NACBHDD National Association of County Behavioral Health & Developmental Disability Directors
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UNDER THE MICROSCOPE

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PERSPECTIVES ON PEER SUPPORT

Nationwide, more than 25,000 Certified Peer Specialists (CPS) represent a key segment of the behavioral health workforce that continues to grow. Dennis Grantham recently visited the 10th Annual International Association of Peer Support (INAPS) Conference in Philadelphia, where more than 600 peers met to review trends in their work. Dennis compiled a number of perspectives on the peer workforce, including:

- Data on Certified Peer Specialists nationally
- Three broad categories of working peers
- Understanding of the work of peers
- How peers "connect" with individuals
- How peers activate individuals' self-determination
- How the Veterans Administration is working with peers
- Taking action to expand peer support services
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INTRODUCTION

In late August, Philadelphia -- one of the hotbeds of the peer support movement – hosted the annual international Association of Peer Supporters (INAPS) conference. The Day 2 plenary session of that conference offered a series of poignant and deeply personal reflections, shared by peers, including these:

- An Australian woman who, in recovery, described herself as "gloriously noncompliant." She spoke of the freedom she discovered by turning the language of deficiency into strength, for example, and how her own journey of recovery helped to turn her – a once "manic" "manipulative" and "noncompliant" patient with SMI -- into an individual now described as "energetic," "creative," and "entrepreneurial."
- A Pennsylvanian, who, after a long string of hospitalizations, determined that her course "to stability and sanity" would be through devotion to work. After suffering humiliation at the hands of an employment counselor, she found her own job with the U.S. Census, which honored her work as "a credit to the community." Today, she works for the Copeland Center, continuing a recovery journey that saw her dump SSDI in 2007, marry, and continue her successful career.
- A striking Indian woman, now a naturalized U.S. citizen, who, from her greeting onward, let "the light within me honor the light within you." She took the first steps toward her own recovery when an aging woman – someone we would call a peer today – entered her hospital room and became present, instantly and completely, not only to her hopelessness at the depths of mental illness, but to the hope of a way forward – a path known to the older woman that the younger woman only then began to see.

- A retired Army colonel, who, through his own battle with a behavioral health problem, discovered that the mission of instilling hope in people with mental health and addiction problems is every bit as urgent and vital as any mission he ever tackled while in uniform.

For video of this event, go to the conference playlist on YouTube: INAPSConference 2016.

Data on Certified Peer Specialists (CPS) Nationally

These people, and dozens of others who spoke, listened, and learned at the three-day INAPS conference, represent some of the most passionate voices in the peer support movement. Nationally, according to a soon-to-be released survey compiled by the National Peer Career Development Project (www.bhpcd.org), there were more than 25,400 certified peer specialists (CPS) in the United States by early 2016. Additional comments by researcher Jessica Wolf, PhD, indicate that the number of CPS ranges higher, to perhaps 35,000 or 40,000, including many who are no longer active.

The survey found that CPS are trained and certified by a complicated web of organizations (depending on the state) that range from state agencies or boards, to regional or national entities, to state-approved peer-run or peer-focused entities, and even to provider organizations.

According to INAPS, education and training expectations for CPS are much, much different from those typical of professional clinical personnel. Though standards vary by state, typical requirements for peers seeking certification are that they:

- hold a high school diploma or GED
- have a lived experience of mental illness and treatment, or SUD and treatment
- be in "active recovery" (or sobriety), often for a period of time (e.g., 6 mos. to 2 years)
- in some places, accumulate a certain amount of paid or unpaid experience.

The National Peer Career Survey found that about one in three peers have completed some college or an Associate degree, while about one in five hold a Bachelors or graduate degree.

While the plethora of CPS programs and certification requirements have made it somewhat easier for people to pursue becoming a CPS, the survey found that there are also significant concerns:

- The cost of training and certification, and particularly, the limited availability of employment for CPS.
- Standard/mandated CPS curricula vary widely by state in content, cost, and requirements, as does ethical training.
- CPS participation in the public sector has continued to grow rapidly, while it has been much more limited in private-sector healthcare, due in part to lack of "legally defensible" national standards for training and certification. (Mental Health America's recent effort to launch a national peer certification is the first attempt to bridge this gap. See NACBHDD's July UTM.)

The National Peer Career Survey also offered a census of CPS nationwide, including 50 states, plus the District of Columbia and the Veterans' Administration. The census showed that, despite the availability of Medicaid or other funding for peer support services in 38 states at present,

- 12 states have no CPS at all. (Per the survey, Ohio has 0 CPS at present. The state had over 1,000 CPS as recently as 2014-15, but changed its certification standards in 2016, thus invalidating past certifications.);

- 16 states (includes D.C.) have between 1 and 250 CPS;
- 10 states have between 250 and 500 CPS; and,
- 14 states have more than 501 CPS, with just seven having more than 1,000 CPS: The VA (1,050); Michigan (1,630); Georgia (1,700); North Carolina (1,834), Washington (2,500), Arizona (2,524), and Pennsylvania (4,390).

In order for peer support services to be Medicaid reimbursable, peers typically must be trained and certified. While some organizations have hired non-certified peers, INAPS strongly recommends that peers be trained and certified to appropriate standards at the earliest opportunity. INAPS warns that the attrition rate for untrained, uncertified peers is extremely high.

Three broad categories of working peers

Anecdotal information from a variety of sources indicates that the population of Certified Peer Specialists can be broken down into three broad categories:

- **Professional Peers:** "Professional" CPS have good training, stable (though often modest) salaries and benefits, and the good fortune to work in organizations that not only support peers, but appreciate the impact of peer services on recovery. As a result, these CPS are able to focus on and thrive in their work. "Professional" peers work in organizations like the Veterans Administration; for counties in community-based crisis intervention, criminal justice, mental health, or SUD programs; in a variety of well-run and adequately funded peer-run organizations; or in organizations that develop and promulgate peer training or consult in the development of community-based peer services. Most of these individuals were once on disability, but recovered to the point where they lead essentially normal work or professional lives.

- **Peers working in "challenging" settings**: These peers are typically as well trained and capable as many "professionals," but the circumstances of their employment are not optimal. What often occurs is that organizations bring in one or more CPS as part of an effort to be "recovery-oriented" organizations. However, there's hesitancy within the organization to undertake the steps needed for real transformation, and a lack of training, integration, and expectation-setting leads to a lack of teamwork, or active resistance among clinical staff toward the newcomers. In these situations, peers are often too few in number to support each other, or they're treated as low-cost labor and given traditional mental health jobs or more menial jobs that don't allow them to exercise their unique talents. As a result, these peers tend to be far less effective or to burn out quickly. They either move on to other organizations as peers or pursue other types of employment.

- **Transitional Peers**: This group includes many of the newest and most recently certified CPSs and has a fairly high rate of attrition. Many people in recovery embrace training and certification as a CPS as an important step in their individual processes of recovery. They see it as a way to restart their lives following the disruption of illness, a means to start or restart their work lives, and potentially, an economic alternative to living on disability payments. For many, starting work as a CPS will be a springboard to a better peer support position or to another job in the behavioral health field. Others will transition from working as a CPS to employment outside the field of mental health. And, unfortunately, some will determine that they aren't capable of sustaining recovery and working as a peer.

Understanding the work of peers

According to a growing body of practical evidence, the services provided by peer specialists can be highly effective in the lives of people with mental health conditions or SUDs. Peer specialist interventions often help individuals restore a sense of hope, regain the power of personal choice and decision-making, and model the strength and example needed to choose a path toward recovery.

Unlike clinical mental health professionals, whose work is shaped largely by education, the work and the ethic of peer support specialists are shaped by lived experience, often involving personal failure or tragedy. For civilians, this often means mental illness or an SUD, employment problems, homelessness, arrest and incarceration, court-ordered or involuntary treatment. For military veterans, it often means learning how to live despite unforgettable moments of trauma, or learning how to cope with the moral, mental, or physical scars left by months of constant danger.

While clinical professionals depend for success primarily on learned interventions like medications and therapies to change the lives of their patients, peers see their lived experience—both the tragic part and the recovery part—as the keys to connecting with and to inspiring hope and change in others.

After a peer makes that personal "connection" and establishes a relationship, the work can begin. Sometimes the work begins by sharing hope through a personal story of recovery. At other times, it's a bit of intervention, with the peer prompting the individual to think and to choose. The choice is between making a decision and exercising personal autonomy or continuing the cycle that contributed to the crisis: the absence of decision making, the personal drift of helplessness due to an acute mental health problem or ongoing substance abuse. The peer seeks to activate the other, to prompt the "normal" behavior of decision making, even in the midst of a personal crisis. The difference, of course, is that the peer knows through experience that there's a hopeful resolution ahead, while the individual feels only the helplessness of the moment.

To the medical mind, peer support is easy to dismiss or be skeptical about. How can storytelling, dreaming and hoping compare with medications for managing symptoms or restoring and maintaining stability? But peer supporters see things differently. They appeal to the part of the brain where love, security, and humanity are felt. They hope to trigger a spark of self-awareness or hope capable of producing an act of will that is powerful enough for an individual to reassert the self amid illness or crisis.

How peers "connect" with individuals

Lori Ashcraft, PhD, INAPS co-director and a respected expert on the work of peers, explains this complicated interaction and illustrates some of the ways that peer-to-peer interactions differ from traditional clinician/patient interactions.

"If I meet you and you're a person who's in trouble or crisis due to a mental health problem, I know that if I get close to you and I care about you, it's going to hurt me because I'm going to have to feel what you're going through," she says. "Now, right there, the history of the clinical profession has created a firewall—some call it professional distance, dual relationship, or another term—with the purpose of protecting themselves as they move forward with evaluating and treating an individual."

"Peers don't have that—they don't use a firewall," says Ashcraft, noting that the peer's objective isn't to treat anything, but instead to create a relationship and establish trust."

"When a peer gets to that point—the point where it's going to hurt—there's where the love and unconditional acceptance comes in," continues Ashcraft. "A trained peer says, 'I'm going to go ahead. I'm

going to accept the pain that I'm going to feel when I am with you. But, I'm not going to live at the level of that pain, because if I do, I can't be of service to you."

"This is where peers are trained to 'be in two places at once," Ashcraft explains. "So, on one level, as a peer is listening to and feeling all of those things, on another level, he's thinking, 'I've got to keep my head here, so I don't get overwhelmed.' This is where the love comes in, because when a peer makes that commitment to love, fear diminishes. The peer decides, 'I'm gonna go for it here.' At that point, the peer's commitment is to just be with you, completely present in your situation. They know that they aren't there to ask a lot of clever questions—that's the therapist's job—or to fix you or to offer a lot of advice."

"Instead, the peer's job is to work with the person to go deeper inside and learn more. The peer is looking to find and understand the strengths that are within the person, then—amid the person's current crisis—to reflect those back in a positive way so that the person can start finding himself again, and finding his own direction forward."

"The goal is tapping into a person's own powerful sense of self determination," Ashcraft says. But, she cautions, "The moment that I step in or tell you what to do, I rob you of that power, which is what you need most at that time."

How peers activate individuals' self-determination

Shannon McCleery-Hooper, a trained Peer Support Specialist, is the Program Manager in Riverside County, California's Consumer Affairs Division, where she mentors some 160 Consumer Peer Support Specialists working in facilities throughout the county. She recounts an interaction involving a person who was just discharged from county's crisis care facility, where she had just finished a meeting and was going to leave in a county car.

"When people aren't clear, when they're in a situation where they don't feel like they have any power, we try to support them in making decisions. One of the concepts of recovery coaching is to give a person the space to explore what they really want. But doing that means fighting the urge that we often have to tell someone what needs to be done, or to fix the situation."

So, when McCleery-Hooper encountered the just-discharged woman walking outside, holding a bag with her discharge instructions and looking lost, she engaged the woman in conversation. In doing so, she enabled the woman's own sense of self-determination to prevail.

> "You look a little lost right now. Where is it that you want to go?"
> "Well, I want to go see my doctor, because I don't like the medications that I'm on."
> "How are you going to get there?"
> "Maybe I could call my Mom. (Pause) But I don't want to because we had a fight before I went to the hospital. I guess I could take the bus."
> "The bus?"
> "Oh, but I don't have any money."
> "Do you know anyone else with a car?"
> "No." (Pause) "Do you have a car?"
> "Yes, I do."
> "Could you take me to the doctor?"
> "Well, I could. How would you feel about me taking you to the doctor?"
> "That would be great."
> "Well, let's go. Hop in."

McCleery-Hooper acknowledges the obvious: "It would have been a lot faster, a lot more efficient, if I had just offered her a ride. But as a Consumer Peer Support Specialist and a service provider, it's my job to give people the time they need to come up with their own answers."

How the Veterans Administration is working with peers

In 2012, the escalating veterans' suicide crisis put huge pressure on Congress, the Obama Administration, and on the VA medical system to respond. In August 2012, an executive order made $54 million available, with the expectation that the VA would add 800 new peer support personnel by the end of 2013. And Dan O'Brien Mazza, the VA's Director of Peer Support Services, got to work.

Immediately, he ran into some challenges. While he first envisioned having all the new VA peers trained and certified to a single standard so as to assure "a consistent level of capability and quality" on the job, he found that existing VA human resources qualifications made that hope difficult to achieve. The existing qualifications requirements already allowed VA peers to hold either a variety of VA-approved non-profit certifications or state certifications. He notes that VA qualifications also required that peers be in recovery from a mental health condition or SUD (many vets suffer from co-occurring disorders), and that they themselves be veterans.

With no way to require a single certification process, O'Brien-Mazza decided to review all of the peer support training and certification organizations that were providing certification at the time. "We distilled out the competencies that we felt VA peer specialists ought to have," he said, noting that the VA awarded a contract to the Depression and Bipolar Support Alliance (DBSA) as its first approved non-state training/certification provider.

His challenges with adopting a curriculum for peer training and certification mirror those of the peer support field, where a range of training requirements and certifications exist, mostly on a state level. "Think of the VA as having peer specialists trained by multiple versions of a similar curriculum, but having at least one that we developed and contracted a training organization to provide," he said.

Compared to many peer support training programs, he added that the VA differs somewhat in its standards for peer training. "Since the VA is a professional healthcare organization, we part ways with other peer-run organizations that are not requiring their peer specialists to learn about medications or clinical processes. Within the VA, peers are on care teams with professional mental health providers who are speaking about a lot of these things. So in the two weeks of training that they receive, we want them to have this professional-related information, so that they can have basic familiarity and keep up with the team discussions."

By the end of 2013, O'Brien-Mazza said that the VA had added about 900 peer support personnel. VHA is proud to have the largest peer workforce in the nation. The VA's approach was to classify them as entry level GS-5 or GS-6 employees, similar to health technicians with bachelor's degrees. While many peers don't have that much formal education—a high-school diploma or GED is more typical—O'Brien-Mazza noted that peers "are working with very ill people, providing services that in some ways are complementary to those offered by clinical professionals." Therefore, a career ladder was developed which allows them to reach a GS -9 full performance level after completing a year at each lower grade.

These new peer positions were distributed across the nation, based on the behavioral health populations served at each VA facility, though every facility got a minimum of two peers. VA peers may be deployed in many different roles. Many peers work in alcohol or drug rehabilitation programs, or at Psychosocial Rehabilitation and Recovery Centers (PRRCs), where, according to O'Brien-Mazza, "they are running

groups, facilitating Wellness Recovery Action Plans (WRAP), teaching veterans basic techniques for managing symptoms, supporting medication or PTSD treatment programs, and sharing their lived experiences with veterans." He adds that peers may also visit veterans in the community and assist them with practical ideas for getting to work and being successful, building relationships, or socializing and dating without resorting to bars and alcohol.

With fewer than three full years of experience having all these peer specialists on the job, O'Brien-Mazza says that "it's almost too soon to evaluate" the initial outcomes of the VA's peer support programs. Though randomized controlled studies of peer support are rare, he says that there's plenty of anecdotal information. He points to "people who are alive, who made it through a period of suicidal thinking with the help of a peer. Or, those who've shared something with a peer that they hadn't been able to share with a psychologist for two years." For reasons like these, he says that "peer support services are integral to, not adjunctive to, VA health services."

Taking action to expand peer support services

There's a wealth of information available from various organizations to assist counties and organizations who are interested in training peers and developing peer workforces. INAPS and its members nationwide offer support, consulting, and a range of resources (publications, guidelines, videos, and webinars). To learn more visit www.INAOPS.org.

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