Scottish Recovery Network

scottishdevelopmentcentre for mental health

Mental Health Delivery Plan

Development of Peer Specialist Roles: A Literature Scoping Exercise

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CONTENTS

1. INTRODUCTION

The Scottish Recovery Network commissioned the Scottish Development Centre for Mental Health to undertake a scoping exercise on the Development of Peer Specialist Roles in Scotland. This paper reports on two aspects of the project;

1. A literature scoping exercise on existing models of accredited training and peer specialist roles
2. Telephone interviews with existing peer specialist / peer support projects in Scotland, and the US.

The purpose of these activities was to transfer learning on the development of peer specialist roles, to aid the creation of a model of peer support appropriate within a mental health setting in Scotland.

1.1 METHODS

Literature search

The following medical, psychology and sociology databases were searched for relevant articles:

- Medline
- PsychINFO
- Sociological Abstracts
- Social Services Abstracts
- Cochrane Library
- Web of Science

Combinations of relevant search terms were utilized, including; “peer” “consumer” “provider” “support” “specialist” “mental [health OR illness]”.

In additional to databases, the internet was searched for published grey literature.

Telephone interviews

A list of Scottish and international organisations involved in developing peer support was generated by the project Steering Group. As a result, the following agencies were approached, and agreed to take part in telephone interviews;

- The WISE Group
- Scottish Peer Education Network
- NHS Highland Transitional Discharge Scheme
- CREW 2000
- Georgia Certified Peer Specialist Project
- META Services.

The interviews lasted approximately one hour each and covered the following themes:

- The model of peer support in their organisation

- Boundary issues
- Skills, experience and abilities required by a peer specialist
- Training and supervision requirements
- How clients access the service
- Where the roles sit within the wider (mental health) system and links in with other professionals
- Steps taken to promote other professionals' understanding of the peer specialist role
- Impact of the role on:
    - On the people who are supported
    - On other staff in the organisation
    - On the wider (mental health) system.

2. DEFINING PEER SUPPORT

The concept of peer support exists in many settings and in many forms. Phyllis Solomon (2004) summarises peer support definitions as follows:[1]

Peer support is social emotional support, frequently coupled with instrumental support, which is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change (Gartner & Riessman, 1982). Mead, Hilton, and Curtis (2001) have further elaborated that peer support is "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful" (p. 135). Through the process of offering "support, companionship, empathy, sharing, and assistance," "feelings of loneliness, rejection, discrimination, and frustration" frequently encountered by persons who have a severe psychiatric disorder are countered (Stroul, 1993; p. 53). Peer support may be either financially compensated or voluntary. A peer in this context is an individual with severe mental illness who is or was receiving mental health services and who self-identifies as such (Solomon & Draine, 2001).

In different settings, different terms may be used to describe peer support activities, including peer counselling, consumer or user providers and peer education. For the purpose of clarity, this paper will refer to peer activities as "peer support", and peers who work within these initiatives as "peer specialists". Cindy-Lee Dennis (2003) suggests that peer support tends to develop in response to 3 different situations:

Transitional Stressors
Transitional stressors are those which arise from a particular situation, for example, teen pregnancy or post natal depression.

[1] Solomon, P (2004) Peer Support/Peer Provided Services Underlying Processes, Benefits and Critical Ingredients, Psychiatric Rehabilitation Journal, Spring 2004, 27, 4, pp392-401

Chronic & Acute Situational Stressors
Chronic and acute situational stressors which have prompted the development of peer support responses include diabetes, HIV and parents with children with disabilities.

Health Promotion
Peer support has also been developed to provide a health promotion function around issues such as sexual transmitted disease and substance misuse.

2.1 VALUES AND PRINICPLES OF PEER SUPPORT

According to Clay (2005), all peer support services share a number of common values; these include the “Peer principle” and the “Helpers principle”. The peer principle emphasizes the equality and reciprocity that should exist within the peer relationship, with both peers sharing learning with each other. The helper principles suggests that 'working for the recovery of others facilitates personal recovery' (Clay, 2005). These two principles may be considered the cornerstones of the peer specialist role.

2.2 DIFFERENT MODELS OF PEER SUPPORT

The literature and interviews highlighted four broad models of peer support;

1. User run drop-in
2. Formalised peer specialists
3. Training programmes for peer specialists
4. Peer education

2.2.1 User / consumer run drop-in

Peer run drop-ins are found in a number of settings and covering a range of different subjects, including: mental health, drugs and alcohol misuse, sexual health, young peoples’ health and wellbeing. Drop-ins are often set up and managed by users themselves, promoting accessibility, appropriateness, and the ability to self refer. In terms of peer roles, there are often a range of ways in which users can get involved, for example as trained peer specialists, admin roles, cleaning and management etc. However user run drop-ins, particularly those in the US, have often been set up as alternatives to traditional mental health services, and therefore may, quite deliberately, distance themselves from the wider mental health system. This can make developing a seemless pathway of care more difficult.

Examples of drop-in model

CREW 2000 in Edinburgh runs a drug misuse / sexual health drop-in shop for young people. The shop is staffed by volunteers who provide information,

and non judgmental listening to young people that drop in. Volunteers also undertake outreach work at clubs and festivals.

The Mental Health Client Action Network in California runs drop in centre staffed and managed by adults diagnosed with major mental disorders. The centre has also developed and run peer counselling training, some graduates of which are recruited to work in the drop-in, with others working elsewhere. (Schell, 2005)

The St Louis Empowerment Centre runs a range of self help groups, a friendship line, and one-to-one support. It is staffed by paid "prosumers" who provide a training and support function, and programme assistants, who may be receptionists, cleaners or staff on the Friendship line. The centre thereby offers a range of different employment opportunities, at different levels of responsibility (Minth, 2005)

2.2.2 Formalised Peer Specialists

Formalised Peer Specialists provide peer support within defined parameters, and have often undertaking a structured training programme to qualify for this position. Formalised peer specialists may work within drop-ins, stand alone teams, or increasingly within multi-disciplinary statutory teams.

Examples of formalized peer support workers

The Wise Group in Glasgow, together with the Scottish Prison Service, have recruited ex-offenders to act as Life Coaches to provide peer support to 'at risk' prisoners upon their release from prison. The project aims to reduce incidents of suicidal behaviour, increase motivation, self esteem and employability of ex-prisoners, and reduce levels of recidivism.

Project WINS (Works Interests and Needs Study) in Michigan recruited Peer Support Specialists to work as Vocational Specialists to meet the vocational needs of the project's clients. Peer Support Specialists, who were paid, worked from a few hours, to 30 hours per week, depending on availability, desire and financial need (Mowbray et al, 1994).

The Assertive Community Treatment Team (ACT) in Maryland recruited 2 consumers to act as paid Consumer Advocates (CA) within the team. ACT works with people who are homeless and have a severe mental illness and provides direct psychiatric and nursing services and support and peer counselling from consumers. The team is available 24 hours a day. (Dixen et al, 1997)

META Services, Inc started in Arizona as a crisis response service employing peer specialists to provide peer support to their clients. The organisation has

since developed a peer specialist training programme which has rolled out across the US, and New Zealand.

2.2.3 Peer Support Training programmes

Most peer specialists within any model will have received some training prior to taking up their role. However, with the development of more formalized peer specialist roles, the need for accredited training programmes has increased. A number of specialized training agencies, some user run, have developed peer support training programmes, to which a range of employers may refer individuals they have recruited as peer specialists. There may also be follow up training and support provided by the training agency after initial training is completed. Others agencies may train people, to enhance their employability, with no guarantee of future employment.

Examples of peer support training programmes

The Georgia Peer Specialist Certification Project has been delivering certified training since 2001. Graduates work as paid employees within public and private sectors, such including Assertive Community Treatment Teams and Community Support Teams. Certified Peer Specialists will have different job descriptions, based on the environment in which they are working, but there are some universal components (see Appendix I for Georgia's CPS job description). Applicants currently employed by a Medicaid billable service are given the highest priority for training. Those that work in a peer service that is not Medicaid billable or those who are not employed and want to improve their own skills are given subsequent priority. This system was devised to assist program providers in meeting guidelines that have been set by Medicaid.

The University of Kansas implemented the Consumer As Provider (CAP) education program in 1999. This later became known as the Leadership Empowerment Advocacy Project (LEAP). CAP/LEAP offers college courses for mental health consumers to enable them to take up positions such as community leader, advocate, student and/or human service provider. Alongside the college course, participants are expected to undertake a 90 internship at a relevant organisation (Ratzlaf, 2006).

2.2.4 Peer education

Peer education is normally undertaken in a group format, where a group of young people for example, will go into a school and talk about a particular subject to another group of young people. The key advantage of peer education is that peers are often seen to be able to offer more credible and up to date information than professionals. This can make the information delivered more powerful. For peer education to succeed, steps need to be taken to ensure that it is not parachuted in to an organisation, and that relationships and trust are built up prior to the education process. Benefits

for peer educators include increased self esteem and confidence, however there is little documentary evidence about the effectiveness of peer education for recipients. Indeed, in some cases peer education has proven to have a negative impact on desired behaviours (Webster et al, 2002).

Examples of peer education model

The Scottish Peer Education Network (SPEN) has network of 75 groups throughout Scotland involved in peer education. Many of these groups work with children and young people. SPEN provides a co-ordination function for these groups, encourages good practice and gives development support to organisations wishing to develop peer education approaches.

The Peer Support for Mental Health Project is an Australian combined mental health prevention and promotion project aimed at young people whose lives have been affected by an identifiable mental illness. The Project, based in Adelaide, used young peer consultants to undertake a combination of community peer education and hospital visiting (Higgs, 2001).

While there are certainly lessons to be learned from all four of the models of peer support discussed above, the model that most closely fits the proposed model for mental health peer support in Scotland is that of the formalized peer specialist.

3. EVIDENCE BASE FOR PEER SPECIALIST SERVICES

The evidence base for peer provided services is small. Solomon and Drain (1995) in a randomised trial of a consumer case management service found that consumer case management teams were equally effective as non consumer teams in terms of symptomology, clinical and quality of life outcomes. However, clients also reported less satisfaction with the consumer case management team overall. Chinman et al (2000) also found consumer case management teams to be equally effective as their non consumer counterparts in terms of the outcomes achieved.

Clarke et al (2000), in a randomised control trial of consumer and non consumer operated Assertive Treatment Teams found fewer people were hospitalised or visited emergency rooms when they were served by consumer providers rather than non consumer providers. The first psychiatric hospitalisation of clients of consumer providers also occurred later than with clients of non-consumer providers, although hospitalisation periods tended to be longer for this group.

In Felton et al (1995), clients served by teams with peer specialists demonstrated greater gains in several areas of quality of life and an overall reduction in the number of major life problems experienced. They also reported more frequent contact with their case managers and gains in the areas of self- image and outlook and social support.

3.1 BENEFITS OF A PEER SPECIALIST SERVICE

The literature on peer specialist services highlights a range of potential benefits for clients, peer specialists themselves, and the wider mental health systems in which they operate.

3.1.1 Individual Benefits

Acceptance / Empathy / Respect

One of the key benefits of peer support, as opposed to other forms of mental health services is the greater perceived empathy that peer specialists have for the people they support (Campbell & Leaver, 2003). Sally Clay (2005) describes this empathy as follows

'Since we have been crazy ourselves, we feel compassion for the confusion of others rather than fear of their madness, and we strive to offer unconditional respect to those who are "in the same boat" as we are.'

This respect can in turn help to build a trusting relationship, where emotions are not 'pathologised', and it is safe to talk about ones innermost feelings. Peers are also often better placed to be positive and optimistic about peoples' skills and abilities, and focus on an individuals strengths rather than weaknesses (Clay, 2005).

S*haring what works / strategies for recovery / fostering hope*

Shery Mead suggests that 'When people identify with others who they feel are "like" them, they feel a connection.' (Mead et al, 2001). This in turn fosters an environment where individuals can share suggestions and tips for recovery with each other, and try out different strategies, with the support of their fellow peer(s).

Clay suggests that peer specialists telling their own stories of recovery, can provide both encouragement and technical assistance to others. In this respect, peer specialists act as a role model to show that recovery is possible. (Clay, 2005)

Empowerment

Peer support advocates individuals taking responsibility their own recovery. Peer specialists can support this ethos, by encouraging individuals to define their own needs, think about the choices that are open to them, and support experimentation in terms of different recovery strategies. (Campbell & Leaver, 2003)

Holistic / non medicalised approach

Peer support promotes a culture of health and ability rather than one of illness and disability (Mead et al, 2001). In this respect, Clay (2005) suggests that 'Peer support providers treat consumers / survivors as full human beings rather than disease entities.'

Social support

Social skills can be enhanced through peer support, and isolation reduced. Peer support may also be beneficial for people leaving psychiatric inpatient care, in terms of helping them to re-integrate into their community. (Forchuk et al, 2005)

Reducing psychiatric symptoms and hospital admissions

In a non-randomised study of Recovery, Inc (a self help programme for people with mental health problems), Galanter (1988) showed that participation in peer support decreased psychiatric symptoms and hospitalizations.

3.1.2 Benefits for peer specialists

Alongside benefits for recipients, the literature also reveals a number of benefits of peer support for peer specialists themselves.

Mental health / well-being benefits

Ratzlaff et al, found that participants in a Consumer As Provider (CAP) program, showed significantly increased levels of hope and self-esteem, using the Snyder Hope Scale and Rosenberg Self-Esteem Scale (Ratzlaff et al 2006). Hutchison et al suggest that one explanation for this change may be that; 'Employment can provide an identity shift from patient / consumer / client to that of valued worker and contributing citizen. (Hutchison et al, 2006)

Skills / Employment benefits

Training and working as a peer specialist can increase an individual's skill base, which in turn, makes them more employable and opens up other employment and educational opportunities. (Ratzlaff et al, 2006). The importance of financial rewards in terms of building independence, and the value of developing a daily routine should also be recognized (Mowbray et al 1998; The WISE Group).

3.1.3 System benefits

Finally, peer support has the potential to be a force for positive change within the wider mental health system. Change can be achieved in a number of ways:

Increased understanding of user perspective / user involvement culture

Peer specialists can educate mental health professionals about the experience of living with mental health problems. (Campbell, 2005) Dixen et al (1997) found that staff with experience of working with consumers as colleagues had more favourable attitudes towards them, 'suggesting that the collaboration with consumer advocates in this agency influenced how staff feel about mental illness and persons suffering from it.'

Peer support also adds strength to the consumer movement by developing informed, confident consumers. However, the extent to which culture change is achievable through the employment of peer specialists alone, is debatable. (Mowbray et al 1998).

Engaging hard to reach groups

Because of their non-medicalised, recovery based approach, peer support projects have the potential to reach individuals who, for various reasons have chosen not to participate in traditional mental health services. Depending on where the service is located and how it is accessed, peer support can also reach individuals who have been 'overlooked' by the system (Campbell & Leaver, 2003; Clay, 2005). Engaging positively with people who have not engaged previously can also make them more willing to engage with other services in the future.

Increasing choice within existing mental health system

Campbell & Leaver (2003) state that 'When peer support services are included within the continuum of community care, the mental health system expands quantitatively, by reaching more people, and qualitatively, by helping people become more independent and interdependent'.

Reducing workload

Introducing peer specialists into the mental health system may remove some pressure from other overstretched staff (Mowbray et al 1998). In this respect, Minth (2005) suggests that peer support 'reduces the reliance on mental health professionals to meet consumers' needs for recreation, social support and companionship'.

Cost-effectiveness

Hutchison points to the potential cost-effectiveness of employing peers;

'By increasing their trained peer personnel, an agency can increase the number of people served and their own cost-effectiveness due to the flexibility in scheduling and organisational commitment that is often inherent in the employment of peers' (Hutchison et al, 2006)

The WISE Group have also been able to show the cost benefits of recruiting Life Coaches to reduce recidivism rates compared to the costs of keeping someone in prison.

3.2 BARRIERS TO PEER SUPPORT

There is potential for the benefits of peer support to become restricted by a number of constraints, some of which are system based, and others inherent within the role's function. These barriers need to be fully considered, and strategies to deal with them implemented, if the benefits of peer support are to be fully realized.

3.2.1 Work related stress factors

The peer specialist role can be stressful, particularly if adequate training, supervision and support is not in place. Some potential problems that can arise within the role include;

'conflict, criticism, failed social attempts, emotional over-involvement resulting in congation stress, reinforcement of poor behaviours, diminished feelings of self-efficacy, lack of stability…' (Dennis, 2003)

As this quote suggests, maintaining the self esteem and mental health of peer specialists is crucial to the success of the role. Yuen & Fossey (2003) found in their interviews with consumer-staff, participants talked of the need to monitor their own workloads and the demands being placed on them, as well as developing their own 'relapse prevention strategies', such as taking time out when required.

However, while it is important to recognize the effect of stress on peer specialists, it should not be over-emphasised. The Highland Transitional Discharge Scheme found that prior to the development of the project, the negative impact of work related stress was considered by professionals as one of the key limitations of the peer support model. However, in reality these fears proved unfounded, and work related stress was not thought to be a major issue in the scheme. Crucial to this were the restrictions placed on the number of individuals peers supported at any one time (usually only one).

3.2.2 Maintaining peer specialist role in an integrated setting

Some consumers have argued for a distance to be maintained between peer run programmes and traditional mental health services, to ensure their integrity and independence (Clay, 2005). It has been suggested that 'mental health consumers who are working with professionals would not be in control of their program due to the uneven power relationships between professionals and the recipients of services.' (Campbell & Leaven, 2003). At the heart of this statement is the perceived reluctance, on the part of some professionals, to view the peer specialist role as valuable, and peer specialists as their professional equals (Mowbray et al, 1998). In practice this can mean that recovery messages are undermined by other staff, or that peer specialists are drawn into traditional mental health service agendas and ways of working.

Within Project WINS, peer support specialists talked about differences in status between themselves and other mental health professionals they worked with, suggesting that differing levels of educational qualifications could undermine confidence in their abilities. Likewise consumer staff within the New Haven ACCESS project found that workplace discrimination was a real issue for some, particularly after they had disclosed information about their history of mental illness. Similarly, experiences of discrimination were also related by individuals involved in Lindow & Rooke-Matthews' study (1998).

However, while some professionals may be reluctant to view peer specialists as colleagues, this was not by any means a universal stance. Dixen et al (1997) found that most staff who worked with consumer advocates recognised the benefits of having peer specialists in their team.

Well integrated peer specialists within statutory teams, can of course cause further issues, for example when clients view peer specialists as having become 'part of the system'. This situation can undermine the peer to peer relationship and place the peer specialist role 'in a grey area in which they were neither consumer nor professional.' (Mowbray et al 1998)

Fisk et al (2000) suggested that this 'transitional position' can raise difficult emotions in peer specialists, commonly feelings of inadequacy and self-doubt. Mowbray et al (1998) suggests this situation occurs, not because failings in the peers themselves, but because of a lack of 'anticipatory socialization of all the principle stakeholders involved in the transition – including peers, supervisors, administrators, and consumer service providers.' Preparation for the introduction of peer support within an organisation, is therefore key.

3.2.3 Boundaries

The ambiguity of the peer specialist role can also mean that boundaries between user and provider are sometimes crossed. Mowbray et al, when evaluating Project WINS, found that some Peer Support Specialists developed friendships with the clients they were supporting. This caused a range of

difficulties for the peer specialists in terms of trying to separate out their support and friendship roles (Mowbray et al 1998). The Transitional Discharge Scheme in Highland emphasized the importance of peer supporters not giving out their home contact details. However, in one instance a client turned up in crisis at the peer support worker's home. Other boundaries such as not lending or borrowing money, and not developing sexual relationships with clients were also emphasized. It should be remembered however, that professionals are capable of overstepping boundaries, as well as peer specialists.

Boundaries between staff and peer specialists can also be an issue from time to time. With the ACT team in Baltimore, there was a concern that staff had access to information about the CA's personal lives. Fisk et al (2000) also highlighted the possibility that peer specialists could have previously received support from professionals they were expected to work with. This was also raised as an issue with the WISE Group Life Coaches, with respect to their relationship with prison officers.

While personal experiences of mental illness were seen as being important to the role, it could also make developing team relationships based on equality more difficult. The extent to which peer specialists disclose about their personal experiences with their colleagues and clients therefore, has to be controlled by the peer specialist. It was the experience of META however, that problems around disclosure became less common as mental health staff became more familiar with working with people who were open about their mental health histories.

Boundaries therefore need to be carefully drawn, and sensitively enforced. Tackling boundary issues quickly if they do arise, and using a fair and just approach to transgressions were also highlighted as important factors.

3.2.4 Difficulties ensuring user involvement

User involvement in planning as well as delivery is a key component of peer support. However, ensuring meaningful user involvement relies on there being well developed and active local user networks to tap in to. Experience from the Highland Transitional Discharge Scheme has shown that, even where local networks exist, there may not be local capacity for getting involved in peer support planning and training.

3.2.5 Funding

Many independent peer-run support services struggle to obtain long term funding. However, while funding for integrated services may be becoming more readily available, Schell (2005) highlighted the risk that, by funding peer support, statutory bodies can feel they have met their user involvement obligations. Planners and commissioners therefore should be encouraged to

see peer support as complementary to a range of other user involvement practices.

Statutory funding can also bring certain requirements e.g. for standardised training and formalized job descriptions, which can downplay the importance of the individual peer relationship. CREW 2000 thought long and hard before accepting statutory funding, because of concerns that it would be detrimental to the organisation's independent image. For the same reason, they have also been highly selective of the agencies they have chosen to work in partnership with.

4. FUNCTIONS AND PRACTICALITIES OF THE PEER SPECIALIST ROLE

4.1 FUNCTIONS

Clay (2005) describes the peer specialist role as consisting of two broad functions; emancipatory functions and caring functions.

The *emancipatory functions* of a peer support worker are based on empowering clients to take control of their own recovery, and define their own needs, aspirations and goals. A key aspect of this is encouraging people to tell and share their own stories, and providing them with information to help them make informed choices about forms of support they need. Within this function is the belief that telling one's story has a therapeutic value, and the process of sharing histories can shift an individual's perspective towards a recovery-based outlook and away from an illness-based viewpoint.

For Reifer (2003) emancipatory functions would include tasks such as identifying services and activities which promote recovery, articulating ones own recovery story and promoting personal responsibility for recovery.

The *caring functions* of the peer support worker role focuses on proving empathetic social support and encouragement rather than pressure. It involves the process of engendering hope and mutual respect, and makes the client feel safe.

One core function of many peer specialists is facilitating *Wellness Recovery Action Planning (WRAP)*. Started in Vermont, by Mary Ellen Copeland, WRAP is 'a personal monitoring system in which an individual documents techniques and strategies for reducing symptoms as well as for ongoing management and prevention of symptoms. Components of the WRAP include:

- a plan for daily maintenance
- identification of situations that trigger symptoms and strategies to address these
- identification of early warning signs and what to do when they appear

- a plan for how to deal with pre-crisis and crisis situations.'

(source: http://www.mentalhealthrecovery.com/vtrecovery.html)

Individuals interested in becoming peer specialists for META must have completed their own WRAP before training can commence.

Despite having common functions however, different stakeholders may view the role of peer specialists in different ways. Consumer Advocates, employed in a Assertive Community Treatment Team in Maryland, were viewed as providing a range of different functions by different members of the team, including; bridging the gap between consumers and the mental health system, serving as a role model, educating staff on the consumer point of view and helping the client meet their daily needs. (Dixen et al,1997). It may be that peer specialists will provide different roles at different times. A clear role description is evidently desirable in these circumstances. (See Appendix I for examples of two peer specialist job descriptions).

To take the pressure off individual peers to be change instigators, and reduce workplace isolation, it has also been suggested by a number of researchers and practitioners that services should recruit more than one peer specialist within a team (Yuen & Fossey, 2003; Georgia Certified Peer Specialist Project; META services). Because of the high risk nature of the intervention, the WISE Group also insist on having 2 Life Coaches present at every client meeting.

4.2 TIMING AND LENGTH OF THE INTERVENTION

Roberts & Wolfson (2004) indicate that with recovery based interventions such as peer support, timing can be key to their success. Individuals need to be ready to think about their own needs and what recovery would mean for tem. This readiness requirement has implications for how people are referred to peer specialists.

Both META Services and the Georgia Certified Peer Specialist Project also suggested that, because each individual's recovery is a unique process, no restrictions should be placed on the length of the time peer specialists could support individuals for. However, alongside this, it was also thought important for both parties to agree the goals for and the limitations of the peer relationship, and ensure that relationships continued to be purposeful in terms of working towards achieving these goals.

4.3 PAYMENT AND HOURS

When peer specialists are providing a professional function within a multi-disciplinary team, both Mowbray et al (1998) and Fisk et al (2000) stressed that payment should be equitable with those carrying out similar functions. The WISE Group also paid the Life Coaches on a full time basis. The number

of hours worked per week can also affect whether it is financially worth an individual's time to take a peer support position. The financial reward must be balanced with the stress impact of the role, as the greater the number of hours worked per week, particularly direct support hours, will increase the stress placed on peer supporters. The experience of SPEN has shown that not everyone will want to jump into immediately undertaking paid employment, particularly if it means coming off benefits.

Neither the literature nor the interviews revealed an optimum number of weekly working hours; the hours worked by the various peer specialist roles discussed in this paper varied from a few hours per week, to full time. The size of individual caseloads also varied from project to project. The Transitional Discharge scheme limited caseloads to one or two maximum, whereas the WISE Group restricted numbers to 5.

4.4 FLEXIBLE WORKING PRACTICES

Lindow & Rooke-Matthews (1998) suggest adopting the following working practices, to ensure that the working environment is flexible and supportive of peers needs:

- 'Modify the workplace to give some privacy or space with minimum distractions
- Encourage support groups for workers.
- Facilitate access to professional counselling if needed
- Create flexible work schedules
- Give time off during the day or allow people to leave early when stressed
- Authorise leave for periods of distress
- Permit 'at home' working
- Allow exchange of duties with another employee
- Encourage a climate of extra tolerance for unusual behaviours
- Have guidelines for providing negative feedback
- Look at creating a scheme for on the job peer counselling.'

4.5 CAREER DEVELOPMENT

Peer Support Specialists in Project WINS highlighted the lack of opportunity for career development as being a structural failing of that model of peer support. It was recommended by Mowbray et al (1998) that opportunities to develop skills and experience be enhanced both within discrete projects, so that different levels of peer specialist role develop, and within the wider mental health system, so that peer specialists are made aware of relevant job opportunities when they are ready to take on more responsibilities.

META Services have been able to provide career development for peers employed within their own services; for example, peer specialists have gone on to become team leaders and managers. Indeed they argue that

experienced peer specialists are best placed to offer supervision to new peer workers. However, META also recognize that career development for trained peer specialists has been more difficult to ensure in external agencies, particularly where state regulations insist that supervisors have professional backgrounds. Ensuring career development opportunities are available for peer specialists within a Scottish mental health system may therefore require some rethinking of what skills and experience are required to undertake a supervisory role.

4.6 TRAINING

4.6.1 Training for Peer Specialists

While all peer specialist models discussed in this paper incorporate some degree of training, the content of these training programmes varies from organisation to organisation. Appendix II lists the different components of 4 peer specialist training programmes; META Services, CAP/LEAP, the Mental Health Action Network Training and the WISE Group Life Coaches. Topics included in at least 3 of the 4 training programmes were:

- Listening skills
- Patient rights, confidentiality & ethics
- Suicide prevention.

Throughout the literature and interviews, there was a significant degree of variance in terms of views about the optimum amount of training required, and over what time period. In Kansas, those going through the CAP/LEAP programme take one year to complete their training, over 3 semesters, and include an internship of no less than 90 hours (Ratzlaf, 2006). META Services training takes 70 hours to complete, where as Project WINS provided 20 hours of training over 2 weeks (Mowbray et al, 1997). At the other end of the scale, the experience of the Georgia Certified Peer Specialist training has suggested that 5 days may be the optimal length of training.

There are arguments for and against both cases. Certainly, longer training enables subjects to be covered in more depth and breadth, and allows for greater discussion of case studies / role play, as well as job experience in the form of internships. It could be argued that with more training, peer specialists are better prepared and will be more acceptable to other mental health professions.

However, long training programmes can also act as a demotivator, particularly if there is no guarantee of a job at the end. Dennis (2003) suggests that care must be taken to ensure that the content of a training programme focuses only on essentials, to ensure that the training process does not become devalued. Dixen et al (2003) also argue that a balance has to be created between giving people enough training to enable them to do the job in a safe and supported manner, and giving them enough freedom to use their own experience and background to promote recovery.

4.6.2 Training for Other Professionals

In addition to the appropriate systems and structures being in place to support the peer specialist role, the wider mental health system has to be ready to accept this way of working. Peer workers cannot be successful in supporting recovery if other mental health professionals supporting an individual are undermining this approach. Recovery based approaches should be encouraged across the mental health sector. It is not the peer support worker's job alone to 'do recovery'.

There is also the question of whether mental health professionals are ready to accept service users as colleagues, and to involve them in decision making processes. As those involved in peer support in Georgia suggest:

'Staff of the Peer Support Program must be treated as equal to any other staff of the facility or organisation and must be provided equivalent opportunities for training…and pay and benefits that are competitive and comparable to other staff based on experience and skill level.' (Reifer, 2003)

To overcome these problems Mowbray et al (1998) and Fisk et al (2000) suggest developing a program of training for professional staff covering, amongst other things; the history of the consumer movement, the success of consumer integration efforts and contributions that consumers have made to mental health services, the potential for recovery from mental illness. It was also suggested by Fisk et al that consumers should take a key role in delivering this training. One example of training for professionals is PACE (Personal Assistance in Community Existence) based in Massachusetts, which provides training designed to shift the culture of mental health care to one that is more recovery focused (Campbell & Leaver, 2003).

The experience of CREW 2000 has shown that changing attitudes towards peer support is possible. When the organisation began, their risk minimization approach to drug information, was viewed by traditional drugs and alcohol services as highly controversial. However, through demonstrating their effectiveness in working with a hard to reach group, they have changed their position in the system to one where their involvement is actively sought by the police, insurance companies and other drugs and alcohol services. Leading by example therefore, may also be an important method of achieving culture change.

4.7 ACCREDITATION / CERTIFICATION

Accreditation and certification have become increasingly important considerations within peer support programmes. Accreditation occurs where a programme receives an endorsement from an objective third party organisation, such as the Peer Accreditation Association in New York, which has developed a peer accrediting initiative for use with peer support

programmes in the state (Campbell & Leaver, 2003). The Association agrees accreditation based on the quality of the service, and the contribution the service makes towards developing genuine peer run alternatives to traditional mental health care.

Statutory and voluntary sector agencies both in the UK and the US are increasingly requiring community mental health workers to be certified based on a comprehensive set of workforce competencies. In this culture, as Campbell & Leaver say:

'The need for peer support to be recognized as a professional discipline is clear if the programs that employ consumers in helping roles are to be funded and the peer workforce is to be eligible for career benefits. Respect from within the mental health service community could also be a de facto result of certification.'

Life Coaches in the WISE Group are asked to undertake NVQ Level 2 Advice & Guidance as part of their training programme. Examples of certification programmes in the US include the Georgia Peer Specialist Certification Project and the Psychiatric Rehabilitation Certification Program which provides certification services for psychiatric rehabilitation professionals, including peer support specialists. Applicants for certification under this program must meet the eligibility criteria and pass a written exam to become Certified Psychiatric Rehabilitation Practitioners (CPRP) (Campbell & Leaver, 2003). It is uncertain, however, how appropriate it is for assessing peer support competences.

4.8 SUPERVISION

4.8.1 Line management / clinical supervision

The supervision of peer specialists may be undertaken by team leaders, or by other managers within the wider service. With ACT, formal supervision was provided for the Consumer Advocates (CAs) by the program director and medical director, with informal supervision also provided by case managers as required. This system was found by Dixen et al (1997) to be generally satisfactory by all team members, although case managers felt that supervision could stray into 'therapy' on occasions. Interestingly, the CAs involved did not feel that this was a problem.

With Project WINS however, supervision was thought by many Peer Support Specialists to be inadequate, not because of the quantity of time set aside for supervision, but because this time was largely 'superficial' in nature. Specialists suggested that more emphasis be placed on improving practice and skills, and discussing the complexities of the role (Mowbray et al, 1998). At the same extent, some peer specialists also recognized that it was their

responsibility to actively seek out help for particular work related issues when required, rather than wait for supervisors to bring them up.

The key messages from the literature therefore are that supervision has to be regular, accessible and meaningful. It is also considered good practice that supervisors should have gone through the peer support training programme themselves, to fully familiarize themselves with the role and functions of the job (Reifer, 2003).

4.8.2 Peer supervision

In addition to supervision received from a line manager or clinical lead, peer specialists interviewed by Dixen et al (1997) felt that additional support would have been helpful for them, possibly from a support group of consumer mental health providers. The Transitional Discharge Scheme in NHS Highland, made a similar recommendation; suggesting that engaging a local user group to provide supervision, support and training for peer specialists would have been an appropriate and valuable means of supporting their peer specialists.

Peer Support Specialists at Project WINS suggested that opportunities for peer supporters to get together for social activities would also have been a beneficial addition to the project, to act as a pressure release (Mowbray et al 1998).

In all these cases it was envisaged that peer supervision would take place at a local level. This assumes that there are appropriate user networks in place locally to provide this support function. If this is not the case, a national model of peer supervision may be more appropriate. The Georgia Certified Peer Specialist Project for example, has developed an online bulletin board where peer specialists across the US can communicate with each other about their role (see http://www.gacps.org/Home.html for further information). The project also facilitates regular events, where those who have graduated from the training programme can come together and continue to develop their skills.

4.9 ADVISORY BODY

Reifer (2003) suggests setting up an Advisory Body to oversee the development of the peer support role in every locality. For Scotland, it may be appropriate to have one of these in every Health Board. The Advisory board should have strong user representation on it, as well as a range of other professionals. In Georgia, the function of the Advisory Body is to:

- Develop programmatic descriptions and guidelines (these may be provided centrally in Scotland)
- Review and comment on peer support programme budgets and activity
- Participate in dispute resolution for the programme. (Reifer, 2003)

4.10 ORGANISATIONAL PLAN

Alongside the Advisory Body, Reifer also recommends that agencies providing peer support develop an Organisational Plan, which includes the following components:

- Service philosophy reflecting recovery principles
- Description of service model, e.g. activities
- Description of staffing pattern, including staff to consumer ratios and plans for staff absence/ illness
- Description of how peer support workers will be given the opportunity to meet with other consumers
- Description of how consumers will be encouraged and supported to become peer support workers – how recruited / supported through training etc.
- Description of how peer support workers will participate in clinical team meetings. [With ACT, the CAs attended all team meetings, treatment planning meetings and conferences. CAs were expected to contribute to the discussion (Dixen et al, 1997)]
- Description of programme's decision making processes – how consumers can be involved in direct decision making, dispute resolution processes etc.
- Description of Advisory Body
- Description of how requests for discharge or change in services are handled. (Reifer, 2003)

5. SUMMARY OF KEY POINTS

Based on the findings of the literature and interviews, the following key points were raised with regards to developing a peer specialist programme;

1) PROMOTING THE RECOVERY MODEL AND PEER SUPPORT

To prepare local statutory mental health services for the introduction of the peer specialist role, a promotion and training programme needs to be implemented, focusing on:

- The evidence base behind the recovery model and peer support
- The benefits for mental health services of employing peer specialists
- Adjustments that will need to be made to traditional ways of working
- The supervision and support requirements of peer specialists

If possible, service users should be involved in developing and delivering this training.

2) DEVELOPING A STANDARDISED ROLE DESCRIPTION

A broad job description will need to be developed for a peer specialist, ensuring that enough flexibility exists within it to enable the worker to use their own experiences to aid recovery. It should be grounded in the recovery model and the peer and helper principles. The role description should also consider issues such as optimum caseloads, remuneration levels and hours of work. Remuneration should be at an equitable level with other professionals working to similar job descriptions and similar levels of responsibility.

For further consideration:

- How flexible can the peer specialist role be? Is there opportunity for part time peer specialists as well as full-time?
- How can we ensure opportunities for career development within the peer specialist role?

3) DEVELOPING AND DELIVERING A STANDARDISED TRAINING PROGRAMME

A standardized training programme will need to be developed to train peer specialists in the basic knowledge and skills required for the position. Again service users should be involved in developing and delivering this training. It would also be preferable if supervisors and local project leaders could benefit from all, or aspects of this training.

For further consideration:

- The length and content of this training programme
- Whether the training takes place at a national or local level

4) DEVELOPING LOCAL ADVISORY BODIES AND ORGANISATIONAL PLANS

Local advisory bodies and organisational plans should be developed in each locality, to oversee and shape the introduction of the peer specialist role in the local area and deal with any difficulties that arise therein. Again service users should be involved in the membership of the advisory bodies, and in developing the organisational plans.

If possible, other opportunities for user involvement with peer support should be encouraged locally, (e.g. marketing) to give individuals a range of different ways of contributing.

5) DEVELOPING LOCAL SUPPORT AND SUPERVISION PROCEDURES

Appropriate levels of support and supervision should be available to peer specialists. This should be a combination of regular clinical supervision from team leads and the opportunity for feedback and discussion of the role with other peer specialists on a local and / or national basis.

Peer Specialists should be encouraged to be pro-active in seeking support from supervisors. This also demands that supervisors need to be accessible and available to peer support specialists when required.

It is advisable that at least two peers specialists are recruited to each team, to reduce both isolation and the likelihood of being co-opted into other mental health agendas.

6) PROVIDING CENTRAL CO-ORDINATION

Managing the training and development of the peer support worker role requires central co-ordination. The function of this central body could include:

- Develop and run the training course for all peer support workers
- Provide a forum where all peer support workers could get together for mutual support, learning, feedback
- To support the local Advisory Bodies, monitor progress etc.
- To evaluate the impact of the peer specialists on those supported, the wider system and the peers themselves.

6. REFERENCES

Articles & Publications

Campbell, J (2005) 'The historical and philosophical development of peer-run support programs' in Clay, S ed. *On our own, together: peer programs for people with mental illness*. Vanderbilt University Press: Nashville.

Campbell, J. and Leaver J (2003) *Emerging New Practices in Organized Peer Support: Report from NTAC's National Experts Meeting, March 17-18, 2003.* Available online at http://www.bu.edu/cpr/repository/documents/campbell-leaver2003.pdf

Chinman, M., Rosenheck, R., Lam, J., & Davidson, L. (2000) 'Comparing consumer and nonconsumer provided case management services for homeless persons with serious mental illness' *Journal of Nervous & Mental Disease*, 188, 446-453

Clarke, G., Herinckx, H., Kinney, R., Paulson, R., Cutler, D., & Oxman, E. (2000) 'Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: Findings from a randomised trial of two ACT programs vs. usual care' *Mental Health Services Research*, 2, 155-164

Clay, S. (2005) 'About us: what we have in common' in Clay, S ed. *On our own, together: peer programs for people with mental illness*. Vanderbilt University Press: Nashville.

Dennis, C.L. (2003) 'Peer support within a health care context: a concept analysis' *International Journal of Nursing Studies* 40, 321-332.

Dixon, L., Hackman, A. & Lehman, A. (1997) 'Consumers as staff in assertive community treatment programs' *Administration and Policy in Mental Health* 25, (2), 199-208.

Felton, C., Stastny, P., Shern, D., Blanch, A., Donahue, S., Knight, E., & Brown, C. (1995)' Consumers as peer specialists on intensive case management teams: impact on client outcomes' *Psychiatric Services*, 46, 1037-1044

Fisk, M., Rowe, M. Brooks, R., Gildersleeve, D. (2000) 'Integrating Consumer Staff Members Into a Homeless Outreach Projects: Critical Issues and Strategies'. *Psychiatric Rehabilitation Journal* 23(3): 244-252.

Galanter, M (1988) 'Zealous self-help groups as adjuncts to psychiatric treatment: A study of Recovery, Inc,' *American Journal of Psychiatry*, 145 (10), 1248-1253

Higgs, L. (2001) *Peer support for mental health: young people helping each other Project* Evaluation Report: The Second Story Youth Health Service.

Hix, L (2005) 'BRIDGES in Tennessee: Building Recovery of Individual Dreams and Goals through Education and Support' in Clay, S ed. *On our own, together: peer programs for people with mental illness*. Vanderbilt University Press: Nashville.

Hutchinson, D.S., Anthony, W.A., Ashcraft, L., Johnson, E., Dunn, E.C., Lyass, A. & Rogers, E.S. (2006) 'The personal and vocational impact of training and employing people with psychiatric disabilities as providers' *Psychiatric Rehabilitation Journal* 29, (3), 20-213.

Lindow, V & Rooke-Matthews, S (1998) 'The experiences of mental health service users as mental health professionals' *Joseph Rowntree Foundation: Findings 488*

Mead, S Hilton D & Curtis L (2001) 'Peer Support: A theoretical perspective' *Psychiatric Rehabilitation Journal*, 25, 2 134-141

Minth, H (2005) 'The St Louis Empowerment Center, St Louis, Missouri' in Clay, S ed. *On our own, together: peer programs for people with mental illness*. Vanderbilt University Press: Nashville.

Mowbray, C.T., Rusilowski-Clover, G., Arnold, J., Allen, C., Harris, S., McCrohan, N.M. & Greenfield, A. (1994) 'Project WINS: integrating vocational services on mental health case management teams' *Community Mental Health Journal* 30, (4), 347-362.

Mowbray, C.T., Moxley, D.P. & Colllins, M.E. (1998) 'Consumer as mental health providers: first person accounts of benefits and limitations' *The Journal of Behavioural Health Services & Research* 25, (4), 397-411.

Ratzlaff, S., McDiarmid, D., Marty, D. & Rapp, C. (2006) 'The Kansas consumer as provider program: measuring the effects of a supported education initiative', Psychiatric Rehabilitation Journal 29, 3, 174-182.

Reifer, M (2003) *Georgia's Consumer-Driven Road to Recovery: A mental health consumer's guide for participation in and development of Medicaid reimbursable peer support services*, Office of Consumer Relations: State of Georgia

Roberts, G. & Wolfson, P. (2004) 'The rediscovery of recovery: open to all' *Advances in Psychiatric Treatment* 10, 37-49.

Schell, B (2005) 'Mental Health Client Action Network (MHCAN), Santa Crus, California' in Clay, S ed. *On our own, together: peer programs for people with mental illness*. Vanderbilt University Press: Nashville.

Solomon, P (2004) 'Peer Support/Peer Provided Services Underlying Processes, Benefits and Critical Ingredients', *Psychiatric Rehabilitation Journal*, Spring 2004, 27, 4, pp392-401

Solomon, P. & Draine, J. (1995) 'One-year outcomes of a randomized trial of consumer case management' *Evaluation & Program Planning*, 18, 117-127

Webster, RA, Hunter, M & Keats JA (2002) 'Evaluating the effects of a peer support programme on adolescents' knowledge, attitudes and use of alcohol and tobacco' *Drug and Alcohol Review*, **21**, 7-16

Yuen, MSK & Fossey, EM (2003) 'Working in a community recreation program: A study of consumer-staff perspectives' Australian Occupational Therapy Journal, 50, 54-63

Websites

Crew 2000
http://www.crew2000.co.uk/

Georgia Certified Peer Specialist Project
http://www.gacps.org/Home.html

Mary Ellen Copeland, Mental Health Recovery & WRAP
http://www.mentalhealthrecovery.com/

META Services
http://www.metaservices.com

Scottish Peer Education Network
http://www.fastforward.org.uk/peer-education/scottish-peer-education-network.php

Veteran Recovery Website
http://www.veteranrecovery.med.va.gov/

Appendix I: Certified Peer Specialist Job Descriptions

Georgia Certified Peer Specialist Job Description, Responsibilities, Standards and Qualifications

Under immediate to general supervision, the Certified Peer Specialist (CPS) provides peer support services; serves as a consumer advocate; provides consumer information and peer support for consumers in emergency, outpatient or inpatient settings. The CPS performs a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. The CPS will role model competency in recovery and ongoing coping skills.

1. Using the 10-step goal setting process the CPS will:
    a. Assist consumers in articulating personal goals for recovery
    b. Assist consumers in determining the objectives the consumer needs to take in order to reach his or her recovery goals.

2. The CPS will document the following on the Individual Service Plan (ISP) by:
    a. Assisting consumers in determining "Problems"
    b. Assisting consumers in identifying recovery goals
    c. Assisting consumers in setting objectives
    d. Determining interventions based on consumers recovery / life goals
    e. Observing progress consumers make towards meeting objectives
    f. Understanding and utilizing specific interventions necessary to assist consumers in meeting their recovery goals.

3. Utilizing the CPS' specific training the CPS will:
    a. Lead as well as teach consumers how to facilitate Recovery Dialogues by utilizing the Focus Conversation and Workshop methods
    b. Assist consumers in setting up and sustaining self-help (mutual support) groups
    c. Assist consumers in creating a Wellness Recovery Action Plan (WRAP)
    d. Utilize and teach problem solving techniques with individuals and groups
    e. Teach consumers how to identify and combat negative self-talk
    f. Teach consumers how to identify and overcome fears
    g. Support the vocational choices consumers make and assist them in overcoming job-related anxiety
    h. Assist consumers in building social skills in the community that will enhance job acquisition and tenure.

i. Assist non-consumer staff in identifying program environments that are conducive to recovery; lend their unique insight into mental illness and what makes recovery possible.
j. Attend treatment team meetings to promote consumer use of self-directed recovery tools.

4. Utilizing their unique recovery experience the CPS will:
    a. Teach and role model the value of every individual's recovery experience
    b. Assist the consumer in obtaining decent and affordable housing of his or her choice in the most integrated, independent, and least intrusive or restrictive environment
    c. Model effective coping techniques and self-help strategies

5. Maintain a working knowledge of current trends and developments in the mental health field by reading books, journals and other relevant material.
    a. Continue to develop and share recovery-orientated material with other CPSs at the continuing education assemblies and on the CPS electronic bulletin board
    b. Attend continuing education assemblies when offered by the CPS Project
    c. Attend relevant seminars, meetings, and in-service trainings whenever offered.

6. Serve as a recovery agent by:
    a. Providing and advocating for effective recovery based services
    b. Assist consumers in obtaining services that suit that individual's recovery needs
    c. Inform consumers about community and natural supports and how to utilize these in the recovery process
    d. Assist consumers in developing empowerment skill through self-advocacy and stigma-busting.

PEER SUPPORT SPECIALIST

(Health Technician GS 7)

Incumbent is assigned as a Peer Support Specialist to the Psychosocial Resource Center. Incumbent participates in interdisciplinary team for treatment and is responsible for effective and efficient operation in provision of a recovery environment to consumers with serious mental illness (SMI) and possible co-morbid problems. At the GS 7 level, incumbent is also responsible for maintenance and operation of all facets of the volunteer peer support program, including provision of training of new volunteer peer supports.

I. MAJOR DUTIES AND RESPONSIBLITIES

A. The incumbent provides an important point of contact for consumers with SMI and acts as key avenue of access to services provided by the Psychosocial Resource Center. The incumbent may also act as an avenue of access to community resources if necessary. In so doing, the incumbent will receive and respond to numbers of unclear inquiries from patients concerning a variety of medical, personal and administrative matters. Determines the nature of the inquiry and independently responds to all questions. May accompany the consumer or family member as an escort, and may provide transportation if needed. May assist patients, visitors, and other requesting information, guidance or referral for special assistance.

B. Provides supportive assistance to this specialized treatment program. Performs direct support work including personal care which may be delivered individually or in groups. Such care is educational and supportive in nature and may consist of printed material, audio-visual or modular material. The incumbent is expected to use his/her own experiences with recovery as a vehicle to establish rapport and relationship building with the consumer or family member. May provide visits to consumers in community settings and may organize a variety of small group activities in the community. When necessary, the incumbent may act as an advocate for the consumer. In all cases, the Peer Support Specialist models living skills and communication skills for consumers. The incumbent monitors consumers' actions and identifies and reports data relative to more complex, non-routine clinical situations including sudden, unexplained changes in behavior or condition. Documents in the medical record.

C. The Peer Support Specialist may assist consumers and family members in times of crisis by providing information on access to resources and enabling the consumer or family member to access needed resources at

such times. In this role, the incumbent will coordinate with all necessary clinical services and facilitate referral to appropriate staff.

D. The incumbent is actively involved in development of the peer support training program, in evaluative/outcome analysis of the program and in training of veterans wishing to provide peer support services throughout the medical center.

II. FACTOR 1. KNOWLEDGE REQUIRED BY THE POSITION;

A. Practical knowledge of standard procedures using any one of several technical procedures. Skill in the operation and use of specialized procedures and materials. Thorough knowledge of community resources and recovery philosophy and literature.

B. Knowledge about psychosocial rehabilitation and the recovery model is essential.

C. Knowledge of personal resources necessary to deal with recovery from serious mental illness.

D. Knowledge and skills sufficient to use community resources necessary for independent living and to teach those skills to consumers with a serious mental illness.

III. FACTOR 2. SUPERVISORY CONTROLS:

A. The supervisor assigns the employee to work area and expects the employee to independently complete assignments. The employee plans and carries out the successive steps and handles problems and deviations in work assignments in accordance with standard practices and written procedures. Unusual problems that develop are referred to the supervisor for assistance.

IV. FACTOR 3. GUIDELINES:

A. Guidelines include operating policies and practices of the clinic; accepted materials, procedures and techniques; facility publications. The employee uses judgment in selecting and adapting techniques, procedures and materials most appropriate for the specific condition of each patient. Situations requiring deviations from the guidelines are referred to the higher-grade technician.

B. This job has little precedent in the VA and standard procedures may need to be modified as developments happen.

V. FACTOR 4. COMPLEXITY:

A. The work follows a sequence of steps or processes that the employee can follow without supervisory assistance. Decisions regarding what needs to be done involve various choices requiring the employee to recognize the differences among a few easily recognizable, specified alternatives. At this level, the employee must adjust both peer support interaction style and methods of instruction to suit the unique needs of those populations served.

VI. FACTOR 5.SCOPE AND EFFECT:

A. The work involves the performance of a variety of routine, standardized tasks that facilitate work performed by higher level technicians, and contributes to a base of patient care provided by the facility.

VII. FACTOR 6.PERSONAL CONTACTS:

A. Contacts are with consumers, their family, personnel within the facility and with community agencies as necessary.

VIII. FACTOR 7. PURPOSE OF CONTACTS:

A. The purpose of contacts with consumers is to exchange information and in so doing, assist consumers in achieving their recovery goals. Contacts with family are for intervention or providing education that will help the consumer's recovery plan. Contacts with the treatment team are for the purpose of providing and receiving information concerning the consumer's plan of care. Contact with the medical center personnel are for the purpose of increasing consumer access to services. Contacts within the community are for the purpose of assisting consumers in enhancing their independent living skills.

IX. FACTOR 8.PHYSICAL DEMANDS:

A. The work is primarily sedentary but also requires some standing, walking, bending, lifting and carrying of light items. The work requires above average agility and dexterity. The work may require heavy lifting of equipment or patients and may involve driving a government car or van.

X. FACTOR 9. WORK ENVIRONMENT:

A. The work environment includes a wide range of settings and involves risks typically associated with these setting. Setting may include the medical center, the consumer's home, community based settings and transport vehicles. Work involves regular and recurring exposure to moderate risks or discomforts that require special safety precautions.

Other Significant Facts

Customer Service
Meets the needs of customers while supporting VA missions. Consistently communicates and treats customers (veterans, their representatives, visitors, and all VA staff) in a courteous, tactful, and respectful manner. Provides the customer with consistent information according to established policies and procedures. Handles conflict and problems in dealing with the customer constructively and appropriately.

ADP Security
Protects printed and electronic files containing sensitive data in accordance with the provisions of the Privacy Act of 1974 and other applicable laws, federal regulations, VA statutes and policy, and VHA policy. Protects the data from unauthorized release or from loss, alteration, or unauthorized deletion. Follows applicable regulations and instructions regarding access to computerized files, release of access codes, etc., as set out in the computer access agreement that the employee signs.

Taken from:
http://www.veteranrecovery.med.va.gov/announce/positions/Peer_Support_Specialist_Waco_GS7.htm

Appendix II: Table of key components in peer support training programmes

	META Services, Inc[2]	Kansas CAP / LEAP Program[3]	Mental Health Client Action Network Training[4]	The WISE Group Life Coaches
Basic helping skills		x		
Communication	x			x
Community resources	x			
Conflict resolution	x			x
Cultural diversity	x		x	
Dealing with difficult people			x	
Documentation		x		x
Emergency first aid				x
Employment and benefits issues			x	x
Boundaries	x		x	
Group facilitation skills			x	
Health and Safety				x
History of consumer movement			x	
Listening skills	x		x	x
Mirroring and empathy			x	
Patient rights, confidentiality & ethics	x	x	x	
Recovery and wellness (planning)	x	x		
Resilience and emotional intelligence	x			x
Strengths orientated practice		x		
Suicide prevention	x		x	x

[2] Hutchison et al (2006)
[3] Ratzlaff et al (2006)
[4] Clay et al (2005)