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Assessment #1

Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention

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**Enhancing the Medicaid Peer Provider Workforce:
Recruitment, Supervision and Retention**

This document has been produced by the National Association of Consumer/Survivors Mental Health Administrators, state mental health department senior managers committed to expanding the participation of consumers/survivors in all aspects of the public mental health system. This guidance is intended to increase the successful capacity of the peer provider workforce within behavioral health systems and authorities through recruitment and hiring, and supervision and retention efforts. It builds on the larger policy and practice work of a recovery oriented and evidenced based mental health model of care for recipients of mental health services. Funding for this project has been provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Peer support is an evidenced based practice that is an important workforce component in behavioral health care. Although peer services have been around for many years, Georgia was the first state to implement peer services as a Medicaid billable service in 1999, and as of July 1, 2014, 32 states plus Washington, D.C., also allow Medicaid reimbursement for these services. With health care reform and the integration of behavioral and primary health, an opportunity exists for peer support services to find a meaningful place in a new venue—primary care. Peer providers can play a meaningful role in primary and behavioral health while simultaneously easing the burden on over-stretched staff due to shortages in the behavioral health workforce. As states rolled out peer provider services it was not without challenges. Nanette Larson, BA, CRSS, Director of Recovery Support Services for the Illinois DHS/Division of Mental Health, said they were challenged by a lack of understanding about peer services from the community agencies, employees and consumers. They created and distributed documents and resources to help improve the understanding in the provider community and conducted many training events with providers and potential peer providers to help increase understanding across the lines.

Faith Boersma, BA, Coordinator for the Office of Consumer Affairs in Wisconsin, said they experienced similar challenges. Wisconsin used strategies to bring together people to build commonalities by holding a large kickoff event with peers, providers, administrators and other stakeholders.

Both Nanette Larson in Illinois, and Katherine Roberts, MPH, South Carolina Office of Consumer Affairs, said supervision has been challenging. Nanette has several tools that she makes available to any supervisor who asks for assistance. They are included in the appendix.

The toolkit is designed to be brief and guide community providers and state hospital administrators to integrate peer providers into their recovery-oriented services or to expand them. **A wealth of material has been written on recruiting and hiring, but very little on supervision and retention. This toolkit will emphasize these two areas.** The toolkit includes a list of resources.

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I. Benefits of Provider Services to the Service Delivery System

- ▶ Peer provider services are recognized as evidenced based.
- ▶ They are creative, non-traditional, and beneficial to individuals using traditional services.
- ▶ The evidence of peer services in traditional settings can be effective or more effective than other services. (Gates and Akabas, 2007)
- ▶ Empowerment, meaningful relationships, and opportunities to improve their lives are benefits to people engaged in these services.
- ▶ Recovery, resiliency and wellness are components of peer provider services.
- ▶ Peer providers serve as role models, modeling recovery to other staff, families and peers receiving behavioral health services.
- ▶ Substance use peer recovery support and other recovery support activities demonstrate improved relationships with providers and social supports, increased satisfaction with the treatment experience overall, reduced rates of relapse, and increased retention in treatment. (Reif, 2014) Note: There are concerns that the methods used in the studies do not distinguish the effects of peer recovery support from other recovery support activities)

Benefits of Peer Provider Services to Individuals

- ▶ Reduced substance use
- ▶ Reduced hospitalization and crisis services
- ▶ Improved quality of life and health
- ▶ Improved self-esteem
- ▶ The (re)discovery of hope
- ▶ The development of relationships of trust

Benefits to the Peer Provider

- ▶ Healing benefits from role as helper
- ▶ Social support from other co-workers and reciprocity with the people they serve
- ▶ A sense of self-sufficiency and self-efficacy due to increased income
- ▶ Purpose to their lives through meaningful work

"In my humble opinion, the power of Peer Support, in hospital and community mental health settings, is more significant and valuable than any other evidence-based practice I have ever seen. I started, with guidance from Gayle Bluebird, to integrate peers into mental health work settings back in 1991. In every work arena since, peer support staff were the "magic makers." The innate skills of peer support workers are legendary in my personal experience. And at this point I strongly believe that at least 50% of the mental health provider system needs to be peer support workers if we are to get to a system of care that is truly recovery oriented, trauma informed, ADA compliant, and where people with serious mental illness can find hope, courage and the energy to recover their lives in a way that works for them."

Kevin Huckshorn. PhD, RN, MSN, CADC, Director, Division of Substance Abuse and Mental Health, Delaware Health and Social Services

A. Definition of Peer Provider

“A peer provider (e.g., certified peer specialist, peer support specialist, recovery coach) is a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency.”

SAMHSA (See List of Resources)

SAMHSA Working Definition of “Recovery”

“A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

SAMHSA (See List of Resources)

B. What Peer Providers do

They facilitate support groups and work one-on-one with individuals who use mental health services and in integrated health settings. They share their personal recovery stories and assist people in learning recovery skills and self-management skills for other chronic health conditions. They advocate with individuals for what they need. They provide support during crises. They provide Medicaid peer provider billable services. They are an equal part of the clinical team, although they do not provide clinical services.

What Peer Providers do not do

They do not give medical advice or advice about medications. They do not make diagnoses or tell people what they should do. They are not a substitute for a doctor or counselor, and they do not provide psychotherapy.

C. Sampling of Peer Provider Job Titles

As a best-practice model for supporting people who have been diagnosed with mental illness and/or substance use disorder, peer support can be one of the most significant tools a person can use on the journey to recovery. This model relies on individuals who live with mental illness to provide peer-to-peer support to others, drawing on their own experiences to promote wellness and recovery. Peer support is about getting help from someone who’s been there. Based on mutual respect and personal responsibility, peers share with one another their experiences, their strengths, their hope—a powerful combination for recovery.

► **Certified Peer Specialist** – Individuals who have progressed in their recovery, who are trained in their state in the competencies of the peer support specialty and certified to work as a peer provider.

► **Whole Health and Resiliency Peer Specialist** – A trained and certified peer provider who supports and motivates individuals to improve their health, wellness and resiliency. This service is identified with the integration of mental health/substance use and physical health care services.

► **Forensics Peer Specialist** – Individuals who have been diagnosed with mental illness and/or substance use and who have been incarcerated. They are trained and certified to work in jails and prisons, in jail diversion programs, and with referrals from mental health courts and drug courts to provide ongoing support to individuals to avoid incarceration in the future.

► **Recovery Support Specialist** – Recovery Support Specialists use their personal recovery experience to facilitate and support others in their recoveries. They are individuals in recovery from mental illness and/or substance use. They work in community agencies and state hospitals.

D. Additional Types of Peer Support

▶ **Family and Youth Peer Support** – Family and youth peer support helps to build resiliency in care givers and youth. It also strengthens the capacity of families who care for their children at home.

▶ **Veteran Peer Support** – Veterans in recovery from a mental health and/or co-occurring condition are trained and certified to help other veterans with symptom management, goal setting, skills acquisition and other aspects of community integration.

▶ **Peer Support for Older People** – Peer providers are trained and certified into a specialization to work with older people.

▶ **Firestarters** – Native American peer leaders responsible for building local recovery communities.

▶ **Promotoras: Bilingual Peer Specialists** – This peer-to-peer support method offers a culturally competent and cost-effective way to reduce mental health stress in Spanish speaking communities.

II. Challenges to Peer Provider Integration

▶ Other staff attitudes towards peer workers and recovery – Some staff believed that people with mental health problems are “too sick to work.” Some thought that peers were cheap labor and unable to handle the stress of working and that they “dumbed down” the professional staff. These attitudes foster stigma and discrimination in the workplace. (Gates and Akabas, 2007)

▶ Role transformation and conflict – One problem is that other staff would pathologize the behaviors of peer workers as symptoms of illness or relapse rather than typical work-related stress, which is a discriminatory practice stigmatizing peer workers.

▶ Lack of clarity about confidentiality – Some staff perceptions is peer providers should not have access to client records because they believed peers are less trustworthy and would share information with others.

▶ Peer jobs and salary range not well defined – Integrating the peer provider position within the agency or hospital can cause success or failure for peer providers and their services.

When they are not compensated at the same level as other comparable jobs, when they lack clear performance standards and have no path for promotion, they are less likely to receive quality supervision. The positions will be seen as dead-end jobs. This is considered tokenism.

▶ Lack of support – Supervision is an important support to peer providers; when it's not taken seriously, peer providers can flounder. Peers need support as they transition to the new role of peer provider from that of recipient of services. They need both an internal and external support network.

“It was a little rough going at first, mostly with one psychiatrist articulating to his team that I should not be involved in someone’s treatment, because ‘I am, mentally ill’ as well.”
Name withheld

“The supervision issue seems to be the one that is ‘hottest’ right now. The new retention challenge is providers ‘stealing’ great RSS staff from other providers.”
Nanette Larson
Illinois

- ▶ Finding qualified individuals – Some individuals want to be peer providers but they lack the proper training. They do not have the necessary skills for the responsibility of the requirements of a Medicaid billable service, such as writing skills to document notes, organizational skills to meet documentation deadlines, or computer knowledge to use an electronic medical record. (See List of Resources: South Carolina Peer Support Services)
- ▶ Criminal Background Checks – Some individuals in recovery who are qualified to be peer providers fail background checks and are not hired. More information is often needed regarding the fail background check to see if they may have been arrested but not convicted, convicted but not incarcerated, or convicted of a non-violent crime.
- ▶ Working at the agency where peer provider receives services – If an individual serves as a supervisor and a mental health provider to the same person, an unethical dual relationship on the part of the supervisor is created that loses sight of appropriate boundaries.
- ▶ Ethics and Boundaries – Policy and practices regarding ethics and boundaries need to be clarified. Peer providers should always operate under a code of ethics. Other professionals' codes of ethics do not apply to peer providers and the services they provide. (See List of Resources: Peer Support National Ethical Guidelines)

A. Integrating New Peer Services

Leadership Strategies

For successful integration of peer providers and services, the board of directors and executive management staff in community agencies and governing body and management staff of state hospitals must be committed to hiring people in recovery as peer providers.

- ▶ Board of Directors and hospital governing bodies must review vision and mission statements to reflect recovery in their vision and peer providers and their services in their mission.
- ▶ Strong leadership role supporting the vision and mission and commitment to peer providers is essential to shifting the culture or continuing to shift the culture to a recovery-oriented service system. This must be clearly communicated to all staff and people who use agency and hospital services.
- ▶ Identify champions among management staff and other staff who will take a leadership role in assisting with the transition and implementation of peer provider services as one way to succeed.
- ▶ Define and plan your peer provider services with peers using your services and multiple stakeholders. Your peer support plan should be well thought out, identifying your peer program in a recovery-oriented service system including cultural competence.

Readiness Assessment for Peer Workforce Integration

- ▶ Conduct an assessment to determine if the agency is prepared to integrate peer providers and their services. (See List of Resources: Advocating and Planning for a Behavioral Health Peer Support Program)

- ▶ Based on the assessment, prepare the existing workforce by conducting sensitivity training about the integration of peer providers. Focus on attitudes, stigma and discrimination in the workplace, Americans with Disabilities Act, communication of vision and mission, and other training needs identified by the assessment to integrate peer providers successfully.
- ▶ Adopt the policy of (and provide training on) using people-first, recovery-based language, such as referring to “a person with schizophrenia” rather than a “schizophrenic.” (See List of Resources: Boston University)
- ▶ The goal of your workplace environment needs to be a stigma-free/discrimination-free workplace.
- ▶ Once you have a safe place for workers with mental health issues that is free from stigma and discrimination, other workers who may be experiencing mental health problems will know it’s safe to seek help.

Policies Review and Development

- ▶ Human Resources needs to promote peer provider integration by reviewing policies and practices that may impact peer providers, such as recruiting and hiring staff. Write universal policies for all staff; do not target peer providers. For example, write policies and procedures to safeguard staff members who have dual relationships or to safeguard staff from exploitation and marginalization.
- ▶ Review the HR policy and procedure on fingerprinting and background checks to see if it will exclude peers from being hired based on their criminal history. For example, some peers may fail a background check because of their criminal history with drugs or alcohol or some other reason. Also, look into state requirements for background exemption; there may be an appeal process or waiver that can be filed so that the individual can be hired. Be aware, the state may exclude certain criminal activity that they will not consider waived, such as domestic violence, other violence, and an arrest or conviction of sexual molestation or an arrest or a conviction of rape.
- ▶ When it comes to arrests without conviction, a conviction without a term of incarceration, or a conviction of a non-violent crime, a best practice related to criminal background checks is that policies and procedures be tailored to the essential job requirements and the actual circumstances under which the job will be performed rather than the criminal history. (See List of Resources: EEOC Enforcement Guidance)
- ▶ Policies on criminal background checks should be that any exclusion for hiring individuals with a criminal background should be job-related for the position and consistent with business necessity.
- ▶ Review your health insurance policy to see how it will affect hiring peer providers. Peers may have health insurance coverage gaps as they transition to employment. One strategy is Medicaid buy-in for working people with disabilities or extending the period of eligibility.
- ▶ Identify policies, procedures and structures that other agencies have in place to assist the development of the peer workforce over time.

Define Position, Write Job Descriptions, Salary Ranges and Benefits

- ▶ Develop clearly written job descriptions and performance expectations for peer providers, including the essential functions of the job.
- ▶ Identify the purpose of the peer provider (whole health, forensic, etc.) before you consider the essential tasks/responsibilities required to perform the job.
- ▶ For purposes of hiring the best qualified individual, list knowledge, skills and abilities needed to perform the essential functions of the job. Best practices include requirement that applicants must be in recovery and current or former recipient of services, must be trained and certified as a peer support provider, and list the minimum qualifications, such as high school education or GED, age 18 or older, etc.
- ▶ Provide benefits counseling will help prepare peers to make informed choices about the number of hours to work if they are transitioning to working for the first time, ensuring they do not lose crucial benefits, like housing, until they have successfully integrated into the workforce and increase their working hours.
- ▶ Ensure salary ranges are competitive and comparable to other jobs.
- ▶ Provide access to the same benefits package that other employees receive.

Peer Support as a Medicaid Reimbursable Service (See Map of [Medicaid Peer Provider States](#), page 14)

- ▶ Once Medicaid became a funding source for peer providers, standardization in training and experience were required.
- ▶ Implement Medicaid requirements for billing peer provider services: (1) “peer providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. ...ongoing continuing educational requirements for peer support providers must be in place.” (2) “Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.” And (3) “peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.” (See List of Resources: CMHS SMDL #07-001)

Training and Certification of Peer Providers for Medicaid Reimbursement

- ▶ Determine if your state has an established peer provider training and certification as a requirement for billing Medicaid for peer services.
- ▶ Training programs must include competencies that peer providers need to achieve in order to deliver the best peer services.
- ▶ Many peer provider training and certification programs include a Code of Ethics, setting standards that peer providers abide by when delivering services. The Code of Ethics can address dual relationships between peers receiving services and peer providers who are friends, among other issues.

- ▶ State programs may require periodic training for recertification of the peer provider credential.
- ▶ Programs must require a number of annual hours for continuing education credits to maintain certification.
- ▶ Train peer providers about documentation standards and on how to write properly documented progress notes into the clinical record.

Find Funding Sources to Hire Peer Providers

- ▶ After defining the peer service, find funding sources to train and hire peer providers and to implement the services. Possible funding sources include state VR agencies, state and local health departments, state and local criminal justice departments, U.S. Department of Labor, and the U.S. Department of Justice. Agencies can also use funding streams from existing unfilled positions or eliminated positions and divert the funding to peer provider positions.

Evaluation of Peer Services

- ▶ Once you have implemented the new services, be sure to monitor progress and make changes as needed along the way.
- ▶ Evaluating your peer service is important in the design of your peer support service.
- ▶ A good evaluation program will identify what peer support looks like, delivery of peer service, and demonstrate the impact it has on the quality of life and health outcomes of people using the service.
- ▶ Evaluation will highlight areas needed for improvement, a critical process in sustaining your peer provider service.
- ▶ Evaluation will enable you to highlight the outcomes of your peer service. Outcomes are crucial for securing funding.
- ▶ Consider evaluating the cultural competency of your peer services too.

B. Strategies for Recruiting and Hiring of Peer Providers

Plan first and take the time to define the role of the peer provider within the work environment and clinic services. This must be a thoughtful process with a well-developed plan of action to ensure you do not hire a person with a disability who is not qualified to perform the *essential functions of the job, even with or without a reasonable accommodation*.

Recruiting

- ▶ All advertising may include a statement that reads: “Position requires experience as a former or current user of mental health services.” This statement ensures that the target population applies.
- ▶ To help applicants meet the minimum qualifications, include wording such as “paid or volunteer work can substitute for paid work year for year.”
- ▶ Recruiting individuals with life experience of having a mental illness and/or substance use disorder into these positions will need wording that supports the hiring process, such

as “must self-disclose as a current or former user of behavioral health services” and “must have personal experience with recovery.”

- ▶ Recruit qualified individuals by screening them to ensure that they meet the minimum requirements as identified in the job announcements.

- ▶ Recruit applicants from existing Peer Provider Training lists of individuals who are certified and ready for employment. Other strategies for recruiting applicants include contacting peer groups or peer-run organizations, seeking referrals from the state rehabilitation division/department, contacting student employment offices at local community colleges or universities, running ads in daily newspapers and neighborhood newspapers, listing openings on websites that post job announcements, and sending announcements to state employment services.

Hiring

- ▶ Follow universal policies on hiring employees and establish minimum requirements so that hiring a peer is not any different from hiring any other employee.

- ▶ Establish a selection committee to interview candidates, select the top candidate, and refer the top candidate’s information to Human Resources for reference checks, background checks, and fingerprinting.

- ▶ Add at least two peers who use your services to your selection committee to involve essential stakeholders in the selection process. Others to include on your selection committee are one of your champions, the peer provider supervisor, and anyone who will be coaching or mentoring the peer provider.

- ▶ Value the need to attract and hire qualified peers on the same level as other equivalent positions.

- ▶ Create a pleasant experience for the new peer provider’s first day of work. For example, assign a buddy to show the peer provider the office layout and make introductions to other staff; provide a space with a desk and office supplies.

C. Strategies for Supervision and Retention of Peer Providers

The supervision and retention of peer providers are areas that do not appear in the literature as much as recruiting and hiring. The relationship of the worker and supervisor is one reason why peers stay or leave; they are not leaving the job in many cases, they are leaving the supervisor. Retention is no different for peer provider staff than it is for any other staff. The best supervision for peer providers combines support with mentoring, coaching, and training that improves the peer’s skills and the quality of their service. This kind of supervision proves invaluable in retaining peer providers.

Supervising Peer Providers

Medicaid requires that peer providers must be clinically supervised by a competent mental health professional defined by the State. Review your State Practice Act to identify the scope and duration of supervision that peer providers will need. Clinical supervision by a mental health professional helps to ensure that the peer provides the highest standard of service delivery in the best interest of the client. The clinical

supervisor and administrative supervisor can be the same person or two different supervisors, with one focusing on clinical issues, skills training, etc. and the other on administrative issues such as timesheets, work hours, etc.

Clinical Supervision

- ▶ The best supervisors are “champions” of developing the agency peer provider workforce.
- ▶ A single supervisor may meet the Medicaid standard for clinical supervision of the peer provider to provide both clinical and non-clinical supervision.
- ▶ A good practice for clinical supervisors is to go through the peer provider training to familiarize themselves with the role and functions of the job.
- ▶ A peer in recovery with experience as a peer provider who meets the State’s Medicaid standards for a competent mental health professional can provide clinical supervision of peer providers.
- ▶ A clinical supervisor also needs to be involved in interviewing applicants for peer provider positions.
- ▶ Supervision must be regular, accessible, and meaningful. Schedule regular face-to-face meetings for clinical supervision.
- ▶ Supervisors must be available for consultation at all times for peer providers, at least by phone.
- ▶ Extra supervision, training and/or mentoring can ease a peer provider’s shift into the provider role and the workplace.
- ▶ Clinical supervision is supervision of the peer provider’s practice issues and not administrative issues. It has more to do with a peer provider’s career development in relation to training and the required skills needed to perform their duties.
- ▶ Review peer providers’ documentation and coach them on documentation standards. Provide training as needed on how to write notes in the clinical record.
- ▶ Clinical supervision should include discussion of issues such as job and role clarification, performance, confidentiality, disclosure, working with other staff, boundaries, and others as they arise within the peer provider’s practice.
- ▶ Make the focus of peer provider supervision on their strengths, skills and professional development.

Administrative Supervision

- ▶ An administrative supervisor assigns work duties, manages time, does administration and record keeping duties, plans and monitors workload, approves time records, approves requested days off, and resolves employee complaints and conflicts.
- ▶ Be knowledgeable about reasonable accommodations and how to apply them if or when requested. (See List of Resource: Job Accommodation Network)
- ▶ Provide and support ongoing education and training. Your State may require annual continuing education for recertification of peer providers.
- ▶ Conduct an annual performance review and develop a performance plan for the peer provider to encourage improvements in knowledge and skills.

▶ Follow human resources policies and practices in all areas of employment up to and including discipline and termination.

Mentoring and Coaching

▶ Mentoring can be a powerful professional development tool for staff, including peer providers. A mentor provides counsel, insight and guidance and is a sounding board for ideas and decisions about career goals.

▶ Whereas, coaching is a method used to assist individuals or teams to improve their performance through direction and instruction to develop skills or work toward a goal. Workshops, seminars and training events are coaching activities to learn and practice new skills.

Retention

▶ Provide good pay and competitive benefits.

▶ Provide regular feedback on how the peer is performing.

▶ Publicly recognize a peer provider's contribution to the organization.

▶ Offer flexible work schedules that recognize an employee's need for work/life balance.

▶ Create a workplace culture that is inclusive of peer providers and their services.

▶ Promote recovery services through a change in attitude and opportunities to work.

▶ Eliminate stigma and discrimination through new hire orientation and on-going staff sensitivity training.

▶ Provide individual, flexible and accessible support during the peer's transition into the workforce.

▶ Provide training and educational opportunities for peer providers to grow and be promoted along a career path of their choice.

▶ Role clarity promotes job satisfaction and retention.

▶ Hire more than one peer provider. This offers opportunities for networking and support, prevents isolation and burnout, and fosters long-term retention.

III. Expanding Existing Peer Provider Services

The changing healthcare environment presents possibilities for the expansion of peer provider services in not only behavioral health but in other health arenas as well.

A. Pillars of Peer Support

This is a national initiative designed to provide ongoing resources to promote Peer Support Services in state mental health systems. State representatives began meeting annually in 2009 and have continued meeting annually through 2014. They bring together nationally recognized experts and stakeholders from across the country to identify and create consensus around factors that facilitate peer support services in the behavioral health service delivery system. (See List of Resources: Pillars of Peer Support)

"Certified peer specialists are people who have experienced a major illness; they are in recovery and have completed extensive training that gives them the tools necessary to help others."

*Rosalynn Carter
Pillars of Peer Support*

B. NASMHPD Morbidity and Mortality in People with Serious Mental Illness Report

In 2006, the NASMHPD report indicated that people with mental illness who are dependent on the public mental health system die 25 years earlier than the general population. The report motivated behavioral health providers to investigate how to improve the health outcomes over the long term of the people they serve. The report found that approximately 40 percent die from injuries or suicide, but that 60 percent of people are dying from preventable cardiovascular, pulmonary, and infectious diseases. The report states that “state mental health authorities need to embrace two guiding principles: 1. Overall health is essential to mental health and 2. Recovery includes wellness.” They recommended that people need access to physical health care and that behavioral health and physical health must be integrated.

C. Integration of Behavioral Health and Primary Care

As a result of the NASMHPD report, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) jointly fund the Center for Integrated Health Solutions (CIHS). CIHS promotes integrated primary and behavioral health services to address the health needs of people diagnosed with mental illness and substance use disorders. The people served in the public behavioral health system have many obstacles to accessing primary health providers. They have poor health habits, such as smoking; poor nutrition and lack regular exercise; all of which contribute to health conditions such as high blood pressure, diabetes and obesity—health conditions that are highly treatable and preventable. The Center provides training and technical assistance to health care providers to create sustainable integrated services that can help to improve the overall health and wellness of people with behavioral and physical health issues.

“We are the first workforce that has come since the shift in beliefs in our strengths and that we can and do recover from mental illness. It’s a workforce that aligns itself up well to the whole person in recovery, putting mind and body back together.”

Larry Fricks

The CIHS developed the Whole Health Action Management (WHAM) program, which trains peer providers how to encourage wellness and resiliency in other people who are receiving mental health and substance use services. Georgia was the first state to expand their peer providers to become certified as Whole Health Coaches using WHAM and billing Medicaid for these services.

D. Affordable Care Act

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. The aim of the ACA is to transform healthcare in the United States by increasing access to health insurance to uninsured Americans, improving affordability of health insurance, reducing health disparities by focusing on vulnerable populations, increasing public health preparedness, expanding the healthcare workforce, improving the quality of health care delivery, and lowering health care expenditures.

The Affordable Care Act requires that mental health and substance use services be covered at the same rate as physical health services.

At the end of the first enrollment on March 31, 2014, 7.1 million people enrolled, an additional 4.8 million enrolled into the expanded Medicaid and Children's Health Insurance Program (CHIP) programs, and about 3 million young adults enrolled in their parents' insurance plans. The ACA has created an increased demand for services, causing concern that there are not enough providers to take care of everyone needing behavioral health and medical services for chronic illnesses.

"Peer support and peer supporters have a wonderful opportunity going forth with the Affordable Care Act which is very friendly to whole health and peer integrated services."

Ron Manderscheid

Prior to passing the Affordable Care Act, a study in the American Journal of Public Health estimated that 40% of people without health insurance died annually. The study estimated that in the year 2005, an estimated 45,000 people died because they lacked health insurance.

The need for behavioral health peer support is growing nationally as it is proven to be more cost effective than traditional treatment. A 2003 Georgia study found that the cost of day treatment was \$6,400 compared to \$1,000 for peer services. The study compared patients who had peer support in day treatment with those who only had day treatment services and they found that people who had access to peer support had better health outcomes and at a lower cost. (See List of Resources: Kaiser Health News)

Peer support services fit into several key objectives of the ADA: integrating into community-based care, improving the quality of healthcare delivery, lowering healthcare expenditures and reducing health disparities.

E. National Uniform Claim Committee (NUCC) New Code to Boost Peer Support Professionalism with the Veterans Administration (and State Authorities)

Since CMS approved peer provider services as a Medicaid billable service in 2007, many individuals in recovery have become paid employees within medical-model community agencies and state hospitals including the VA, which is the largest employer of peer specialists in the nation. Dan O'Brien-Mazza, Director of Peer Support Services for the Department of Veterans Affairs (VA), spearheaded the request to the NUCC, with the support of other peer leaders in the nation, for a new code.

The new classification has raised peer specialists to a professional status. Peer support specialists in the VA were told they lacked the same essential quality of personhood as in other classifications of professionals, which only added to discriminatory attitudes and practices based on their diagnosis/label. This new classification is vital to reducing discrimination in the VA. Person class codes are a provider classification system

overseen by the NUCC. (See List of Resources: VHA Directive 2012-003, Person Class File Toxonomy)

The NUCC approved the provider class for peer specialists within the Other Service Providers category, not Behavioral Health Counseling. The new classification is important to the VA as it strives to expand peer specialists into larger, whole health roles. The new code will be effective October 1, 2014. The NUCC defines the new classification as “individuals certified to perform peer support services through a training process defined by a government agency such as the Department of Veterans Affairs, or a state mental health department/certification/ licensing authority.” The new code will simplify billing and make it easier to track peer support activities and services. As a result of the new code, the bar for peer support is now raised to the same level as other professions in the field, making them equals on treatment teams and validating the services they provide. Other systems may follow.

“This classification puts peer specialists on par with other mental health professionals. It is a measure of respect and recognition of the important and valuable services peer specialists provide. It better allows peer specialists to work alongside other mental health professionals. No one can say peer specialist is not a legitimate health care profession.”
Dan O'Brien-Mazza

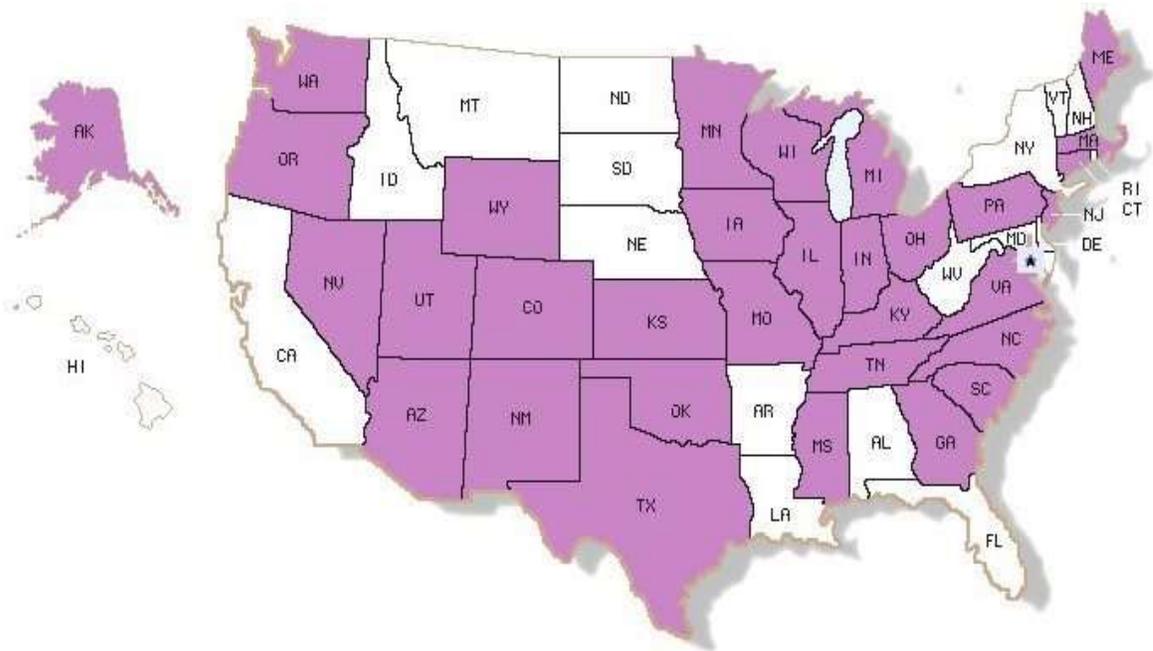
Final Thoughts

On September 4, 2014, SAMHSA released the 2013 National Survey on Drug Use and Health. (NSDUH) The report estimates that “nearly 1 in 5 adults aged 18 or older (18.5 percent) had a mental illness (i.e., “any mental illness,” or AMI) in the past year; 4.2 percent had a serious mental illness (SMI); and 3.9 percent had serious thoughts or suicide in the past year.” The report indicates that “1 in 10 adolescents (10.7 percent) had a major depressive episode (MDE) in the past year and 38.1 percent received treatment or counseling for depression the past year.” The report includes estimates for substance use disorder (SUD) in adolescents and adults, including co-occurring MDE and SUD. The report focuses on the percentage of individuals with behavioral health problems in the U.S. and those receiving treatment or counseling. (See List of Resources: NSDUH report)

Under the Affordable Care Act, it is expected that 20 million more people will be insured in 2015; 25 million people will be insured each year from 2017 through 2024; and 13 million more through Medicaid and CHIP. As more people access health insurance, there is excellent opportunity for the future growth of a peer provider professional workforce in behavioral health and primary care through integrated health services. (See List of Resources: Affordable Care Act)

It is the hope of the National Association of Consumer/Survivor Mental Health Administrators that this toolkit helps to integrate or expand peer providers and their services.

Map of States Providing Medicaid Peer Provider Services
(List of Medicaid Peer Provider States Provided by NASMHPD)



★ = Washington, D.C.

Peer Support Medicaid States ■

List of Resources

Gates, L.B., & Akabas, S.H., (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. Administration and Policy in Mental Health and Mental Health Services Research (2007) 34:293-306

<http://www.psychodyssey.net/wp-content/uploads/2012/02/Developing-strategies-to-integrate-peer-providers-into-the-staff-of-mental-health-agencies..pdf>

Reif, S, Ph.D., Braude, L., Ph.D., Dougherty, R. H., Ph.D., Danierls, A. S., Ed.D., Ghose, S. S., Ph.D., Salim, O., Ed.D., L.P.C., Delphin-Rittmon, R. E., Ph.D., (2014). Peer Recovery Support for Individuals with Substance Use Disorders: Assessing the Evidence. Psychiatric Services. Ps.pshyciatryonline.org, July 2014 Vol.65 No. 7

<http://ps.psychiatryonline.org/data/Journals/PSS/930450/853.pdf>

A Model for Reflective Practice and Structured Supervision

<http://www.brightontherapycentre.org.uk/wp-content/uploads/2011/11/Edmunds-H-2013-Model-for-Reflective-Practice-and-Structured-Group-Supervision.pdf>

A Report on Peer Support Supervision in VA Mental Health Services Depression and Bipolar Support Alliance (DBSA)

<http://www.dbsalliance.org/pdfs/surveys/Peer%20Support%20supervision%20survey.pdf>

Advocating and Planning for a Behavioral Health Peer Support Program

http://peersforprogress.org/wp-content/uploads/2014/03/20140313_advocating_and_planning_for_a_behavioral_health_peer_support_program.pdf

Affordable Care Act – Updated Estimates of Insurance Coverage

<http://www.cbo.gov/publication/45159>

Boston University Center for Psychiatric Rehabilitation, Use of Language

<http://cpr.bu.edu/about/use-of-language>

Clarifying Guidance on Peer-to-Peer Services for Children under 18, Parents/Legal Guardians

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>

Clinical Supervision Guidelines for Mental Health Services

<http://tinyurl.com/px5996k>

CMS Letter dated August 8, 2007 (SMDL #07-011)

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf>

CMS Mental Health Services

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental_Health_Services_ICN903195.pdf

Creating a Culture of Retention: A Coaching Approach to Supervision

<http://phinational.org/sites/phinational.org/files/clearinghouse/PHI-CoachingOverview.pdf>

Cultural Competency in Peer-Run Programs

<http://www.power2u.org/downloads/CulturalCompetencyInMentalHealthPeer-runProgramsSelf-helpGroups.pdf>

EEOC Enforcement Guidance of Arrest and Conviction Records in Employment Decisions under Title VII

http://www.eeoc.gov/laws/guidance/arrest_conviction.cfm

Evaluate Peer Support

<http://peersforprogress.org/take-action/evaluate-peer-support>

Family and Youth Peer Support

<http://cmhconference.com/files/2013/cmh2013-1a.pdf>

Forensic Peer Support: An Emerging Workforce

http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/forensic_issues/Policy%20Brief.pdf

Job Accommodation Network

<https://askjan.org/>

Kaiser Health News – Peers Seen Easing Mental Health Worker Shortage

<http://www.kaiserhealthnews.org/Stories/2013/September/11/peer-mental-health-workers.aspx?p=1>

Leading by Example

http://www.centreformentalhealth.org.uk/pdfs/leading_by_example.pdf

Medicaid Handbook: Interface with Behavioral Health

<http://store.samhsa.gov/shin/content//SMA13-4773/SMA13-4773.pdf>

Mental Health Recovery Philosophy Into Practice – A workforce development guide

<http://mhcc.org.au/home/publications/workforce-development-guide.aspx>

NASMHPD - Georgia's Peer Support Expansion into Whole Health

http://www.integration.samhsa.gov/health-wellness/NASMHPD-CIHS_GA_Peer_Whole_Health_Coaches.pdf

Peers as Valued Workers: A Massachusetts Road Map to Successfully Integrating Peer Support Specialist

http://transformation-center.org/wp-content/uploads/2012/02/Roadmap_long-version_final-2.20.pdf

Peer Support National Ethical Guidelines – iNAPS

<http://na4ps.files.wordpress.com/2012/09/nationalguidelines1.pdf>

Peer Specialist Training and Certification Programs A National Overview

<http://sites.utexas.edu/mental-health-institute/files/2014/07/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview-2014-Update.pdf>

Peer Specialist Toolkit – Implementing Peer Support Services in VHA

http://www.mirecc.va.gov/visn4/docs/Peer_Specialist_Toolkit_FINAL.pdf

Peer Support Within Criminal Justice Settings

<http://www.mhselfhelp.org/storage/resources/tu-clearinghouse-webinars/ForensicPeerGAINSCenter%201.pdf>

Peer Support for Health

http://peersforprogress.org/wp-content/uploads/2014/04/20140402_peer_support_in_health_evidence_to_action.pdf

Peer Support Training Providers – International Association of Peer Specialist

<http://inaops.org/training-providers/>

Pillars of Peer Support

<http://www.pillarsofpeersupport.org/>

Ready to Work: Job-Driven Training and American Opportunity (July 2014)

http://www.whitehouse.gov/sites/default/files/docs/skills_report.pdf

Reimburse of Mental Health Services in Primary Care

<http://www.integration.samhsa.gov/financing/SMA08-4324.pdf>

A Reflective Practice Model of Clinical Supervision

SAMHSA's Definition of Peer Provider

<http://www.integration.samhsa.gov/workforce/peer-providers>

SAMHSA-HRSA Peer Support

<http://www.integration.samhsa.gov/workforce/peer-providers>

SAMHSA-HRSA WHAM Training for Peer Providers

<http://www.integration.samhsa.gov/health-wellness/wham/wham-training>

SAMHSA- 2013 National Survey on Drug Use and Health (NSDUH)

<http://store.samhsa.gov/product/Substance-Use-and-Mental-Health-Estimates-from-the-2013-National-Survey-on-Drug-Use-and-Health-Overview-of-Findings/All-New-Products/NSDUH14-0904>

SAMHSA Working Definition of “Recovery”

<http://www.samhsa.gov/newsroom/advisories/1112223420.aspx>

South Carolina Peer Support Services (Sample: Training Information Packet, Definitions for Peer Support Specialists, Position Descriptions and Pay Ranges, Readiness Self-Assessment)

http://www.state.sc.us/dmh/client_affairs/peer_support.htm

Summary of Findings on Peer Specialist Training and Core Competencies Committee and Age-Specific Workgroups

http://file.lacounty.gov/dmh/cms1_194804.pdf

Supervision, Mentoring and Coaching

<http://mhcc.org.au/media/10589/wfdg-pathway-8-supervision-mentoring-coaching.pdf>

VHA Directive 2012-003 Person Class File Taxonomy

http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2477

Wellbriety – American Indian Recovery Services Coaches

<http://www.williamwhitepapers.com/pr/Recovery%20Coach%20Roles%20%26%20Responsibilities%20Coyhis.pdf>

Wellness Coaching Supervisor Manual

http://www.integration.samhsa.gov/pbhci-learning-community/peer_wellness_coaching_supervisor_manual.pdf

WHO Human Resources and Training for Mental Health

http://www.who.int/mental_health/policy/services/4_Humanresource&training_Infosheet.pdf

APPENDIX

Source: Nanette Larson, Director of Recovery Support Service, Illinois, DHS/Division of Mental Health

Supervision:

- Supervisor must be committed to concept and culture of recovery
- Employee needs to believe supervisor is supportive of recovery
- Contextual; don't coddle but address if performance seems off. Don't do "therapy" at every supervision session.
- It's a disservice to RSS in general to not hold other RSS accountable
- Support and accountability should be consistent regardless of employee's status as RSS or not
- If supervisor is new; train the supervisor
- Supervisor and employee should attend training together
- Supervisor's training should be ongoing
- Include recovery education as a regular component of quarterly/regular staff meetings

Essential qualities:

- Understand principals
- WRAP; have a WRAP of their own
- Patience
- Excellent communication skills
- A good supervisor
- Commitment to recovery/belief/hope

Challenges:

- Supervisor who don't understand WRAP; not recovery oriented
- Understanding of the expectations of the job beyond just a job description
- Clearly defined role
- Contingency plans
- Supervisors who think they are the employee's therapist
- Micromanagement

Successes:

- Supervisor who lets people do their job
- New CEO who is open to recovery/input
- Supervisor certified in WRAP
- Agency that hires person in recovery in a supervisory administrative role

Disclosure: Don't have to tell everything:

- Do use person-first language
- Do set up program that meets community needs
- Keep an open mind
- Continuing Education
- Do include employee in developing supervisory process

Supervision:

- Unique considerations
- Focus on strengths
- Decrease stress
- Boundary issues
- Focus on transition from consumer to employee
- Hardest thing is not to become their therapist
- Confused perspective on what accommodation means
- True understanding of the RSS role
- Supervisor needs supervision on this change in responsibility too
- Training
- Become familiar with concepts
- CRSS training/study guide
- WRAP training
- Advocacy
- Supportive
- Openness to learn
- Give up the "expert" role
- Ability to discuss in advance/contingency plan
- Knowledge of WRAP
- Trust
- Trustworthiness
- Self-disclosure/boundary issues
- Agency culture that is not supportive
- Any negative history or failure of the program is difficult to overcome

Successes:

- Supporting the role of RSS with other staff in agency
- Combined planning meeting
- "Wins" sharing success stories in staff meetings
- Adapting the circumstances of supervision to the individual

Do's and Do not:

- Don't micromanage
- Don't hover
- Don't theraporize
- Do clearly define role
- Do communicate
- Do at least weekly supervision
- Do provide access to supervisor outside regularly scheduled supervision time

Source: Nanette Larson, Director of Recovery Support Service, Illinois, DHS/Division of Mental Health

**Institute for Health and Recovery
Trauma-Informed Supervision Guide
*The Process of Supervision***

A trauma informed environment feels safe and welcoming to everyone. The way that staff members treat each other affects that environment and the people being served. Supervision should model the characteristics of a healthy empowering relationship so that staff members can develop similar relationships with the people being served.

A trauma-informed supervisor will:

Attend to the relationship by being aware of the impact of what they say and how they say it on their relationship with their supervisees. This includes:

Acknowledge Culture

The relationship between a supervisor and supervisee is influenced by the culture that each person comes from. By culture, we mean the attitudes, beliefs, values, assumptions and behaviors that a person has learned as result of their origins, social group and history. A trauma-informed supervisor maintains awareness of their own attitudes, beliefs, values, assumptions and behaviors as well as those of their supervisee, and pays attention to and acknowledges how these affect the relationship and the work.

Be Respectful, Honest, Kind and Fair

A supervision relationship is one in which the supervisor has more power than the supervisee. It is important to be aware of this fact. If a supervisee does not feel safe in the relationship, they will be unable to share their difficulties, doubts and struggles, and will instead try to make the supervisor think they are "on top of everything" even when they are not. It is therefore especially important to be respectful, that is to acknowledge and appreciate the supervisee's experience and point of view even when it is different from that of the supervisor.

Supervisors must be honest as well so that trust can build in the relationship over time. However, honesty must be tempered with kindness. A supervisor will need to be able to speak directly to a supervisee about the areas of work in which they still have learning to do. However, a trauma-informed supervisor will communicate the expectation that the supervisee will improve over time. Supervisors must also be fair, giving all supervisees equal treatment, regardless of differences in "likeability".

Accentuate the Positive

A trauma-informed environment focuses on and builds on people's strengths. In supervision, this means noticing and acknowledging what a supervisee is doing well, rather than addressing only the areas that need improvement.

Be Calm and Calming

When people are upset, they do not do their best thinking. When a crisis occurs or a supervisee makes a serious error, it is natural to become upset. A trauma-informed supervisor will take at least a moment to calm down before addressing a difficult situation. More time may be taken if an immediate response is not required. The goal is to be able to evaluate and discuss the situation in a calm manner. This is good modeling for the supervisee, and leads to better communication and more productive problem-solving.

Ask Questions

One goal of supervision is to encourage self-reflection and emotional self-awareness. This is sometimes called reflective supervision. We want staff members to be aware of what they are doing and why they are doing it. Asking questions and listening closely encourages people to self-reflect. In addition, asking questions prevents misunderstandings that result from mistaken assumptions.

Empower Others

The goal of supervision is to enhance the skills of the supervisee. For this reason, it is better practice to elicit solutions from the supervisee than to tell them what to do. If the supervisee cannot identify any potential solutions, it is good practice to brainstorm a number of solutions and then encourage the supervisee to select one by considering the pros and cons of each. A good supervisor allows a supervisee as much choice and control as possible.

Promote Self-Care

In the course of our work, we are exposed to painful circumstances and difficult situations that naturally stimulate feelings. Sometimes these feelings can accumulate and affect our attitudes, behavior and well-being. It is important for a supervisor to be aware of and acknowledge the impact that the work may have on all of us.

A trauma-informed supervisor models good self-care and supports supervisees in finding and implementing self-care strategies that work for them. Self-care strategies include but are not limited to healthy living; work/life balance; setting appropriate boundaries with co-workers and participants; and using peer and professional support.

Source: Nanette Larson, Director of Recovery Support Service, Illinois, DHS/Division of Mental Health

Supervision

- 1) Start with a compliment. Give specific feedback (observations/assessment); share positives and areas to improve; give direction, and clear expectations.
- 2) Ask for employee's reactions to #1
- 3) Focus on the employee's interests/needs: "What kinds of questions do you have for me?"
- 4) Offer assistance: "Is there anything you need from me right now to help you do your best in your work?"
- 5) End with a statement of belief in/appreciation for the employee