduction for BN2 New Clients		Unit Introduction for TW1 New Clients		
13:00		Unit Introduction for TE1 New Clients			
13:15				Discharge Check-in for TE2 Clients	Recovery Road Show – TW2
13:30			Recovery Road Show – TW1		
13:45					
14:00					
14:15	Discharge Check-in for BN2 Clients				
14:30		*Break*	*Break*	*Break*	Break
14:45	*Break*	Discharge Check-in for TE1 Clients		Recovery Road Show – TE2	
15:00					
15:15	Recovery Road Show	Follow-Up Calls (CRC)			
15:30					
15:45			Discharge Check-in for TW1 Clients		Discharge Check-in for TW2 Clients
16:00					
16:15	Statistics	Statistics	Statistics	Statistics	Statistics

Appendix F

Post-Discharge Follow-up Consent Form

FRIENDS HOSPITAL	**Post- Discharge Follow-up Call Consent**	

What is a post-discharge follow-up call?

A follow-up call is a telephone call you can receive in the days following your discharge from the hospital. It is made by a staff person whom you met during your hospital stay. The staff person will ensure that you have the information about aftercare that you received from your treatment team. For some people, having a familiar voice on the phone is a nice way of transitioning back to their life outside of the hospital.

Do I have to get a follow-up call?

No – this is a service you can choose. No one will call you unless you sign this consent form.

How many follow-up calls can I get?

Typically people who choose to receive a follow-up call are telephoned twice.

Will the person leave a message?

If you choose, the staff person can leave a message. The message will not contain any private information, but the person will say that he or she is from Friends Hospital.

Can I call the staff person to talk?

You are welcome to call the hospital's Warmline if you feel speaking with a Certified Peer Specialist would be helpful. The warmline is open ___ between ___ and ___. The number is _____.

Consent for Follow-Up Call	
My preferred contact phone number is:	If you cannot reach me, it's okay to call: Name:_____ Phone:_____ Relationship:_____
The best time of day to reach me is: _____Morning _____Afternoon	
If the call goes to voice mail, you may leave a message. Yes_____ No_____	Interpreter Needed? Yes No Language_____

By signing below, I give consent for a Friends Hospital Representative to contact me after I am discharged in order to provide support for my recovery.

Individual's Signature:	Date:	Time:
FHP Staff Signature:	Date:	Time:

Appendix G

Sample Follow-up Call Documentation Form

FRIENDS HOSPITAL	Follow Up Call Documentation *(Pilot)*	

Client Name:
Discharge Date:
Inpatient attending psychiatrist:

Caller:	
Date of call:	**Time of call:**
☐ Initial Call	☐ Follow-Up Call (Number) __
Caller left message: **Y N**	

Follow-up call check-list (outgoing follow-up calls)			**Comments**
Personal Empowerment Plan reviewed with client	Yes	No	
Outpatient appointments reviewed with client	Yes	No	
Client asked about additional resources accessed	Yes	No	
Client guided through resource directory	Yes	No	
Client directed to crisis support	Yes	No	
Client directed to inpatient treatment team member	Yes	No	

Signature & Credentials	
Signature/Title:	Date / Time: April 9, 2020 10:24 AM

Appendix H

Draft Instructor's Agenda

People **E**ngaging and **E**mpowering **R**ecovery **R**esponses Through Crisis

Philadelphia Crisis Response Centers 2-Day Institute

For: Institute for Recovery & Community Integration (A program of MHASP)

Description: This 2-Day Institute is intended for multi-stakeholder groups seeking to further recovery-oriented practices into crisis response support services. Participants will be engaged in facilitated dialogues to learn from experiential perspectives, understand current research and be a part of planning next steps for implementation.

Objectives: Through this Institute participants will be able to:

1. Define recovery principles into their practice of support
2. Describe a recovery based response to crisis situations
3. Identify several key tasks of peer support in a CRC setting
4. List challenges, tools and actions steps to implementation of recovery and peer support

8:30 -8:45 **Registration**

8:45 -9:30 am **Welcome/Introductions**

- Welcome
- *Context of the initiative*
- *Overview of the schedule*
- *Learning objectives*

9:30-10:15 **Keynote "Help that Helps and Help that Hurts"**

- *An engaging presentation that based on presenters journey of recovery including support that helped and didn't help.*

10:15 – 10:30 **BREAK**

10:30 -10:45 **Participant Introductions and Guidelines for Learning**

10:45 am – 11:30 **Recovery to Practice**

- Institute speaker presents on foundation recovery orientation providing information on background, need, research, literature and basic principles of recovery.

11:30 -12:30 pm **Crisis and Peer Support Creating a Culture of Recovery**

- This section focuses on the concept, literature, research and principles of peer support as well as peer specialist as a method of offering peer support formally as a part of our services.

- **Peer Support and Crisis-**After going over the didactic information ask participants to think about the qualities of peer support they said was helpful on those lists made earlier as well as points made in the presentation. In small groups they should discuss barriers need in the crisis centers that might make it difficult to implement those helpful qualities of a peer support relationship. Reconvene as a large group to discuss those barriers and prioritize 5, or less, barriers.

12:30 - 1:30 **LUNCH**

1:30 – 2:30 **Panel Presentation (Psychiatrist CPS, other's who have implemented CPS in Crises Centers)**

2:30 - 2:30 **BREAK**

2:30 - 3:15 **Team Wellness Recovery Action Planning**

- Introduce a basic overview of WRAP® and the value on a personal and team level. Present the key concepts as a basis for our thinking to create change around the barriers we just discussed.

3:15 -3:45 **Planning for Recovery & Peer Support**

- Using the 5, or less, themed changes that have been captured previously break into teams to begin to tackle the need for change. Each group has two tasks: 1) develop a "wellness toolbox," list of accessible and doable tools that can help in addressing these challenges.) 2) Describe what peer and recovery supports "look like" when it is implemented well in the CRCs, i.e. what are the kinds of things that the peers are doing, what do all staff interactions look like etc…

3:45 - 4:00 **BREAK**

4:00 - 4:30 **Planning for Recovery & Peer Support cont'd**

4:30 -5:00 pm **Evaluations, Preview of next day and Check Out**

Day Two

8:30 – 8:45 **Registration**

8:45 -10:00 **Welcome Back**

- *Institute trainer checks in with the group inviting people help review what was discussed in the previous day or ask "what was a big take away lesson you got from the day?" Flip chart these responses. Next you might ask what new questions or unanswered questions do you now have about Recovery and Peer*

support. Orient people to the day's agenda including that today you will be taking the barriers mentioned in the previous days and the "tools" to develop team action plans to.

10:00 -10:45 **Peer Specialist and Trauma Informed Care**

- This module will be more on the role of Peer Specialist and other peer based resources that promote alternative crisis responses. We make the connection on the values and ethics of good peer support as a natural fit to the principles of trauma informed care. Key point is that people in crisis are most likely responding to what has happened to them not what is "wrong with them." This section could conclude with a role pay by the Institute modeling both peer based responses and non-peer based response and tasking the group to discuss what they are seeing.

10:45 – 11:00 **BREAK**

11:00 am – 11:45 **Keynote**

11:45 -12:30 pm **Action Planning**

- Preparing for the rest of the day of action planning facilitate the "comfort agreement" in the context of moving forward with the changes discussed in this course and working together the rest of the day to develop next steps. With a large group you may have people break into small groups to develop their guidelines and come back to the group to share what their group guidelines are. This should be a document and process for the CRCs to continue in their working together not just for today.

12:30- 1:30 **LUNCH**

1:30 – 2:30 **Action Planning Continued**

- After checking back in, have group go back to their small groups. Their tasks are to take the barriers previously identified and come up with at least three essential steps. Steps should address individual member's taking action and administrative/organizational actions that can be observed and have time frames. They should be referred to the "Toolbox" for resources on these steps and the "what we look like" for the possible observable change from the action steps.

2:30 -3:30 **Sharing Implementation Planning**

- Large group reporting

3:30 – 3:45 **BREAK**

3:45- 4:30 **Team Wellness Recovery Action Planning**

- Come back to WRAP® but now in the context of individual "burn out" and even trauma that is present for all crisis service workers. Engage audience to think about their wellness tools, Daily Maintenance Plans but be clear that this is only a teaser to how it could benefit the workforce. Conclude with next steps on how an organization can offer WRAP to its workforce.

4:30 -5:00 pm **Evaluations, Preview of next day and Check Out**

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CERTIFIED PEER SPECIALIST TRAINING

COURSE OVERVIEW

The Institute for Recovery and Community Integration is a program of the Mental Health Association of Southeastern Pennsylvania

Curriculum Table of Contents

Managing Our Differences

Session 6 Managing Our Differences

Module 1- Cultural Competency.

Module 2- Group Facilitation

Engagement Strategies

Session 7 Working With People Who Appear Unmotivated

(from Pat Deegan's Videotape Presentation)

Session 8 Engagement Strategies

Module 1 – The Cycle of Engagement

Module 2 – Problem Solving

Workplace Issues & Boundaries

Session 9 Co-occurring Disorders and Boundary Issues in Peer Support

Module 1 – Introduction to Co-Occurring Disorders

Module 2 – Boundary Issues in Peer Support

Session 10 Workplace Issues and Practices

Module 1 – Proficiency Test Workplace Practices

Module 2 –Test

Attachments Session Evaluation Forms

Introduction

The course material in this manual has been developed within the framework of a ten- session format. It is designed for a maximum of 20 participants. Each session corresponds to one day of training. Additionally, each session contains two modules (a morning module and an afternoon module), sometimes covering distinct topics, and sometimes a continuation of the same topic. The training sessions are designed to run from 9:00AM – 5:00PM each day. Each module is approximately 3 ½ hours in length with a scheduled 15-minute break. A one-hour lunch period is included in this time frame.

This curriculum is designed to give a general overview, or a thorough introduction to the topics presented. It is comprehensive in its scope in that it covers a wide variety of material. It is also a curriculum that is designed to be presented in 10 days. As such, it cannot present all the material that there is to know about a particular topic. Participants will use this training experience as a starting point as well as a stepping-stone to increasing their

knowledge and expertise in providing peer support services. It is important that the trainers emphasize this point with participants numerous times throughout the length of the curriculum presentation.

Participants' prior knowledge of the material and current understanding of the material as it is presented can serve as an assessment for their understanding of their own developmental needs as peer support specialists. That is to say, it will ground them in the key philosophies of recovery and peer support, develop and/or enhance their helping skills set, and identify the areas where they need continued growth and education.

The key philosophical mind shift that trainers want to observe in the participants is the notion of what it is that makes peer support services different than traditional mental health services (see accompanying Shery Mead articles, Peer Support: A Theoretical Perspective, 2001; and Peer Support: What Makes it Unique, 12/04). Traditional mental health services are often predicated on the medical model, focusing on diagnosis, functional deficits, maintenance of symptoms, dependence on the system, and one-sided power relationships. Peer support services are founded on a recovery-oriented model that focuses on mutual relationship, collaboration, individual consumer strengths, skills development, personal choice, interdependence and community integration.

Peer specialists do not pathologize an individual's experience, that is to say, relegate all their thoughts and feelings to the category of symptoms of illness, rather they help individuals understand their subjective experiences and develop strategies and skills to maintain wellness. Peer specialists do not create dependency and attempt to solve an individual's problem, rather they help the person thoroughly explore the issue that is presenting difficulty, and teach the necessary skills for individuals to successfully identify and follow through on their own solutions. Peer specialists work with individuals to help them identify and participate in valued roles of their choice in the community beyond that of "mental patient." Peer specialists must not simply become "consumers" providing mental health services in the traditional medically-oriented model.

A Note About Confidentiality

A key concern in all group work and a key norm to be established in the Peer Specialist Training is that of confidentiality. It is not only the trainers who have the responsibility to keep the confidences of the participants, but the participants themselves who are bound to keep each other's confidences. All group members are responsible to respect the confidentiality of all of the personal sharing done by participants throughout the training – including the large group discussions, small group exercises, and role playing exercises. This point should be reviewed periodically by the trainers throughout the length of the course.

Additionally, participants should be reminded regularly that they have the right to control the personal information that they share in the large and small group discussions. They are in charge of their self-disclosures and need only disclose that which they are comfortable disclosing. Hopefully, as the trusting environment builds over the course of the training curriculum, participants will feel comfortable in appropriately disclosing more of themselves.

Training Design

The **Certified Peer Specialist** curriculum is designed with recovery as the core value. It places the consumer at the center of decision-making, believing that personal choice is a fundamental element of a recovery-oriented system of care. Recovery is a deeply personal and unique experience and it is this participant internal resource that the training is designed to develop and nurture. The curriculum is developed within the framework of a three-tiered design focusing on providing:

1. education,

2. skill building, and
3. an experiential process.

1. Education:

Training sessions are designed to provide an atmosphere that is conducive to learning core philosophies, helper attitudes, concepts, and skills related to recovery and peer support. Education is important component in a recovery model. It is a key factor in making good decisions about treatment, lifestyle, career, relationships, living arrangements, recreation and free time.

2. Skill Building:

Training sessions are designed to provide a "hands-on" experience translating concepts and skills into practice. Skill development is a key focus with time allotted for skill demonstration, participant behavioral rehearsal, instructor feedback, large/small group process and discussion. Key skills such as active listening, group facilitation, personal sharing, helping skills, problem solving, and others are incorporated into the training program.

3. Experiential Group Process:

Training sessions are designed to provide an experiential process to parallel potential Certified Peer Specialist practice expectations. The curriculum is designed to help solidify learning by relating each session of the training encounter to the participant's personal experience of recovery. Training participants will participate in small group dialogues throughout which will give them the opportunity to do this.

By participating in the training, it is expected that participants will:

a. gain new knowledge;

b. develop new skills;

c. increase their personal awareness; and

d. enhance their personal recovery.

Session Goals and Module Objectives

Each session starts with a statement of the goals for that particular training session. These goal statements give a broad outline of what each session is designed to facilitate. Following the goal statements is a more specific listing of the teaching objectives for each module. It is important that each trainer understands the goals and objectives for each session and the incorporated modules. Additionally, a description of the resources needed to facilitate the module, resources or handouts provided to the participants (see **participant workbooks** below), and approximations of the time needed for the module are presented. As noted above, trainers need to be thoroughly familiar with the content of all the article handouts prior to conducting the training.

Module Agendas

The primary teaching instructions in the manual are provided in the format of a module agenda. Each module agenda lays out the time frames for each of the lecturettes, power point presentations, large group discussions, and small group exercises. Accompanying time frames for each of the segments of the module, including scheduled breaks are carefully noted.

Morning Check-in

At the beginning of each session (starting at session 2) the trainers will facilitate the morning check-in process. The purpose of the check-in is to provide participants an opportunity to ask questions or make comments on any issues covered in the previous day's session. Trainers facilitate the discussion and ask if there are any issues or points of clarification needed. Depending on the time frame, group participation, and assessment of the previous day's session, the trainers may also provide a brief review of the previous day's material.

Additionally, this time is used for individual participants (who are willing) to share excerpts from their journaling or other forms of creative expression (see **homework assignments**). Trainers encourage all group members to share their journal entries across the length of the 10-day course. At their discretion, trainers may also facilitate an appropriate group "icebreaker" to start the day.

Session Review, Closure Activities and Evaluation

Daily Summary

At the end of each session, trainers take a few minutes to briefly walk participants through a review of the day's material highlighting the important topics that were covered. Trainers welcome participant comments and questions during this time. The objective is to give the trainers the opportunity to highlight the key points discussed throughout the day as well as to give participants the opportunity to clarify any information that remains unclear to them.

Preview of Next Session

The trainers should briefly inform the participants what topics/issues will be presented at the next session. Trainers will need to have reviewed the agenda for the next day at this point. Any preparation that might be expected of the participants should be discussed at this time (see homework assignments).

Homework Assignments

Homework assignments can be used as a way to help training participants integrate the material they are learning throughout the course of the training. In this curriculum, homework is optional and the trainers do not check to see if participants have completed it. That being said, the trainers strongly encourage each participant to follow through with homework assignments. Generally, there are three types of assignments used regularly in this curriculum: (1) reading the supplemental articles at the back of each session in the participant workbook; (2) preparing for self-disclosure to be used in group exercises scheduled for a given day; and (3) journaling.

1. **Reading the Supplemental Articles**

Some of the training sessions have additional reading material included in the Participant Manual. These are generally in the form of articles on which the material for the session was founded or that attempt to provide supplemental information to the session. When these articles are present, the trainers should refer participants to them and encourage them to review the material at their leisure.

2. **Preparing for Self-disclosure**

Some of the training sessions (e.g., skill building modules such as active listening, problem solving) expect some level of role-play self-disclosure on the part of the participants. Participants are free to completely role-play their part, that is to say, "make it up as they go along" or share something real from their personal life. In any case, the role-play scenarios should not be overly complicated so as to make it too difficult to pay attention to the skills being demonstrated. When the following session will require this kind of participation from the group,

trainers need to inform the members what will be expected of them so that they can be prepared at the appropriate times.

Important Note: The focus of the role-playing and the self-disclosure during these skill-building modules is solely on the role of the peer specialist demonstrating the skill being presented. Participants playing the role of the "consumer" in these role plays need to understand that the role play is not designed for the group to focus on the issues that they bring to the role play – it is on the skill being learned. More often than not, participants will not come to a resolution of the issues they bring to the role-play scenario. Because of time constraints, the role-play will be cut off and the feedback from the group will focus solely on the skills performed and how they can be enhanced by the person demonstrating them. Training participants need to understand this so that they do not bring potentially emotionally charged material or issues that they have not resolved into the role-play.

Additionally, it is important to remind the group about the importance of confidentiality as it was identified in the **Session 1** discussion on setting group norms or guidelines. All group members are responsible to respect the confidentiality of all of the personal sharing done by participants throughout the training – including the large group discussions, small group exercises, and role playing exercises.

3. Journaling

The benefits of journaling include, providing an out let for participant thoughts and feelings related to the course material, recovery, or any issues that are present as a result of exposure to the course material; an opportunity to think about and review the days training material; an opportunity to reflect on important issues related to recovery, peer support, employment; and an opportunity for other forms of creative self-expression, e.g., poetry, short stories, personal narratives, etc.

> **Journaling Exercise**: Participants are encouraged to experiment with journaling throughout their training experience. Participants are instructed to use the journals to document their experience in the training and their individual responses to the training program via poetry, prose, artwork, etc.

Alternatives like the one described below can be provided at the trainers' discretion.

> **Building Bridges Exercise**: Participants build (draw) a bridge on paper (or in their journal), the bridge shows how the participant might incorporate what he or she has learned today into their work or personal life (from Warm Ups and Wind Downs: 101 Activities for Moving and Motivating Groups, S. Hazouri and M. McLaughlin, Educational Media Corp., 1993).

Participants are informed that each morning session will start with an opportunity for them to share their journal entries (see **morning check-in** above).

Closing Check-out

It is extremely important for each trainer to recognize that the material covered in each session, or the information shared in both the large group and small group discussions may trigger difficult thoughts and feelings for program participants. Just as the trainers "check-in" with participants at the start of each day, so too should they do a final "check-out" at the close of the day. This check-out will give participants the opportunity to verbalize any difficulty they are experiencing or think they may be likely to as a result of the day's session. The group can offer "peer support" for an individual if it is necessary and appropriate at this point and/or the trainers can spend one-on-one time with a participant if necessary to help develop a plan to deal with whatever issues may have arisen for the participant.

In the closing checkout participants go around the group and share one word that describes how they are feeling. Participants can check-in with each other regarding feelings shared to get clarification on what each member is communicating. Facilitators remind the group that we are all a support resource for each other throughout the training and that if individuals need support, they need to ask for it.

An alternative checkout activity can be substituted here at the trainers' discretion as long as it meets the objectives for the exercise as described above.

Session Evaluations

Getting participant feedback on a daily basis is an important component in the ongoing design and development of the training curriculum. Individual training evaluation forms are included in the participant workbooks for each session. It is the trainers responsibility to make sure that participants are given a moment to complete the evaluation form at the end of each session and to see that the forms are all regularly collected so they can be analyzed upon completion of the training curriculum.

Knowledge and Skills Assessment

Training participants will have to pass a knowledge-based test, either true-false, multiple choice, or a combination of both.

Additionally, participants will be asked to demonstrate appropriate skills taught throughout the course, for example, active listening, problem solving, and motivational enhancement strategies. All facilitators meet after each week to discuss participants using the following weighted performance evaluation. The lead facilitator will ensure that participants receive their WRAP Certifications, and week one test score along with an evaluation letter in a sealed envelop for confidentiality. One facilitator should be designated to be available during breaks or lunch to address participants' questions or concerns about their evaluation. Feedback should be provided to participants at the beginning of the second week about their strengths and areas of improvement as well as the points they are accomplishing (see evaluation letter). The purpose of this is to allow the participant to successfully meet the requirements and gage where they stand mid-way. Facilitators use the sign in sheets to track attendance, indicate punctuality, and note whether home work was shared. Participants must have at least 140 points total for certification.

The following is a weighted scale to judge the participants progress.

- Exam 60 points
- Attendance 30 points (-5 for each unexcused day absent)
- Punctuality 10 (-1 Each day participant is 5 minutes late -2 if 10 min or more)
- Participation: 100 points
    - Participant demonstrates active listening in group activities and class discussion -20 points
    - Participant volunteers as a speaker or recorder for the group; shares homework or discloses personal story to enhance classroom discussion pertinent to the topic -20 points
    - Participant asks relevant questions frequently -20 points
    - Demonstrates understanding of new material in class discussion -20 points
    - Interacts with peers in group consistent with the principles of peer support. - 20 points

Certified Peer Specialist Training

Group Participation Guidelines

In an effort to ensure our work together is productive, collaborative, and safe, we recommend the following group participation guidelines.

Respect

Trust

Confidentiality

Listen

One Person Speaks at a Time

Personal Responsibility

No Criticism (of self or others)

Be on Time

Use “I” Statements / Speak About Own Experience

Others:

Values and Competencies

This document outlines the recovery values embraced by the Institute for Recovery and Community Integration Certified Peer Specialist Program and the competencies that certified peer specialists (CPS) will have following training.

Recovery Values

Hope

Hope is the foundation for recovery—the belief in an individual’s potential to experience a full and satisfying life and the belief that change is possible.

Individuality

Recovery is a unique and personal journey. It is directed by and embraces the individual rather than dwelling on the illness. Recovery respects individuals’ cultural and spiritual differences as well as their special needs.

Self Awareness

By observing and monitoring our thoughts, feelings and behaviors, we become more self aware and empowered to take positive steps toward our own recovery.

Self Determination

Everyone is encouraged to make his or her own informed choices about his or her life and support systems and is personally responsible for these choices.

Meaningful Life

Everyone is entitled to an individually determined life that allows him or her to pursue various roles beyond that of consumer.

Respect

Everyone treats themselves and one another with respect and is respectful of their own and others' choices.

Peer Support

Peer support is a highly valued resource that offers hope through the unique empathy and understanding that come from peer relationships.

Community Focus

A recovery supportive environment provides the opportunity to live in, be connected to and flourish within the community of one's choosing, with access to those community supports and resources that will best promote one's own recovery.

Advocacy

Everyone is offered opportunities to be his or her own advocate and a voice for recovery.

CPS Competencies

Respect

Have a positive demeanor and be empathetic and calm. Be able to respect the desires of the individuals receiving services and their reference group or culture.

Engagement and Mutual Trust

Be able to relate to the individual receiving services based upon where he or she is in the recovery process, utilizing strategies such as affirmation, to build an open relationship and develop mutual trust.

Communication

Have the skills necessary to adapt verbal and written communication to the language style of the individual receiving services and his or her family. Demonstrate active listening skills.

Social and Cultural Factors

Be knowledgeable about how cultural and socioeconomic status affects the recovery of the individual receiving services. Be able to identify social and cultural resources that can facilitate recovery.

Confidentiality

Maintain and reinforce the importance of confidentiality while encouraging inclusion of support system members.

Minimizing Stigma

Understand the importance of reducing prejudice and discrimination. Be able to confront personal prejudices, manage discrimination and advocate for reducing discrimination in the community.

Goals

Be able to help the individual receiving services identify and organize personal goals in the areas of learning, work, leisure and living. Be able to help the individual gain employment, education and/or meaningful activity, when desired. Know how to support his or her unique pace toward goal achievement.

Basic Needs

Know how to elicit choices regarding basic needs (such as financial resources, food, shelter and safety) from the individual receiving services.

Community Resources

Be able to help individuals receiving services access housing, transportation, self-help organizations, mutual support groups and peer companion services. Be able to provide information regarding other treatment and rehabilitation programs and opportunities.

Family and Natural Support System

Be skilled at assessing the preferences of the individual receiving services regarding family involvement. Be knowledgeable about the role of the family and others in recovery and rehabilitation. Be able to help him or her identify and utilize natural supports.

Education

Be able to educate about mental illness, medications and rehabilitation. Be able to communicate the value of recovery, rehabilitation and medication treatment.

Rehabilitation

Be skilled in using current recovery and psychiatric rehabilitation approaches. Be able to teach goal-setting and problem-solving skills, and living, social and illness self-management skills.

Coordination of Care

Be skilled at coordinating service planning and provision. Know the importance of having a fixed point of responsibility for implementation of an integrated care plan, and of including all service providers, the individual receiving services and his or her support system.

Crisis Resolution

Know how to use and teach effective crisis intervention approaches and be aware of the preferences of the individual receiving services regarding previous, successful interventions.

Some material excerpted from “Set of Core Clinical Competencies for Providing Care to Individuals with Severe Mental Illness,” Young, Forquer, Tran et al. *Journal of Behavioral Health Services and Research, 2000.*

Session 1: Orientation to the Certified Peer Specialist Program

Session 1 Goals:

- Educate participants about the Certified Peer Specialist Program expectations;
- Identify participant training expectations;
- Educate participants about the CPS program Values and Core Competencies;
- Identify guidelines for group participation throughout the program;
- Provide participants with a small group experience where they can begin to get to know each other, develop trusting relationships, and experience group process;
- Introduce the concept of boundaries in relationship development;
- Provide background for current support of recovery beliefs in the field
- Gain a firm understanding about the role of Peer Specialists and what they do.

Session 1 - Module 1: Program Orientation and

Participant Introductions

Objectives: By the conclusion of this training module

participants will be able to:

- Identify program and personal expectations for their training experience;
- Identify program values and core competencies;
- Identify at least one unique characteristic about the members in their small group;
- Share personal information about their own life stories;
- Identify qualities of the group process that made it safe for them to discuss information about themselves;
- Discuss the need for boundaries in relationship development;
- Identify one core competency they want to develop over the course of the training.

9:00 – 9:15 ***Welcome and Trainer Introductions***

9:15 – 9:45 ***Introductions of Training Participants***

9:45 – 11:00 ***Orientation to Training Program***

11:00 – 11:15 ***BREAK***

11:15 – 11:30 ***Stepping Stones Exercise: Part 1***

11:30 – 12:00 ***Stepping Stones Exercise: Part 2***

12:00 – 12:30 ***Process Stepping Stones Exercise.***

12:30 – 1:30 ***LUNCH***

Session 1 - Module 2: The Emergence of Recovery Concepts in Behavioral Health

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify personal definitions of recovery;
- ❖ Discuss common recovery themes identified in the literature;
- ❖ Understand the current focus on recovery in the field of behavioral health;
- ❖ Discuss how assigning behavioral health diagnoses can be dehumanizing when not coupled with People First language.
- ❖ Contrast traditional versus recovery belief worldviews of participants.

1:30 – 2:00 ***Teaching Session: Concepts of Behavioral Health Recovery***

2:00 – 2:45 ***Activity: Seeing Ourselves and the World through Our Diagnosis***

2:45 – 3:00 **BREAK**

3:00 -3:20 ***Activity: Advantages of Knowing about Our Diagnoses***

3:20-4:00 ***Recovery Initiatives***

4:00 – 4:30 ***Activity – Overcoming the Shackles of the Medical Model***

4:30 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 2: Recovery and Peer Support

Session 2 Goals:

- ❖ Continue to provide participants with a small group experience where they can work to develop trusting relationships, experience group process, and to share their recovery story;
- ❖ Lead participants to explore and discuss their own definition/vision of recovery;
- ❖ Educate participants about the role of *peer support* in recovery, and explore personal experiences with peer support in personal recovery.

Session 2 - Module 1: Visioning Our Recovery

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Creatively identify and express their own definition/vision of recovery through arts and crafts.

9:00 – 9:30 ***Check-in***

9:30 – 10:00 ***What Recovery Means To Me Exercise: Part 1 – Individual Work***

10:00 – 11:00 ***What Recovery Means To Me Exercise: Part 2 – Group Presentation***

11:00 – 11:15 ***BREAK***

11:15 – 11:30 **Continue *What Recovery Means To Me Exercise:***

Part 2 – Group Discussion

11:30 -12:30 ***Exploring Peer Support Exercise***

12:30 – 1:30 **LUNCH**

Session 2 - Module 2: Exploring Peer Support

Objectives: By the conclusion of this training module

participants will be able to:

- ❖ Identify and discuss the core components of peer support;
- ❖ Identify and describe peer support activities helpful in supporting another person in recovery;
- ❖ Share their personal experience with peer support throughout their recovery;
- ❖ Practice a strengths based approach to learning about their fellow peers.

1:30 – 2:15 ***Teaching Session*: *Exploring Peer Support***

2:15 - 3:15 ***Defining the Role of the Peer Specialist***

3:15 – 3:30 ***BREAK***

3:30 – 4:30 ***Activity: Getting to Know Your Peers***

4:30 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 3: Introduction to WRAP: The Wellness

Recovery Action Plan

Session 3 Goals:

- ❖ Provide training participants with a small group experience where they can continue to develop trusting relationships, experience group process, and share their recovery story;
- ❖ Educate training participants about the key behavioral health recovery concepts of hope, personal responsibility, education, self-advocacy, and support (Copeland);
- ❖ Educate training participants about the development of a Wellness Recovery Action Plan (WRAP);
- ❖ Provide training participants with the experience of developing their own WRAP;
- ❖ Provide training participants with stress reduction/ relaxation exercises and peer listening experience.

Session 3 - Module 1: Key Recovery Concepts &

Developing a Wellness Toolbox

Objectives: By the conclusion of this training module

participants will be able to:

- ❖ Identify and explain the key recovery concepts of hope, personal responsibility, education, self-advocacy, and support (Copeland);
- ❖ Share personal information about how one or more of these concepts plays a role in their personal recovery;

- ❖ Understand and discuss the concept of the Wellness Toolbox;
- ❖ Develop their own personal Wellness Toolbox;
- ❖ Identify and experience at least 2 stress reduction techniques.

9:00 – 9:15 ***Check-in***

9:15- 9:30 **Brief Introduction to WRAP and its 7 Areas (slides 1-8)**

9:30 – 10:15 ***Teaching Session***: ***Key Recovery Concepts***

10:15 – 10:45 **Issues that need to be Addressed (Slides 22-26)**

10:45 -11:00 **BREAK**

11:00-11:45 **Teaching Session: Developing a Wellness Toolbox**

11:45 – 12:15 **Rela*xation and Stress Reduction Techniques***

12:15 – 12:30 ***General Process Session***

12:30 – 1:30 ***LUNCH***

Session 3 - Module 2: The Daily Maintenance Plan

& Identifying Triggers

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify and explain the *daily maintenance plan* and *identifying triggers* components of the Wellness Recovery Action Plan (Copeland);
- ❖ Share personal information in the development of these sections of their own WRAP;
- ❖ Explain the benefits of "peer listening" and identify the steps involved in a peer listening relationship.

1:30 – 2:30 ***Teaching Session***: ***The Daily Maintenance Plan***

2:30-3:00 ***Teaching Session***: ***Triggers (Slides 46-47)***

3:00 – 3:15 ***Break***

3:15-3:45 ***Teaching Session***: ***Triggers Action Plan (Slides 48-49)***

3:45 – 4:15 ***Peer Listening Experience***

4:15 – 4:45 ***Process the Peer Listening Experience: Large Group.***

4:45 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 4: Introduction to WRAP: The Wellness Recovery Action Plan

(continued)

Session Goals:

- ❖ Provide training participants with a small group experience where they can continue to develop trusting relationships, experience group process, and share their recovery story;
- ❖ Educate training participants about the development of a Wellness Recovery Action Plan (WRAP);
- ❖ Provide training participants with the experience of developing their own WRAP;
- ❖ Educate training participants about the development of the Crisis and Post Crisis Planning components of the Wellness Recovery Action Plan (WRAP);
- ❖ Provide training participants with the experience of beginning their own Crisis and Post Crisis Planning components of WRAP.

Session 4 - Module 1: Early Warning Signs and

When Things Are Breaking Down

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify and explain the early *warning signs* and *when things are breaking down* components of WRAP;
- ❖ Identify and explain the *crisis* and *post crisis* sections of the WRAP;
- ❖ Share personal information in the development of these sections of their own WRAP.

9:00 – 9:15 ***Check-in***

9:15 – 10:45 ***Teaching Session***: ***Early Warning Signs and Early Warning Signs Action Plan (Slides 50-53)***

10:45-11:00 **BREAK!**

11:00-12:30 ***When Things Are Breaking Down and When Things Are Breaking Down Action Plans (Slides 54-57)***

12:30 – 1:30 ***LUNCH***

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify and explain the key *crisis planning* and *post crisis planning* components of the Wellness Recovery Action Plan (Copeland);
- ❖ Share personal information in the development of their own WRAP Crisis Plan.

1:30-3:00 **Teaching Session Crisis Plan (58-74)**

3:00- 3:15 **BREAK!**

3:15-4:00 ***Teaching Session Post Crisis Planning (Slides 75-79)***

4:00-4:30 **Lifestyle Issues (Slides 82-96)**

4:30 - 4:45 ***Video Presentation – Large Group Discussion***

4:45 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

5: Communication Skills

Session 5 Goals:

- ❖ Continue to provide participants with a small group experience where they develop trusting relationships, experience group process, and share their recovery story;
- ❖ Review and relearn the core components of effective communication;
- ❖ Educate participants in *Active Listening*, including non-verbal or attending skills, and verbal or reflecting skills;
- ❖ Examine individual attitudes that may serve as barriers to effective communication;
- ❖ Practice communication skill building.

Session 5 - Module 1: Active Listening

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify and explain the core components of effective communication;
- ❖ Understand and discuss the process of active listening;
- ❖ List and discuss common barriers to effective communication.

9:00 – 9:15 ***Check-in***

9:15 – 9:30 ***Basic Model of Communication***

9:30 – 10:30 ***Active Listening Techniques***

10:30– 10:45 ***Barriers to Effective Communication***

10:45- 11:00 ***BREAK***

11:00 – 12:30 ***Skill Building Practice Session#1***

Non-Verbal/Attending Skills

12:30 – 1:30 ***LUNCH***

Session 5 - Module 2: Active Listening Skills Practice

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Demonstrate understanding of and ability to practice the major listening skill clusters in the process of active listening.

1:30 – 3:00 ***Skill Building Practice Session #2***

Verbal/Reflecting Skills

3:00 – 3:15 **Break**

3:15 – 4:00 ***Large Group Demonstrations and Feedback***

4:00-4:30 **Quiz on week one topics**

4:30 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 6: Managing Our Differences

Session 6 Goals:

- Introduce participants to the concept of cultural competence, broaden their understanding of what culture is, provide an opportunity to process the impact that certain aspects of culture have had on their lives;
- Increase participants understanding of the importance of cultural influences/factors on personal recovery.
- Continue to provide participants with a small group experience where they develop trusting relationships, experience group process, and share their recovery story;
- Educate participants about the stages of group development, roles within the group process, and develop group facilitation skills.

Session 6 - Module 1: Cultural Competence

Objectives: By the conclusion of this training module participants will be able to:

- Define and discuss the many different aspects of culture;
- Explore and discuss their own cultural heritage with group members;
- Identify at least 2 critical roles that culture plays in the recovery process;
- Identify and discuss a four step process for developing cultural competency;
- Identify at least one positive step that they can take to begin to increase their cultural competency.

9:00- 9:15 **Check In**

9:15-10:45 ***Teaching Session: Introduction to Cultural Competence***

- Ice Berg Exercise
- Cultural Heritage Exercise

10:45- 11:00 **BREAK**

11:00- 12:30 ***Teaching Session: Introduction to Cultural Competence***

- Continue with Cultural Heritage Exercise.

12:30-1:30 **LUNCH**

Session 6- Module 2: Group Facilitation Skills

Objectives: By the conclusion of this training module participants will be able to:

- Identify and discuss the stages of group development,
- Understand and identify the roles that group members have within the group process,
- Discuss effective group facilitation skills to handle difficult situations that may arise in the group.

1:30 – 2:30 **Teaching Session: *Group Facilitation Skills***

2:30 – 3:00 **Group Exercise: Part 1** (slides 19-20)

3:00 – 3:15 **BREAK**

3:15 – 3:45 **Group Exercise: Group B**

3:45 – 4:00 **Large Group Process of Exercise**

4:00 – 4:30 **Handling Difficult Situations** (slides 23-36)

4:30 – 5:00 **Wrap-up, Homework Assignment, and Check-out**

Session 7: Working With People Who

Appear Unmotivated

(Based on the Pat Deegan video series:

Beyond the Coke and Smoke Syndrome)

Session 7 Goals:

- Educate participants about differing perspectives on motivation, including drug induced apathy, moral judgments, learned helplessness, and stages of change;
- Educate participants about possible action steps to take to address issues brought up by each different perspective;
- Provide participants with additional resources for self-help strategies dealing with troubling symptoms;
- Provide participants with a small group experience where they continue to develop trusting relationships, experience group process, and share their recovery story

Session 7 - Module 1: Reframing the Question

of Motivation – Part 1

Objectives: By the conclusion of this training module participants will be able to:

- Discuss Pat Deegan's concept of the *coke and smoke syndrome*;
- Discuss reasons for looking at an individual's apparent "lack of motivation" from different perspectives;
- Identify and discuss the key principles of the following perspectives:
  - drug induced apathy,
  - moral judgments;
- Identify and discuss possible action steps to take to address each different perspective;
- Share personal experiences of their own recovery with group members.

9:00 – 9:30 ***Check-in***

9:30 – 10:00 ***Teaching Session*: *Video Tape Module 1***

10:00 – 11:00 ***Teaching Session: Video Tape Module 2***

11:00 – 11:15 ***BREAK***

11:15 – 12:30 ***Teaching Session: Video Tape Module 4***

12:30 – 1:30 ***LUNCH***

Session 7 -Module 2: Reframing the Question of Motivation – Part 2

Objectives: By the conclusion of this training module participants will be able to:

- Discuss reasons for looking at an individual's apparent "lack of motivation" from different perspectives;
- Identify and discuss the key principles of the following perspectives:

- learned helplessness,
- stages of change;

- ❖ Identify and discuss possible action steps to take to address each different perspective;
- ❖ Share personal experiences of their own recovery with group members.

1:30 – 2:30 ***Teaching Session: Video Tape Module 6***

2:30 – 3:30 ***Teaching Session: Video Tape Module 7***

3:30 – 3:45 ***BREAK***

3:45 – 4:00 ***Individual Work: Motivation Exercise***

4:00 – 4:30 ***Small Group Work***

4:30 – 4:45 ***Large Group Process***

4:45 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 8: Engagement Strategies & Problem Solving

Session 8 Goals:

- ❖ Continue to provide participants with a small group experience where they develop trusting relationships, experience group process, and share their recovery story;
- ❖ Educate participants about the cycle of engagement in relationship development;
- ❖ Educate participants about Peer Support interventions related to the stages identified in the Recovery Process Model;
- ❖ Role play engagement strategies as Peer Specialists;
- ❖ Educate participants in effective problem solving strategies;

Session 8 - Module 1: The Cycle of Engagement

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Understand and discuss the cycle of engagement including, outreach, engagement, relationship, and empowerment;
- ❖ Identify and discuss the key ingredients of engagement, empathy, listening, affirmation, encouragement, and acceptance;
- ❖ Identify and discuss peer support interventions related to the recovery Process Model.

9:00 – 9:15 ***Check-in***

9:15 – 9:45 ***Teaching Session: The Cycle of Engagement***

9:45 – 10:15 ***Teaching Session: Recovery Process with CPS Interventions***

10:15 – 10:45 ***Engagement Role Plays***

10:45 – 11:00 ***BREAK***

11:00 – 12:00 ***Engagement Role Plays (continued)***

12:00 – 12:30 ***Large Group Process of Engagement Strategy Session***

12:30 – 1:30 ***LUNCH***

Session 8 - Module 2: Problem Solving

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Identify the negative consequences to which ineffective problem solving can lead;
- ❖ Identify common pitfalls of effective problem solving;
- ❖ Identify and discuss the signal value of distress;
- ❖ Discuss and demonstrate effective problem solving strategies;
- ❖ Lead a one-on-one peer discussion teaching the problem solving method.

1:30– 2:30 ***Teaching Session***: ***Introduction to Problem Solving***

2:30-3:00 ***Group Process in Problem Solving***

3:00- 3:15 ***BREAK***

3:15- 4:30 ***Small Group Work in Pairs***

4:30-4:45 ***Large Group Process of Exercise***

4:45- 5:00 **Wrap-up, Homework Assignment and Check Out Session Evaluations!**

Session 9: Intro to Co-occurring Disorders & Workplace Issues and Boundaries

Session 9 Goals:

- ❖ Provide training participants with a small group experience where they continue to develop trusting relationships, experience group process, and share their recovery story;
- ❖ Understand the definition and role of co-occurring disorders in our community
- ❖ Discuss the relationship between addiction and mental illness and effective approaches for the peer specialist
- ❖ Educate participants about the development of professional ethics and the concept of dual relationships in the context of providing peer support services;
- ❖ Review developments in the behavioral healthcare environment that have led to changes in traditional medical model boundary delineations;
- ❖ Teach participants sound principles of ethical decision-making and explore boundary dilemmas that may be encountered in their work.

Session 9 – Module 1: Introduction to Co-occurring Disorders

Objectives: By the conclusion of this training module

participants will be able to:

- ❖ Discuss the prevalence of co-occurring disorders;
- ❖ Identify the historical obstacles to receiving effective treatment for co-occurring disorders;
- ❖ Identify and discuss the commonalities between addictions and mental illness;
- ❖ Identify and discuss the benefits of integrated treatment;
- ❖ Understand and describe the relationship between the stages of change and the stages of treatment;

- ❖ Identify helpful peer support interventions appropriate to stages of change.

9:00 – 9:15 ***Check-in***

9:15- 10:45 ***Teaching Presentation: Introduction to Co-occurring Disorders***

10:45-11:00 ***BREAK***

11:00-11:30 ***Teaching Session: Motivational Approaches***

11:30 – 12:30 ***Group Work: Case Studies***

12:30 -1:30 **LUNCH**

Session 9 - Module 2: Boundary Issues in Peer Support

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Understand the development of professional ethics;
- ❖ Understand and discuss the concept of dual relationships in the context of providing peer support services;
- ❖ Identify and discuss recent developments in the behavioral healthcare environment that have led to changes in traditional medical model boundary delineations;
- ❖ Understand and practice sound principles of ethical decision making in their roles as Certified Peer Specialists;
- ❖ Explore and resolve a number of potential boundary dilemmas they may encounter in their peer support relationships.

1:30-3:00 ***Teaching Session: Identifying Boundaries in Peer Support***

3:00- 3:15 ***BREAK***

3:15- ***3:45 – Ethical Decision Making Boundary Scenarios*** (slide 39)

Small Group Work

3:45-4:15 – ***Ethical Decision Making Boundary Scenarios*** (slide 39)

Large Group Discussion

4:15- 4:45 – ***Clear Boundary Violations*** (slides 40-46)

4:45 – 5:00 ***Wrap-up, Homework Assignment, and Check-out***

Session 10: Work place Issues and Boundaries (continued)

Session 10 Goals:

- ❖ Provide training participants with a small group experience where they continue to develop trusting relationships, experience group process, and share their recovery story;
- ❖ Explore ambivalences about eminent work experiences;
- ❖ Facilitate group process in the development of a workplace WRAP;
- ❖ Review common workplace standard operating procedures.

Session 10 - Module 1: Workplace Practices

Objectives: By the conclusion of this training module participants will be able to:

- ❖ Verbalize anxieties and fears related to approaching employment experience;
- ❖ Verbalize strengths they believe they bring to their new position;
- ❖ Develop a workplace WRAP to help deal with workplace stressors.
- ❖ Understand and discuss standard workplace operating procedures, including calling out sick, supervision, handling conflicts, complying with agency policies and procedures.

9:00- 9:30	**Check In**
9:30- 11:00	***Teaching Session***: ***Workplace Practices***
11:00-11:15	**BREAK!**
11:15 – 12:30	***Teaching Session***: ***Workplace Practices (Continued)***
12:30 – 1:30	**Lunch**
1:30 – 2:15	**Course Review**
2:15 – 3:00	**Proficiency Test**
3:00 – 5:00	**Celebration and Check Out**

Certified Peer Specialist Curriculum

Resources

(References bolded are included in the CPS Instructor Manual)

Session One

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Appendix J

Mental Health Association of Southeastern Pennsylvania
Institute for Recovery and Community Re-integration

Certified Peer Specialist Supervisors' Orientation Training

Overview: This two day session is designed to equip managers and supervisors with the knowledge and skills to operate a peer specialist service as well as support Peer Support Specialists in the workplace. Through shared experiences which include individual and group activities, participants will learn theoretical, historical, and practical aspects of recovery and community integration as they pertain to peer support services. This training also includes a review of Performance Management concepts and skills which incorporates Blanchard's Situational Leadership Model.

Day One: Recovery and Peer Support

Learning Objectives:

 Be able to readily discuss the principles of recovery, peer support and the role of the Certified Peer Specialists.

 Delineate the necessary steps for successfully implementing a peer support initiative within their agencies and program teams.

 Become familiar with the state Medicaid requirements for Peer Support

Services.

Day Two: Performance Management and Peer Support Specialists

Learning Objectives:

 Describe the process of Performance Management, its sub-component parts, and its relationship to Peer Support Specialists.

 Learn how to utilize their agency's performance management system to supervise peer specialists.

 Review ADA guidelines and OMHSAS' Clarification of Act 169 as it pertains to Peer Support Specialists.

THIS PROGRAM IS APPROVED BY THE NATIONAL ASSOCIATION OF SOCIAL WORKERS (PROVIDER #: 886566365-9635) FOR 13.5 SOCIAL WORK CONTINUING EDUCATION CONTACT HOURS.

Appendix G Einstein/Germantown Crisis Response Center Evaluation Form

Please tell us how you feel about this visit…

Please answer the following questions about your experience here at the Crisis Response Center.

Name_____(optional) Date of Visit_____ Time of Visit_____

Strongly Disagree Disagree Neutral Agree Strongly Agree

I felt that the staff cared about me.

The nursing staff treated me with courtesy and respect.

I felt safe at the Crisis Center.

I felt empowered to make choices.

I felt included in forming my treatment goals.

I felt supported in identifying my strengths.

I feel like people listened to my issue.

I understood the plan of treatment.

I believe the plan will help me reach my goals.

I believe that my decisions have an impact on my Recovery.

I feel hopeful about my Recovery.

I feel my personal values and beliefs were honored.

I learned something about myself or my illness.

I was satisfied with the outcome of the visit.

Comments: