A special thanks and recognition to Substance Abuse and Mental Health Service Administration (SAMHSA) for much of Chapter 3: Recovery Concepts and Chapter 4: Culture Shift taken directly from SAMHSA white paper on Peer Services 2008
# Montana Peer Support Toolkit

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INTRODUCTION

It is very humbling to be asked to help develop a peer services toolkit for the state of Montana. To know that the information within these pages will be used to improve services throughout the state of Montana has been a long time coming. As a recipient of mental health service and as a person who identifies as being in long term recovery, I am grateful for the opportunity. It has been a pleasure to work with the Peer Support Task Force members and in particular Conan Green and Stacey Wheeler. These are two fine individuals who truly get what recovery is all about. They both exemplify this in the work they do on the ground with Montana citizens. In the wider view this toolkit is one small part of that recovery movement happening not only in Montana but nationally and internationally. This movement is much more than the simple inclusion of peers in the decision making process. By including peer supporters in the array of services offered a cultural shift happens from a medication model of treatment to a recovery model which includes the message that “recovery is possible”. Peer Supporters in this state and around the world are living proof of recovery. They carry with them a glimmer of hope, words of inspiration and the undeniable connection one person can make with another. As peer supporters we do this because for many of us we have been there and in our darkest hour it was another who did the same for us. It is my hope that you will find great value in this toolkit and consider it a resource for creating new recovery oriented services in your community thus adding another layer to the recovery movement at large.

Jim Hajny
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Thank you for taking the time to learn about Peer Support in the State of Montana. This toolkit has been designed through intense collaboration between advocacy groups, community stakeholders, the Montana Peer Task Force and the Addictions and Mental Disorder Division (AMDD) of Department of Public Health and Human Services (DPHHS). The toolkit development was an action step stipulated in the Request for Proposal regarding Peer Services awarded by AMDD in 2013. The three agencies awarded this grant have worked collectively to complete this toolkit with the expectation that through a standardized and integrated process Peer Services will be a sustainable and deliverable service throughout the state of Montana. The three awardees come together through very different channels including: Advocacy, Mental Health and Wraparound, to build this comprehensive guide to understanding Peer Services, the process of implementing them and vast array of peer supports available to utilize in a systems of care designed to support individuals from treatment to recovery. The three agencies forging this path are The Montana Peer Network, Winds of Change Mental Health Center and Consumer Direct Peer Recovery Coaching program. All three agencies have been implementing Peer Support Services and have been accountable to the Montana Peer Task Force as well as AMDD.

Peer Support Services are recognized nationally as legitimate services in community health care by Federal and State authorities. The Substance Abuse and Mental Health Services Administration (SAMHSA) view peer support as an evidenced based practice that needs to be widely available. There are many state Medicaid programs across the nation not only considering peer services but that also have found ways to reimburse for these services either through grant funds, systems of care collaboration or Medicaid state service plans. Already there are 35 states nationwide implementing Peer Support Services. Out of those 35 states there are 17 states that have built Peer Services into their state Medicaid plan. The federal government through SAMHSA has been assessing Peer Services since 1999 and has now collected enough information to emphasize the importance of recovery support by peers. Through Peer Support Services we have seen a reduction in cost and stress to the mental health system, reduction in recidivism in state hospitals and correction facilities and a better understanding of the support needed for chronic issues that continue long after treatment is complete.

**WHAT ARE PEER RECOVERY SUPPORT SERVICES?**

Peer-based recovery support is the process of giving and receiving non-clinical assistance to achieve long term recovery from mental health, physical health and substance abuse issues. This support is provided by people who are experientially credentialed and trained to assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.

The primary target population for Peer Supporters is people with a chronic condition of mental health needs, addictions, and/or physical health needs along with their family members and significant others. People in a recovery
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design, and as peer service providers, deliver peer recovery support services. Successful peer recovery support programs offer participants a network for building strong and mutually supportive relationships with formal systems in their communities (i.e., treatment programs, housing, transportation, justice, education). Peer services are delivered primarily by individuals in recovery to meet the targeted community’s recovery support needs, as the community defines them. Therefore, although supportive of formal treatment, peer recovery support services are not treatment in the commonly understood clinical sense of the term. Peer supporters offer individuals with mental health, substance abuse and physical health conditions encouragement, hope, assistance, guidance and understanding that aids in recovery. Supports are offered in the community anytime, anywhere when two or more peers are in a mutual supportive relationship.

Peer recovery support services are expected to extend and enhance the treatment continuum in at least two ways. These services help prevent relapse and promote long term recovery, thereby reducing the strain on the overburdened treatment system. Additionally, when individuals do experience relapse or crisis, recovery support services can help minimize the negative effects through early intervention and, where appropriate, timely referral to treatment.

Peer recovery support services are designed and provided primarily by peers who have gained practical experience in both the process of recovery and how to sustain it. They provide social support to individuals at all stages on the continuum of change that constitutes the recovery process. Services may be provided at different stages of recovery and may:

- Precede formal treatment, strengthening a peer’s motivation for change;
- Accompany treatment, providing a community connection during treatment;
- Follow treatment, supporting relapse prevention and focusing on long term recovery;
- Be delivered apart from treatment to someone who cannot enter the formal treatment system or chooses not to do so.

The Four Kinds of Support that Peer Supporters Offer:

- Emotional support- demonstrations of empathy, caring, and concern in such activities as peer mentoring and recovery coaching as well as recovery support groups;
- Informational support- provision of health and wellness information, educational assistance, and help in acquiring new skills, ranging from life skills to employment readiness and citizenship restoration (e.g., voting rights, drivers licenses);
- Instrumental support- concrete assistance in task accomplishment, especially with stressful or unpleasant tasks (e.g., filling out applications, obtaining public benefits) or providing supports such as child care, transportation to support group meetings, and clothing closets;
- Affiliation support- opportunity to establish positive social connections with others in recovery so as to learn social and recreational skills.
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PEER SUPPORTERS ARE NOT:

- Treatment providers including therapists, LAC’s, Case managers, behavioral specialists
- Sponsors for 12 step programs
- Clergy members
- Nurses/ Doctors
- Friends

PURPOSE OF THE TOOLKIT

This toolkit is designed to walk you through the process of establishing a successful peer support service. When carefully planned, employing peer support workers will help create a holistic approach to services that can result in better outcomes for individuals and help produce a stronger, more credible agency. The toolkit includes:

- Information on the Montana Peer Task Force and Montana’s Peer Network
- Understanding the Recovery Movement
- Understanding the cultural shift including organizational readiness to implement peer supports, recovery language and concepts, trends and history.
- Peer services that are already available in the state of Montana and other service programs that could benefit the state as well as funding options
- Recovery Community
- Hiring process of Peer Supporters
- Training and certification for Peer Advocates, Peer Mentors, and Peer Recovery Coaches
- Ethics
- Ongoing Supervision and other policies and procedures useful to standardizing the service array
- Wellness planning and the role of the Peer Support in planning
- Research and quality assurance for peer support programs
- Appendix of references and resources

It is the hope of all contributors that this toolkit be utilized in a way that employers, stakeholders, state agencies and active participants all understand the role of the Peer Support and the relevance and integrity of Peer Support programs so that provision of these services meet the expectations of those utilizing the services, their communities and all invested partners across the state of Montana.
PEER SUPPORT TASK FORCE

The Peer Support Task Force (PSTF) was formed in a collaborative effort between the Addictive and Mental Disorder Division and Montana’s Peer Network in January 2012. The mission of the Peer Support Task Force is “to support and enhance the professional field of peer support for people in the process of recovery from substance use, other addictions, mental illness, or co-occurring disorders.”

The Peer Task Force identified key areas of need in Montana in order to achieve its mission:

- Collaboration
- Study of other state peer services
- Standardization of training
- Funding for sustainable peer services

These four areas are broken down below.

1. COLLABORATION

Since its inception the Peer Task Force has successfully brought together individuals and organizations to ensure a wide view of peer services in Montana that include:

- Peer Supporters
- Montana’s Peer Network
- Mental Health America of Montana
- Disability Rights Montana
- NAMI
- Summit Independent Living Center
- State of Montana – Children’s Mental Health Bureau, Addictive and Mental Disorder Division (includes both the addiction and mental health staff), Job Service, Department of Labor
- Veterans Administration of Montana
- Native American community members
- Western Montana Mental Health Centers
- Center for Mental Health
- Winds of Change Mental Health Center
- Eastern Montana Mental Health Centers
- Consumer Direct
- Helena College
- Parents Let’s Unite for Kids (PLUK)
- Montana State Hospital
2. STUDY OF OTHER STATE PEER SERVICES

Twenty five state peer service directors or managers from around the nation were contacted to better understand the complex issues around developing statewide standardized peer services. Many states sent copies of their state toolkit, handbooks and related documents. These states included: Alabama, Alaska, Arizona, Florida, Hawaii, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming. Many states sent copies of their state toolkit, handbooks and related documents. The PSTF then studied the data to assist in the development of Montana’s plan.

Next the PSTF contacted national experts on peer services and invited them to meetings to share their experience in developing peer services around the country and around the world so we could better understand this complicated process. These experts included, Mark Salzer, Ph.D, Larry Fricks, Director Appalachian Consulting Group, Patrick Hendry Senior Director of Mental Health America National and Robyn Priest consultant of Peerlink National Technical Assistance Center.

The PSTF then collected white papers and resource guides such as:

- SAMHSA’s Strategic Initiative #4 Peer Support [http://store.samhsa.gov/shin/content/SMA11-4629/06-RecoverySupport.pdf](http://store.samhsa.gov/shin/content/SMA11-4629/06-RecoverySupport.pdf)
- Pillars of Peer Support [www.pillarofpeersupport.org](http://www.pillarofpeersupport.org)
- Depression and Bipolar Support Alliance “20 Pillars of Successful Peer Support” [www.dbsa.org](http://www.dbsa.org)
- “Certified Peer Specialist Training Programs Descriptions” Mark Salzer, Ph.D, [www.upennnrct.com](http://www.upennnrct.com)
3. STANDARDIZATION OF PEER TRAINING

In looking at other state plans for peer services we quickly identified the need for standardization. The standardization of peer services will insure the following key quality criteria for providers, the state and peer supporters:

- Standardized training
  - Affordable and accessible peer support training available statewide
  - Continuity in skill sets
  - Professional standing
- Continuity in workforce development
  - Code of Ethics for all peer supporters
  - Scope of Practice for all peer supporters
  - Readiness Assessments (peer supporters and employers)
  - Clinical supervision and support for peer supporters
  - Multiple funding options for employers
- Establishment of a recovery-oriented curricula for peers and employers
  - Three levels of peer support training components identified and developed
  - Identified continuing education requirements
- Paradigm shift on “peer delivered recovery-oriented” organizational and leadership changes to impact the human, social and financial consequences of untreated serious mental illness and substance abuse
  - Toolkit development and implementation
  - Community integration of recovery services
  - Peer services are available in a variety of settings
  - Meets Federal expectations for health care

4. FUNDING FOR SUSTAINABLE PEER SERVICES

Funding for peer services is addressed in Chapter 5
The earliest known peer support and advocacy organization in mental health was the Alleged Lunatic Friend Society established in England around 1845. Its founder John Perceval, a tireless advocate for the reform of the Lunatic Asylums, referred to himself as ‘the Attorney-General of all Her Majesty’s madmen’ (Podvoll, 1990). Some mental health peer run groups also formed in Germany in the late nineteenth century, which protested on involuntary confinement laws. In addiction, peer support and self-help groups have been traced back to the 18th century (Robertson, 2009).

The most well developed peer support community was established in 1937. Alcoholics Anonymous has spread to every country and the twelve steps have been adapted for other addictions and for mental health problems. GROW, a 12 step program started by a priest in Australia in 1957, has also spread to many countries. These forms of peer support are all apolitical.

A new wave of peer support and advocacy in mental health emerged out of the international consumer/survivor movement which began in the early 1970s, around the same time as the civil rights movement, gay rights, the women's movement and indigenous movements. All these movements have in common the experience of oppression and the quest for self-determination. This new wave was based on a critical perspective of psychiatry and society, rather than just the need to ‘reform’ oneself (Chamberlin, 1978). It has been shaped by the limitations and harm done by the mental health system, therefore one of its motivations is to change the system as well as provide alternatives to it (Archibald, 2008; Burstow et al, 1988; Everett, 2000; le Blanc, 2008; O’Hagan, 2004). Many consumer/survivor run initiatives have elements of both peer support and political action.

In the last decade or two many consumers/survivors have started to take up new opportunities to work within the mental health and to a lesser extent the addiction service system, in various roles. It could be argued that we are in a third wave of development in peer support – the use of peer support within mainstream mental health services, where peers are contracted or employed, usually to provide one-to-one support for people using the service. This development gives new opportunities for the growth and funding of peer support, but there is some concern within the movement that the traditional controlling values still operating in many mainstream services may compromise the ‘role integrity’ of peer support (Scott, 2011).
INSTITUTE OF MEDICINE

The Institute of Medicine (IOM) issued two seminal reports—Crossing the Quality Chasm (2001) and Improving the Quality of Health Care for Mental and Substance-Use Conditions (2006)—that inform the foundational qualities of recovery-oriented systems of care. IOM proposed six goals to improving the health care system (2001). Health care should be:

- Safe—avoiding injuries to patients;
- Effective—providing services based on science;
- Patient-centered—providing respectful and responsive care;
- Timely—reducing waiting and delays for service;
- Efficient—avoiding waste; and;
- Equitable—providing equal care to all people without regard to gender, ethnicity, geography, socioeconomic status, or any other factor

IOM concluded that quality health care should employ a patient-centered approach that includes participation of patients and their families in the decision-making and in all aspects of treatment and recovery planning and management. IOM also maintains that patients’ self-management of their own recovery is central to improving the quality of care. In addition, the 2006 IOM report on mental and substance-use conditions recognizes the importance of peer support services and calls for reimbursement for peer support services and other recovery support services.

RESEARCH SUPPORTING RECOVERY SUPPORT SERVICES

Addiction treatment and recovery support services have repeatedly been shown to be effective with many people achieving recovery. As with any chronic disease, however, discrete treatment episodes, supported by continuing recovery support services, are often needed to help people achieve and maintain recovery. Treatment for addictive disorders is not typically a “one-shot” type of intervention. Research indicates that cost savings are associated with a chronic care model when compared to an acute care model (Zarkin, Bray, Mitra, Cisler, & Kivlahan, 2005). A number of studies have been conducted on specific aspects of recovery support services. Several studies indicate that for people with low recovery capital and high disease severity, social supports provided by sober living communities are critically important to long-term recovery (Jason, Davis, Ferrari, & Bishop, 2001; Jason, Davis, & Ferrari, 2007). Other studies on recovery support services involving family members and other allies found that providing social supports helps maintain recovery (Gruber & Fleetwood, 2004; Brown & Lewis, 1998). Studies have also shown that providing comprehensive services assists recovery (Pringle et al., 2002) and that strong social supports also improve recovery outcomes (Humphreys, Moos, & Finney, 1995). Research on peer-recovery support, in addition to the many studies that have been conducted on mutual aid groups, provides evidence for the effectiveness of services in supporting recovery (Humphreys et al., 2004). Another study randomly assigned 150 individuals
to either an Oxford House or usual-care conditions after substance abuse treatment. At 24-month follow-up, those in the Oxford House condition had significantly lower substance use, significantly higher monthly income, and significantly lower incarceration rates that did those in the usual-care condition (Jason, Olson, Ferrari, & Lo Sasso, 2006). Additional studies support the benefit of recovery coaches, mutual aid societies, and social and community supports in achieving long-term recovery (Scott, Dennis, & Foss, 2005; Laudet, Savage, & Mahmood, 2002).

A study by McKay (2005) found that recovery check-ups and active linkage to recovery supports following treatment are important in maintaining recovery. These services can be low cost, such as telephone-based support and checkups, and still be effective. Research by Fiorentine and Hillhouse (2000) found that those who participated in both treatment and recovery support groups had better long-term recovery outcomes than people who used either service alone.

**SAMHSA’S PROGRAMS**

SAMHSA/CSAT (Center for Substance Abuse Treatment) has initiated several grant programs that foster the creation of a chronic care approach for persons with substance use disorders, which can be integral to the development of recovery-oriented systems of care. SAMHSA’s Access to Recovery and the Recovery Community Services Program are the most illustrative examples. These programs support SAMHSA’s goals of accountability, capacity, and effectiveness—as well as the six aims expounded by the Institute of Medicine—by fostering person-centered care, providing choice, expanding capacity, and improving linkages to primary care and community- and faith-based organizations.

1. Access to Recovery

Access to Recovery, a competitive discretionary grant program funded by SAMHSA/CSAT, seeks to expand capacity, support client choice, and increase the array of community- and faith-based providers for clinical treatment and recovery support services. These grants are available to States, Territories, the District of Columbia, Tribes, and Tribal Organizations (all referred to in this paper as “States”). A Presidential initiative, Access to Recovery is a voucher system that gives clients a choice of eligible treatment providers from which to obtain needed recovery services. The first Access to Recovery grants were awarded in 2004 to 14 States and one Indian Health Board for a 3-year period. Grantees maintain a diverse network of community- and faith-based organizations that offer treatment and recovery support services. Second-round grants were issued in 2007.

Access to Recovery offers flexibility in designing and implementing programs, consistent with proven models of care, and ensures that clients have a genuine, free, and independent choice among eligible providers. The voucher program is designed to support a mixture of clinical treatment and recovery support services and to provide cost-effective, successful outcomes for the largest number of people. Access to Recovery provides an array of clinical and recovery support services for people who are diagnosed with substance dependence or substance abuse, and services are individualized to meet each person’s needs.

An important component of the Access to Recovery program is partnering with grassroots providers, including community- and faith-based organizations. These organizations are often
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based in poor and isolated communities where local residents may have few opportunities or resources for other sources of support or help. These groups are often uniquely positioned as trusted institutions in their respective communities and have the cultural understanding necessary to provide long-term recovery support to local residents.

2. Recovery Community Services Program

CSAT initiated the Recovery Community Support Program in 1998 to help the recovery community organize members to participate in public policy discussions and to develop campaigns to combat stigma. The 1998 cohort of grantees consistently voiced the great need for community-based recovery support services to help prevent relapse and promote long-term recovery. In 2003, the name was changed to the Recovery Community Services Program (RCSP), and CSAT began providing funding for grantees to develop and provide innovative, peer-based recovery support services in community settings. These services extend the continuum of recovery by offering strengths-based services that emphasize social support as a factor in initiating and maintaining lifestyle change.

The primary target population for the RCSP is people with a history of alcohol or drug problems who are in or seeking recovery, along with their family members and significant others. People in recovery design and, as peer service providers, deliver peer recovery support services. Successful peer recovery support programs offer clients a network for building strong and mutually supportive relationships with formal systems in their communities (i.e., treatment programs, housing, transportation, justice, education). Peer services are designed and delivered primarily by individuals in recovery to meet the targeted community’s recovery support needs, as the community defines them.

HISTORY OF RECOVERY MOVEMENT IN MONTANA

(Timeline of the recovery movement in Montana)

Early 2000’s  Consumers begin to voice concerns with the medical model approach to treatment. These efforts are largely individualized and lacked cohesion.

2006-2007  Montana Recovery Educators - Consumer/peer movement officially begins in Montana. First recognized peer organization in Montana. The main focus was Copeland Center Wellness Recovery Action Planning workshops or WRAP.

2007-2009  Consumers Asserting Leadership in Montana – Consumers legally organize and incorporate. Many of the early members join advisory councils and begin to vigorously advocate for change. Federal support for the recovery movement in Montana begins via the National Technical Assistance Center.
2009-2011  **Montana Peer Network** – A steering committee is formed to plan and further develop the organization. The name is officially changed and a partnership with Mental Health America of Montana is formed. The organization hires its first employee.

2011-Present  **Montana’s Peer Network** receives its 501c3 non-profit status. The organization recruits a new Board of Directors, and develops a new mission, bylaws and policies. The new mission is to provide opportunities for recovery across Montana. With a coalition of over 500+ members who identify as being in recovery from a mental health, substance abuse or addiction issues the organization is firmly at the head of the recovery movement.

2013  **Grant awarded by AMDD through the Mental Health Trust Fund** – This grant was focused on designing Peer Support Services in the state of Montana with the expectation of standardized training, research and evaluation, direct service provision. Three grantees were awarded this grant including; Montana Peer Network in Bozeman, Winds of Change Mental health Center and Consumer Direct in Missoula. The three grantees have until July 2015 to demonstrate effectiveness of peer support and complete a toolkit for the State of Montana so that Peer Supporters could be utilized statewide.
To truly integrate peer supports within a service structure it is imperative to recognize the importance of a cultural shift in how we deliver services and supports and recognize the value added by including peer supporters in our service array. This chapter will focus on necessary components including; current barriers, organizational readiness, components of peer support, and recovery language and concepts.

CURRENT BARRIERS, CHALLENGES AND SOLUTIONS
(cited directly from the SAMHSA white paper on peer services 2008)

Systems undergoing change—especially those as complex as systems delivering services for substance use disorders—face barriers and challenges to altering the status quo. These barriers and challenges include issues related to infrastructure, regulation, and financing as well as conceptual and attitudinal shifts that must be made. Resistance to change is to be expected as people and institutions worry about their roles, positions, and possible change in status. For example, the professional status of addictions counselors is a relatively recent occurrence compared to many other disciplines, and changes to the system can create new concerns about the status of addictions counselors in the system. In addition, attitudes and stigma about people in recovery can undermine the process. Creating a recovery-oriented system of care, which involves changes at all levels of the substance use disorders delivery system, certainly presents some challenges.

BARRIERS

As described by White and Kurtz (2006), the conceptual and institutional barriers that impede the shift to a recovery-oriented system of care include:

- Difficulty in moving from deficit- or problem-focused thinking to a strengths-based focus and accepting the chronic model of care;
- Addiction professionals’ pride and concerns about status and power, coupled with suspicion about the abilities of indigenous healers as peers;
- Lack of protocols and financing for recovery support services;
- Absence of ethical codes that guide peer recovery services; and
- Weak infrastructure of addiction treatment organizations and staff turnover.

In addition to the barriers among providers and professionals in the field, most faith-based and peer recovery support services are grassroots organizations that lack the infrastructure needed to comply with Federal, State, or local reporting requirements. They often do not have appropriate accounting systems in place to track and justify grant or reimbursement payments. In addition, grassroots organizations need help in setting up an appropriate infrastructure—governance boards; financial, employee, and volunteer policies; ethical guidelines; and volunteer recruitment and training—as well as developing a sustainability plan. This lack of experience, as well as
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Concerns about the respective roles of traditional providers and peer-recovery organizations in recovery-oriented systems of care, are concerns that need to be addressed. Overcoming these barriers requires a concerted leadership effort and the engagement of all stakeholders. Faith-based groups often are reluctant to participate in government programs as they are concerned about the constraints or conditions that come with government funding.

CHALLENGES

The overall challenge to moving to recovery-oriented systems of care is maintaining quality assurance standards while preserving the uniqueness of the peer-recovery and faith-based services and integrating recovery support services into a more structured and regulated system. Utilizing peer-recovery services programs and faith-based organizations to provide services is a critical component of recovery-oriented systems of care, and preserving their status as non-professional grassroots entities is a key factor in maintaining a recovery focus. However, states and other governmental entities also need to ensure that organizations with good management practices are providing quality, competent services to clients and their families without overburdening these nontraditional providers with cumbersome regulations and standards.

In many cases, grassroots organizations need help with establishing appropriate fiscal policies, recordkeeping, and reporting tasks because these groups are very small and often rely on volunteer labor. States also have to ensure that faith-based organizations adhere to the requirements enumerated in the Executive Order on Charitable Choice, including protecting the religious freedom and choice of those seeking services, not using Federal funds for inherently religious activities, and separating recovery services from religious proselytizing. In addition, nontraditional providers need to develop codes of ethics that both are applicable to their status and protect consumers receiving services.

An additional challenge arises from the differences in cultures between faith-based and community-based grassroots organizations on the one hand, and the professional treatment system on the other. Differences may arise from concerns about encroaching on professional services, lack of understanding about recovery support services, resistance to change, and basic philosophical differences about paths to recovery. These differences also stem from concerns about quality assurance issues and how recovery support services fit into the overall system. Developing a rate structure that sustains recovery support services is another challenge that states face as they move toward a recovery-oriented system of care. A number of states, particularly those with Access to Recovery grants, have developed rate structures for recovery support services. Among the services covered are housing, educational and employment services, spiritual coaching, child care, mentoring, family support, life skills training, and vocational training. As States implement recovery support services, they need to review their organizational, regulatory, and funding mechanisms for needed changes.

Other challenges faced in adopting a recovery-oriented system of care, cited by a number of states, include:

- Maintaining ongoing communication between licensed clinical treatment providers and nontraditional recovery support services providers;
• Maintaining the “peer-ness” of peer recovery support services and resisting the pressure to “professionalize” these services, while ensuring quality services and successful outcomes;
• Resisting any pressure, due to budget constraints or other reasons, to replace clinical services with recovery support services, as both are needed;
• Reviewing and modifying regulations and laws that are inconsistent with recovery-oriented systems of care; and
• Obtaining reliable evaluation data to support the efficacy of recovery support services.

SOLUTIONS AND OPPORTUNITIES

Through their experiences in developing recovery-oriented systems of care or in implementing the Access to Recovery grants, States have found many opportunities to respond to the challenges brought on by these system changes. Information from the SAMHSA Recovery Support Services meeting—“Lessons Learned and Future Directions,” held in January 2007—and a report on recovery support services, prepared by the Legal Action Center and presented at this meeting, provide some insights into how States have met the challenges and resolved some of these issues.

A. Overall Approach

In the reports from the States and in documents presented at meetings on recovery support services, an overriding concern about implementation was precisely how to enhance and increase access to services through use of recovery support services. Solutions included the following:
• Have stakeholders work together to identify ways to ensure the quality of recovery support services while allowing them to grow and diversify.
• Use a consensus building process, and bring together all the stakeholders from the outset.
• Keep the oversight of peer- and faith-based organizations flexible enough to adapt to new challenges and lessons learned.
• Provide adequate training to address new standards and regulations.
• Recognize that this is a multiyear process.
• Utilize existing partnerships to assist in the development and implementation of a recovery-oriented system of care.

B. Addressing Quality Assurance

At least 13 States have developed standards and oversight procedures for recovery support services (Legal Action Center, 2007). States have addressed quality assurance for recovery support services with a variety of responses, and examples of their approaches are provided below. In addition, the RCSP grantees developed a set of quality indicators, which may be useful in the development of standards for peer recovery support services programs.

State Responses to Quality Assurance
Montana Peer Support Toolkit

- Connecticut uses a number of approaches to ensure quality by having recovery support services providers obtain certification for each of the services they provide. The State has established practice guidelines for recovery support services that allow the provider to evaluate its capacity to provide services and comply with program requirements. Connecticut performs site visits as part of its monitoring oversight and provides suggestions for improvement. In addition, the State conducts cost analysis of recovery support services and analyzes their comparative effectiveness.

- New Mexico utilizes best practice standards for recovery support services. ValueOptions New Mexico is responsible for credentialing key personnel and volunteers who supervise delivery of recovery support services in the State. Those who provide pastoral recovery support services receive training in alcohol and drug addiction recovery and spiritual support methods.

- Alaska has initiated a Competencies and Credentialing Project to develop core competencies for all behavioral health, including recovery support services. The State is in the process of identifying alternative credentialing processes to operationalize the competencies.

- Arizona has created a new staff category, Peer Support Specialists. These staff members serve as mentors and recovery coaches in treatment programs. Although they originally focused on serving individuals with serious mental illness, 70 peer support specialists have been trained in the past few years to provide substance use recovery services. Training is a critical component of the State’s system to ensure that peer support specialists are qualified for their positions.

- Florida requires that organizations providing recovery support services be certified or obtain credentialed status through the Single State Authority, which has partnered with the Florida Faith-Based Association to assist with the process. The credentialing process includes onsite reviews using a checklist developed for this purpose. Following review, programs receive either approval or a corrective action plan.

- North Carolina has tasked the University of North Carolina at Chapel Hill School of Social Work to develop and manage a certification program for peer support specialists working in both mental health and addictions. The program began in July 2007. Although some people providing recovery support services were grandfathered into the certification program in July 2006, everyone will be required to complete the training program and become certified within 2 years.

Organizational Readiness

Before starting a peer service it is important to review your organizational readiness as an employer. The state of Montana has adopted a scale to help employers review and decide key steps to making sure your organization is ready to provide peer services. This scale is called the “Employer Readiness Self-Assessment”. You will find this scale in the Appendix page 52.

This Employer Readiness Self-Assessment tool was designed by the Peer Support Task Force to assist organizations in the creation, development and/or enhancement of peer services in their organization. In order to ensure success of peer services in an organization, vital components are needed to facilitate a recovery oriented culture.
Common Indicators of Quality in Peer Recovery Support Services Organizations;

At their Annual Technical Assistance Conference in August 2005, the RCSP projects identified 12 common indicators of quality to use as guidelines for the peer recovery services grantees. These quality indicators reflect the insights of the 28 RCSP projects represented at the meeting. Not every RCSP grant project, or even any single project, can demonstrate all of the quality indicators. However, these indicators may be useful to others in the development of program standards or oversight mechanisms. The quality indicators are as follows:

1. Peer recovery support services are clearly defined in ways that differentiate them both from professional treatment services and from sponsorship in 12-Step or other mutual aid groups.
2. The programs and peer recovery support services are authentically peer (participatory, peer-led, and peer-driven) in design and operation.
3. The peer recovery support program has well-delineated processes for engaging and retaining a pool of peer leaders who reflect the diversity of the community and of people seeking recovery support.
4. The peer recovery support program has an intentional focus on leadership development for the peer leaders.
5. The peer recovery support program operates within an ethical framework that reflects peer and recovery values.
6. The peer recovery support program incorporates principles of self-care, which are modeled by staff and peer leaders, and has a well-considered process for handling any relapse of peer leaders.
7. The peer program and peer recovery support services are non-stigmatizing, inclusive, and strengths-based.
8. The peer recovery support program honors the cultural practices of all participants and incorporates cultural strengths into the recovery process.
9. The peer recovery support program connects peers with other community resources, irrespective of types of services offered.
10. The peer recovery support program has well-established, mutually supportive relationships with key stakeholders.
11. The peer recovery support program has a plan to sustain itself.
12. The peer recovery support program has well-documented governance, fiscal, and risk management practices to support its efforts.
COMPONENTS OF PEER SUPPORT

Definition of Recovery
In September 2005, CSAT’s Partners for Recovery Initiative convened a diverse group of 100 stakeholders—including systems professionals, treatment providers, researchers and evaluators, recovery support services providers, mutual aid groups, and recovery advocates—for a National Summit on Recovery. The goals of the Summit were:
1. To develop ideas to transform services, systems, and policies in a movement toward developing recovery-oriented systems of care
2. To articulate guiding principles of recovery that can be used across programs and services
3. To generate ideas to advance recovery-oriented care across different systems and for diverse populations.

One of the tasks assigned to the stakeholders was to develop a working definition of recovery. Their deliberations resulted in the following definition: “Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life” (CSAT, 2007).

PRINCIPLES OF RECOVERY

The stakeholders at the Summit established an overarching framework for recovery articulated in the following guiding principles (CSAT, 2007):

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic, involving the body, mind, relationships, and spirit.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery emerges from hope and gratitude.
- Recovery is a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery is supported by peers and allies.
- Recovery is (re)joining and (re)building a life in the community.
- Recovery is a reality.

The stakeholders further agreed that the recovery process is not linear and may include varying levels of progression through the phases of recovery—pre-recovery preparation, initiation of recovery, continuing recovery, and relapse. Stakeholders were clear that recovery is a personal journey and the path to recovery is uniquely individualized. There are no wrong paths to recovery. Recovery may be achieved through any number of ways, including natural recovery, mutual support groups, peer recovery services, clinical treatment, faith-based approaches, or a combination of these and other methods. The critical variable is that the individual chooses the manner of his or her recovery and the services most appropriate to managing his or her recovery.
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There was consensus that the recovery process is a holistic approach to lifestyle changes that may include a spiritual component defined by Ringwald (2002) as “... an ongoing internal process of change that results in a transformation of the recovering person’s attitudes, values, beliefs, and practices.”

Elements of Recovery-Oriented Systems of Care

Recovery-Oriented Systems of Care (ROSCs) support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems. ROSCs offer a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual’s needs and chosen pathway to recovery. ROSCs encompass and coordinate the operations of multiple systems, providing responsive, outcomes-driven approaches to care. ROSCs require an ongoing process of systems improvement that incorporates the experiences of those in recovery and their family members.

Recovery Management is a chronic care approach to the provision of client-directed management of services and supports for persons with chronic disorders at the provider level that reflects many of the elements of ROSCs. Unlike ROSCs, which are designed to address the full spectrum of needs of individuals with substance use problems and disorders, including screening, brief intervention, brief treatment, and early intervention, Recovery Management is a clinical approach taken from a chronic disease management approach applied in general medical settings.

In recovery-oriented systems of care, the expectation is that contact with the client will continue after the acute stage of treatment is completed and that recovery support services are extended to family members and to people who may not have remained in treatment. Recovery management may include checkups in the form of follow-up phone calls, face-to-face meetings, or emails, as well as assertive linkage to recovery communities.

The stakeholders at the 2005 Summit identified the elements of recovery-oriented systems of care as follows:

- Person-centered;
- Family and other ally involvement;
- Individualized and comprehensive services across the lifespan;
- Systems anchored in the community;
- Continuity of care (pretreatment, treatment, continuing care, and recovery support);
- Partnership-consultant relationship, focusing more on collaboration and less on hierarchy;
- Strengths-based (emphasis on individual strengths, assets, and resilience);
- Culturally responsive;
- Responsive to personal belief systems;
- Commitment to peer recovery support services;
- Inclusion of the voices of recovering individuals and their families;
- Integrated services;
- System-wide education and training;
- Ongoing monitoring and outreach;
- Outcomes-driven;
- Based on research; and
Another difference between acute care systems and recovery-oriented systems is that recovery-oriented systems of care utilize a recovery plan instead of a treatment plan. Recovery plans consider a person’s recovery capital. In keeping with the person-centered focus of recovery-oriented care, the recovery plan is driven by the client, not the treatment professional (White & Kurtz, 2006).

**RECOVERY SUPPORT SERVICES DEFINED**

Recovery support services (RSSs) are nonclinical services that assist individuals and families to recover from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. RRSs may be provided in conjunction with treatment, and as separate and distinct services, to individuals and families who desire and need them. Professionals, faith-based and community-based groups, and other RSS providers are key components of ROSCs.

Recovery support services are typically provided by volunteers or paid staff members who are familiar with their community’s support for people seeking to live free of alcohol and drugs. Often recovery support services are provided by peers—people in recovery or family members. Some services require reimbursement, while others, such as mutual support groups, may be available in the community free of charge. As described in the Access to Recovery grant program, recovery support services may include the following:

- Employment services and job training;
- Case management and individual services coordination, providing linkages with other services (e.g., legal services, Temporary Assistance for Needy Families, social services, food stamps);
- Outreach;
- Relapse prevention;
- Housing assistance and services;
- Child care;
- Transportation to and from treatment, recovery support activities, employment, etc.;
- Family/marriage education;
- Peer-to-peer services, mentoring, and coaching;
- Self-help and support groups (e.g., 12-step groups, SMART Recovery®, Women for Sobriety);
- Life skills;
- Spiritual and faith-based support;
- Education;
- Parent education and child development support services; and
- Substance abuse education.
TYPES OF RECOVERY SUPPORT SERVICES PROVIDERS

Recovery support services can be delivered in a number of settings such as freestanding recovery community organizations, as part of treatment agencies, and as services offered by faith-based organizations. Many of these entities are grassroots organizations with annual budgets of less than $500,000. Recovery support services are also delivered by organizations affiliated with other systems, such as criminal justice, HIV/AIDS services, and child welfare. A number of RCSP grantees are housed—and have peers providing services for recently released offenders—in jails, HIV/AIDS programs, and child welfare agencies. Also, recovery support services can be provided by a variety of personnel ranging from peers and family members who serve in a voluntary capacity, specialized staff trained to provide recovery support services, faith leaders and trained congregants, and credentialed professionals.

PEER RECOVERY SUPPORT SERVICES

Peer recovery support services are designed and provided primarily by peers who have gained practical experience in both the process of recovery and how to sustain it. Within RCSP projects, these individuals are designated as peer leaders. Many peer leaders donate their time to the peer recovery support project out of a desire to give back to their communities by helping others who are seeking to recover or sustain their recovery. In addition, peers derive significant benefit from helping others, which is known as the “helper principle” (Riessman, 1965, 1990).

Peer recovery support services provide social support to individuals at all stages on the continuum of change that constitutes the recovery process. Services may be provided at different stages of recovery and may:

- Precede formal treatment, strengthening a peer’s motivation for change;
- Accompany treatment, providing a community connection during treatment;
- Follow treatment, supporting relapse prevention; and
- Be delivered apart from treatment to someone who cannot enter the formal treatment system or chooses not to do so.

Peer recovery support services expand the capacity of formal treatment systems, e.g. medication assisted therapy, residential, therapeutic community and outpatient, by promoting the initiation of recovery, reducing relapse, and intervening early when relapse occurs. Peer leaders in some RCSP projects also provide social support to the recovering person’s family members.

Peer recovery support services are exemplified by the RCSP projects, funded by CSAT, and based on the concept that a crucial factor in helping people move along the recovery continuum is social support. Four kinds of social support identified in the literature (Salzer, 2002a, 2002b) constitute the core of RCSP services:

- **Emotional support**—demonstrations of empathy, caring, and concern in such activities as peer mentoring and recovery coaching, as well as recovery support groups;
- **Informational support**—provision of health and wellness information, educational assistance, and help in acquiring new skills, ranging from life skills to employment readiness and citizenship restoration (e.g., voting rights, driver’s license);
- **Instrumental support**—concrete assistance in task accomplishment, especially with stressful or unpleasant tasks (e.g., filling out applications, obtaining public benefits) or
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providing supports such as child care, transportation to support group meetings, and clothing closets.

- **Affiliation support**—opportunity to establish positive social connections with others in recovery so as to learn social and recreational skills in an alcohol- and drug-free environment.

PEER RECOVERY CONCEPTS

SAMHSA’s Definition:

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

Ten Components of Recovery

1. Self-direction
2. Individualized and person centered
3. Empowerment
4. Holistic
5. Non-linear
6. Strength-based
7. Peer Supported
8. Respect
9. Responsibility
10. Hope

Stages of recovery

1. Stabilization
2. Deepening
3. Connectedness
4. Integration

Scope of Recovery

1. Primary- focuses primarily on one specific health domain.
2. Whole health approach (holistic)- focus on multiple life domains including but not limited to: physical wellness, environmental wellness, spiritual wellness, emotional/psychological wellness, intellectual wellness, occupational wellness and social wellness.

Process of Recovery (which can include layering of different methods and contexts)

1. Abstinence based
2. Moderation based
3. Medication-assisted
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Contexts of recovery
1. Solo (natural) recovery - involves the use of one’s own intrapersonal and interpersonal resources (family, kinship and social network) to resolve problems without the benefit of a professional treatment or involvement in a recovery support group.
2. Treatment-assisted recovery - involves the use of professional help in the initiation and stabilization of recovery.
3. Peer-assisted recovery - involves the use of structured recovery mutual aid groups to initiate and/or maintain recovery.

Frameworks of Recovery
1. Religious: A framework in which problems are resolved within the rubric of religious experience, religious beliefs, prescriptions for daily living, rituals of worship and support of a community of shared faith.
2. Spiritual: Frameworks of recovery that flow out of the human condition or wounded imperfection, involves experiences of connection with resources within and beyond self and involves a core set of values (e.g., humility, gratitude and forgiveness). Religious and spiritual frameworks of recovery can closely coexist and overlap.
3. Secular: A style of recovery that does not involve reliance on any religious or spiritual ideas (God or higher power), experiences (conversion), or rituals (prayer).

Recovery identity
1. Neutral: persons who have resolved issues but do not identify as a person in recovery.
2. Recovery-positive: Persons for whom the status of recovery has become an important part of their personal identities.
3. Recovery-negative: Persons for whom the recovery status is self-acknowledged but not shared with others due to a personal shame derived from the status.

Recovery capital
Refers to the ‘breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery’.

It is the position of the Montana Peer Task Force that when we are mindful about our body, mind, and spirit we are able to overcome obstacles that stand in our way of recovery. While recovery needs to be individualized for each person, the process of recovery is broad enough to include those in recovery from physical, emotional and addiction issues and that by learning about the recovery concepts one can begin to decide how recovery fits into his/her own personal journey. Peers with a shared experience of recovery are able to motivate and model and coach others just learning about their own mindful recovery process.
In Montana several programs provide peer support services. Some of these are reimbursed and others are not.

**Non-reimbursed programs** include Recovery International support groups and NAMI Peer to Peer. Both organizations train members to become leaders of support groups as needed or peers want to take on more of a leadership role. Availability varies by community.

**The Program of Assertive Community Treatment (PACT)** requires that there be a peer support staff on each team. PACT provides a high intensity of services to persons with severe mental illnesses. The peer acts as a role model and provides support to a specific group of clients.

**The Warm Line** is available to all residents of Montana. Mental Health America of Montana supports this program with training, hiring, and support to peers who answer phone calls. Montanans use the Warm Line to have a peer to talk to, decrease isolation, and increase social interaction.

**VA Peer Supporters** are available to veterans throughout the state of Montana. VA Peer Supporters are thoroughly trained and have assisted a number of veterans already. To find out more information about VA Peer Support contact Robert McCabe at Robert.McCabe@va.gov.

**Montana State Hospital** has two peer supporters on staff and are able to assist those in recovery who are in the state hospital with recovery planning, skill building and reintegration into their home communities.

**Drop In Centers (DIC)** provide a safe place for anyone who identifies themselves as having a mental health or a co-occurring disorder. Generally, they are staff by peers who provide support, information about resources, and referral for services or crisis assistance. Members of Drop In Centers do not have to be clients of a mental health center to participate. The peers perform tasks that keep the Drop In Center running smoothly such as reception, janitorial, and recovery activities.

**Medicaid Waivers**, such as the one for Severe and Disabling Mental Illness, allow the person in services to choose from a menu of services. Peer support, Wellness Recovery and Action Plan, and Illness Management and Recovery are all available to be provided by a peer. The peer provider can be reimbursed as an individual contractor.

**Money Follows the Person Program** is designed to increase the use of home and community based services such as peer support and reduce the use of institutionally based services.
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Recovery Coaches are available in Missoula and Bozeman currently through the grantees. Recovery Coaches perform a variety of tasks as persons with lived experience. The lived experience assists person with their recovery, support, crisis intervention, coordination with other entities including mental health and judicial systems, and as a role model.

1915(i) is a state service plan under Children’s Mental health Bureau that includes Peer Support for both caregivers and youth. Currently this program is not being utilized to its capacity and should be looked at as a sustainable source for Peer Support throughout the Medicaid Mental Health Service Plan.

Treatment Courts – Peer Mentors are currently being utilized in DUI, Drug, VA, Mental Health, Youth and Child/Family Service court systems. Varies by community.

Fee for Service is a growing trend across the nation. Peer Supporters are working as independent contractors offering their services for a fee which is paid directly by the client or through insurance.

There are also Peer Supporters available through disability programs such as Summit Independent Living that has Peers working with individuals who have a physical disability and possibly a mental health disability as well. Summit has a complete training curriculum and should be seen as a pioneer in developing peer services in the state of Montana.

Scope of Practice

Recovery Support

Knowledge, Skills and Abilities

- Be able to share their own recovery story in a meaningful and hopeful way
- Provide peer support that is mutual and respectful
- Be able to assist others in developing their own wellness or recovery plan
- Understand the key components of the recovery process
- Be able to facilitate a peer support group
- Be able to connect others to community resources
- Have a working knowledge of the mind body connection and its relation to recovery
- Provide education around wellness and recovery
- Be able to listen and be present in the moment

Mentoring

Knowledge, Skills and Abilities

- Act as a role model for wellness and recovery
- Assist in others in recognizing and building natural supports
- Be able to support others in planning and achieving their own goals at their own pace
- Utilize a strength based approach
Professional Responsibility

Knowledge, Skills and Abilities

- Fulfill necessary training and continuing education requirements
- Understand the role of peer support in the system
- Understand and abide by a code of ethics and standards
- Be able to work as part of a treatment team
- Understand the importance of confidentiality and HIPAA
- Understand mandatory reporting and why this is necessary
- Participate in clinical supervision
- Understand risk factors for suicide

Advocacy

Knowledge, Skills and Abilities

- Provide education around self-advocacy
- Assure those they work with know their rights and responsibilities
- Provide referrals to other community supports
- Advocate for those we work with when necessary

The Montana Peer Task Force has taken into consideration the variety of Peer Support already in place as well as the supports that will be necessary to offer a true scope of practice. We have broken down these supports into three different categories of Peer Support in regards to training, supervision and continuing education. The three levels of Peer Support are:

1. Peer Advocates
2. Peer Mentors
3. Peer Recovery Coaches

A detailed description of each level of peer support can be found on page 38. A matrix breaking down the three levels including training, supervision and Continuing Education for Peer Supporters in a diagram can be found in the Appendix page 54.
COMMUNITY ASSESSMENT

To develop peer support in your community it will be important to first assess what is available in the community presently that utilizes a recovery framework. This could include groups already in place, advocacy agencies, mental health centers, Disability services, addictions recovery centers, 12 step groups, treatment courts, veterans court, homeless outreach, hospitals etc.

The community assessment is a necessary component to begin offering peer support because it is, at its core, a community process that builds or strengthens a recovery community. You will need active partners to build a network of recovery for those you are supporting. The key to peer support is developing self-efficacy for each participant that gives him/her options of different pathways of recovery and to do that you need to know who the resources are to build a system that supports long term recovery through natural supports.

RESOURCE GUIDE

We recommend that while you are completing your community assessment that you compile a resource guide of all the partners you interview to ensure that you have a complete understanding of what is offered and for whom. Design the resource guide with participants in mind so that it is easy to access and navigate. Again, we emphasize self-efficacy so that the participants not only learn what is available but also build skills and confidence to navigate the recovery community.

AWARENESS

Stigma continues to be a key barrier in recovery and services delivery and availability. This appears to be more of an issue in rural areas. Awareness needs to be raised about Recovery in all of its forms. Many persons are unaware of the Recovery movement and may be interested if they knew about services, meetings, or groups in their community. Another issue is that the small communities may lack resources. One way the Peer Support Network and other organizations can provide support is by assisting communities to come up with solutions that fit their community. This could be a wide range of solutions from an informal coffee group to a more formalized Peer Program to formal service delivery.

EDUCATION

Education appears to be very useful to communities in combating stigma. Informal informational meetings and town halls may be useful in the beginning stage of developing community resources. As the community progresses in accepting and acknowledging the need,
then more formal trainings could be set up. Presentations by advocacy groups have a great impact on participants.

Workshops or a conference may be useful when you have several persons / organizations on board with planning services and resources. Many advocate groups and the State of Montana have resources available to assist in setting up Recovery oriented services.

**CHOICES FOR RECOVERY**

One of the components of recovery is that the person has choices in how their recovery will look. More than one choice for recovery is essential as each person must choose their path. For some it may be 12 Step Groups such as Alcoholics Anonymous (AA) and for others it may be very structured treatment programs provided by Addiction, Mental Health or Physical Health Care providers.

The wider the range of choices allows for each person to decide on their path. It also provides options if a pathway is not working. Ideally, a wide continuum of services would be available within each community. This provides choice and the ability to move on the continuum of recovery to meet the individual’s needs. Sometimes people need more support and at other times less. The key is having a variety of recovery choices available in the community. One size does not fit all.

**RESOURCES**

Social media may be a great resource for persons living in rural areas without many opportunities to participate in recovery in their community. There are many chats available in a wide variety of topics you can join.

Using your phone to connect into meetings or to call the Montana Warm Line is another possibility. Many providers are beginning to offer services over the computer and you may have more choices in the future to pick your prescriber and therapist.

Community Conversations about Mental Health Guide

- Information Brief
- Discussion Guide
- Planning Guide
Montana Department of Health and Human Services website (listed below) contains a toolkit for starting a Local Advisory Council in your community, as well as a list of other resources such as the Network of Care web link to a directory of services. This is a good place to keep updated on community resources.

Other online resources:

http://dphhs.mt.gov/amdd/Mentalhealthservices/LOCALADVISORY
www.facesandvoicesofrecovery.org
http://www.mentalhealth.gov
http://www.mhselfhelp.org/
http://montana.networkofcare.org/mh/index.aspx
http://mtpeernetwork.org/resources
http://www.ncmhr.org/
http://www.peerlinktac.org/
http://power2u.org/
http://www.recres.org/
www.samhsa.gov
The hiring of Peer Supporters begins with the hiring best candidate available. One tool to assist in determining this is the Employee Readiness Scale developed by Helena College and the Peer Task Force. This scale assesses the readiness of someone who is interested in working as a Peer Support and gives vital information to potential employers as to what to look for in a successful candidate for Peer Support. We will also cover profile points that we believe are essential in assessing a potential Peer Support as well as formatted interview questions and a rating sheet. (Note: the interview questions are not mandated but are simply an example of how to tie into the profile points described.). Finally we will conclude this chapter with job descriptions developed by other agencies in Montana and benefits planning contributed by Summit Independent Living Center.

EMPLOYEE READINESS SCALE

This self-assessment is a readiness tool to help a peer or a peer support organization determine if a potential employee is ready to become a peer supporter. You can find this scale in the Appendix Peer Employee readiness scale page 54

ADS FOR RECRUITING PEER SUPPORTERS

Sample advertisement for position openings can be found in Appendix page 55

PEER SUPPORT PROFILE POINTS

1. Recovery experience
2. Recovery stability
3. Nurturer not enabler
4. Ability to teach, mentor, coach others
5. Organizational/ time management skills
6. Accepting/ non-judgmental
7. Flexibility and creativity
8. Team player
9. Basic communication skills
10. Computer skills
11. Transportation
12. Self-care
1. **Recovery Experience** - The primary profile point for a Peer Support is a person who is in recovery who is able to articulate his/her experience with recovery in detail to assist others who are in their own recovery process. A preferred experience is one where the interviewee can detail his/her recovery, has experience navigating the recovery community, is familiar with the treatment providers in the community, and respects individualized pathways to recovery. The level of Peer Support should equate to the level of position including advocate, mentor and coach.

2. **Recovery stability** - The second profile point for a Peer Support is a person who is stable in his/her own recovery process and can articulate his/her family situation, has had work experience lasting longer than one year, identifies his/her pathways of recovery and how they are currently being utilized and identify the supports he/she uses on a regular basis. (not a year prior to peer support work)

3. **Nurturer not enabler** - The successful Peer Support is a person who helps others in recovery find the strength and resources to help themselves, not one who does the work for them. We are looking for a Peer Support, not a personal assistant or friend. The Peer Support will need extremely healthy boundaries when mentoring others to develop his/her own self-efficacy.

4. **Ability to teach, mentor, coach others** - The successful candidate will be able to describe how he/she has coached another and demonstrates skills such as; encouragement, motivation, truth-telling, using his/her experience to connect with a person, identified strengths in others, demonstrating a skill and having another practice that skill, and an individualized approach. It is important that the candidate does not rush to “fix” a problem or tell someone what they have done wrong. A successful Peer Support is one who connects with the person they are coaching and focuses on that person finding his/her own way to gain confidence. The successful candidate will present as one who is inspired by the accomplishments of others and has a passion for supporting others to reach their own goals.

5. **Organizational and time management skills** - The successful candidate will be able to articulate how he/she manages his/her own time, maintains a schedule, is strategic in how he/she completes tasks, has a planner and understands the importance of timely documentation, timesheets and is organized in his/her work duties. Peer Support work is more related to performance than process. A candidate with a reputation for chronic lateness, procrastination or cancellation would probably not be a good fit as a Peer Support.

6. **Accepting/ non-judgmental** - A successful Peer Support does not make personal judgments on others based on lifestyle, culture, faith, income, alcohol or drug use as well as not make judgments regarding professionals in the community. A Peer Support is accepting of others where they are, and can help them to build on their strengths to become the best they can be. A candidate with a rigid personality or personal grudges would probably not be a successful-or happy- Peer Support.
7. **Flexibility and creativity** - Flexibility is a crucial trait of the successful Peer Support who understands that crisis begets chaos, and that chaos is the foe of planning. The successful Peer Support understands that plans can quickly go awry, and instead of being frustrated, consider it a challenge to overcome crisis with alternate strategies. The Peer Support is able to realize that a creative approach is important when working with an individualized planning process. A candidate who is overly concerned with standard working hours, focused on structure and routine, and cannot think on his/her feet is probably not the successful candidate for a Peer Support.

8. **Team Player** - The recovery planning process requires that all participants be team players, and this is especially true for the Peer Support, who often acts as a liaison between treatment providers and the recovery process. It is imperative that a Peer Support is able to present professionally by honoring each team member for the strengths and skills they have.

9. **Basic communication skills** - While the Peer Support position places more importance on experience than education, a successful Peer Support candidate will demonstrate basic communication skills including active listening, reflective listening, reading comprehension, writing skills and the ability to speak clearly and logically. A successful Peer Support will be comfortable making phone calls, meeting new people regularly, and presenting professionally in community and team meetings. A successful Peer Support will be able to manage conflict and tension by using proactive and assertive communication skills.

10. **Computer skills** - A successful candidate will have a general knowledge of Microsoft Word and Excel and be able to maintain electronic records for administrative purposes. A successful Peer Support also can navigate the internet to locate and access resources when needed.

11. **Transportation** - **Reliable transportation** is a must for the successful Peer Support. The job requires that Peer Supporters are able to get around the community to meet with the participants and team members throughout the day. There may be different transportation requirements based on different organizations.

12. **Self-care** - A successful candidate for a Peer Support will be someone who understands the importance of balance in his/her own life and will be able to provide information on how he/she makes time for his/her own care including mind, body and soul approaches. To teach self-care and balance a Peer Support will be able to identify what works for them and how they use time to be healthy.

**INTERVIEW FORMAT**

Interview questions and scoring sheets can be found in Appendix page 57.
Chapter 8: Training Peer Supporters

An integrated effort between mental health, physical disabilities, and addictions has been underway for quite some time. The goal was clear that Montana needed a standardized training process for Peer Supporters to ensure that those supports would be knowledgeable and certified to provide this level of care. The following chapter reflects the work that the Montana Peer Task Force has developed over the past few years and will be adopted as minimum expectations for anyone providing Peer Support through state or federal service plans.

Training Curriculum Design

Our agreement as a Task Force was that we would not dictate the training curriculum utilized by a specific provider; however we would want to ensure that core competencies would be addressed and that each curriculum be reviewed by the Montana Peer network before being accepted as the standard of our practice. If there is a discrepancy between MPN and the agency the curriculum would go before the designated oversight council.

How Do I Locate a Trainer for Peer Support?

Currently there are local trainers certified to train Peer Supporters in the state of Montana. The following agencies have developed a training curriculum that is supported by the Montana Peer Task Force and can be accessed for training in the state of Montana. These agencies are:

1. Montana Peer Network (MPN) offers training for Peer Advocates (level I) and Peer Mentors (level II) and Peer Recovery Coaches (Level III) Level I is 10 hours and Level II and III are for hours each. The best way to reach out to MPN is through their trainer and Executive Director Jim Hajny at jim@mtpeernetwork.org. MPN also has a website that has upcoming training dates and locations at mtpeernetwork.org.

2. Summit Independent Living also has an instructional course for Level I and II. For more information please contact Chris Clasby at cclasby@summitilc.org.
You may also choose to either develop your own training curriculum or seek training from national trainers outside of Montana. We simply ask that you submit your curriculum to the Montana Peer Network for review to ensure certification that is recognized within the state of Montana. We anticipate that other national training centers will submit curriculum for approval in Montana over time.

**WHAT IF I WERE TRAINED IN ANOTHER STATE?**

We acknowledge there are Peer Supporters who have been trained in other states with their own system and that we would again ensure certification if the training curriculum met the core competencies for Peer services. If competencies were missing from the original training, individuals would be expected to meet those requirements as needed.

**WILL I BE GRANDFATHERED IN IF I HAVE BEEN TRAINED ALREADY AS A PEER SUPPORT?**

The question regarding grandfathering in those already who have gone through a training process within the past 5 years has also been raised and it is the consensus that these trained people would be accepted as Peer Supporters, however continuing education would be an expectation for all Peer Supporters to maintain skills and desired level of professionalism on an annual basis. The expectations for continuing education can be found in the matrix in chapter 5. For the first year of standardized Peer Support ends July 1, 2016) we will grandfather anyone who has been trained as a Peer Supporter (level specific) who has completed the expected continuing education expectations and continuous work experience (80% of that time) as a Peer Support. It is the responsibility of the Peer Supporter to provide proof of training, education and work experience. Individual requests will be reviewed and decided on by the oversight council.

**WHERE DO I GET CERTIFIED AS A PEER SUPPORT?**

It is the agreement of the Montana Peer Task Force that the Montana Peer Network (MPN) would be responsible for reviewing curriculum and certifying each Peer Support as accepted by the Department of Public Health and Human Services (DPHHS). The Montana Peer Network has agreed to be the gatekeeper and tracker for not only initial training but continuing education requirements. Once processed, the MPN will issue an initial certification as well as a two year recertification when requirements are met. If an issue arises between MPN and a Peer Support regarding certification, then that dispute will go before the peer support oversight council for review. Ruling by the oversight council is accepted as final.

**EXPECTED TIME IN RECOVERY TO BE A PEER SUPPORT**

It is our expectation that a Peer Support should be in recovery no less than six months (depending upon level of certification) and may be receiving community services. The desired
Peer support is someone who has been able to demonstrate stability and has learned skills and developed confidence to facilitate his or her own care.

THE THREE TIERS OF PEER SUPPORT

The Montana Peer Task Force has worked in a collaborative effort with all stakeholders regarding Peer Support and has developed a training matrix that reflects the three tiers of Peer Support. Job titles and levels may vary within different organizations independent of definitions within this document.

1. Peer Advocate (level I)
2. Peer Mentor (level II)
3. Peer Recovery Coach (level III)

PEER ADVOCATE (level I)

The Peer Advocate position is a universal position throughout different divisions within DPHHS. The Peer Advocate may be a volunteer or a paid Peer Support. The Peer Advocate is expected to complete 10 hours of training and have 5 hours of continuing education each year of service. There is also an expectation that the Peer Support receive regular clinical supervision to review performance in the role and address any issues or concerns as they arise (we will discuss clinical supervision more in chapter 9).

Pay range for a Peer Advocate is typically volunteer based to $9.00 per hour.

Current examples of Peer Advocates would be: warm line responders, Peer Support in mental health and physical health domains.

Required Competencies for Peer Advocates are;

- Recovery orientation and concepts
- Understanding the role of the Peer Support
- Ethics and Boundaries of Peer Support
- Telling your story/ Self-Disclosure
- Cultural Awareness
- Stress, Self-Care and burnout
- Safety, conflict resolution
- Facilitating groups
- Advocating for others
PEER MENTOR (level II)

The Peer Mentor is a more professionalized position than the Peer Advocate. There are the same requirements for the Peer Advocates but an additional 40 hours of training. Peer Mentors are expected to have clinical supervision.

A Peer Support must be supervised one hour for every 40 hours of work.

A Peer Support should have no more than two weeks between supervision sessions.

- Peer Supporters working less than ten hours per week receive 2 hours per month
- Peer Supporters working between 10-20 hours per week receive 3 hours per month
- Peer Supporters working between 20-30 hours per week receive 4 hours per month
- Peer Supporters working between 30-40 hours per week receive 5 hours per month

50% of clinical supervision can be conducted in a group setting

Peer Supporters are expected to have 20 hours of continuing education every two years of service. Pay range for a Peer Mentor is typically $9.00-$12.00 per hour.

Examples of Peer Mentors currently in Montana; Montana State Hospital support staff, drop in center staff, Peer to Peers in the 1915i state service plan, support specialists in mental health centers who are Peers.

Required competencies for Peer Mentors in addition to initial training for Advocates are;

- Suicide Awareness
- Stages of Change
- Trauma informed care
- Pathways of Recovery
- Accessing community resources
- Emotional Intelligence
- Mentoring others in recovery

Depending on the recovery process that your peer supporters will by utilizing we require a 101 course (or multiple courses) in that specific domain including;

- Mental health 101
- Addictions 101
- Physical Disabilities 101
- Developmental Disabilities 101

PEER RECOVERY COACH (level III)

Peer Recovery Coaches require an additional 40 hours of training after the Peer Support has completed both Advocate and Mentor training (a total of 90 hours of training, shadowing and live coaching). This level of support also requires that each coach has had at least 2 years in recovery and is willing to also complete 20 hours of continuing education annually to maintain certification. Peer Recovery Coaches can also act as mentors and coaches for other peer
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supporters and need specialized skills in planning, interviewing and coaching outside of the standard curriculum. We also expect that each Peer Recovery Coach receives 1 hour of clinical supervision every week from a Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Professional Counselor (LCPC).

The pay range for Peer Recovery Coaches is typically between $12.00-$15.00 per hour. Examples of Peer Recovery Coaches currently in the state are; Recovery Coaches, PACT, Waiver, Peer to Peer Coach for Children’s mental health, and advanced drop-in center staff.

Required Competencies for Peer Recovery Coaches include:
- Role of the coach
- Motivational Interviewing
- Learning principles and learning styles for adults in recovery
- Multiple Intelligences
- Wellness recovery planning
- Shadowing another coach
- Live coaching

In addition we anticipate that each Peer Recovery Coach will expand their knowledge in additional domains including:
- Mental health 101
- Addictions 101
- Physical Disabilities 101
- Developmental Disabilities 101

Specialized Peer Supporter

There are peer supporters that are specifically trained to work with a specific population. We require that there is additional training to focus in a specialized area including:
- Veteran
- Youth
- Family
- Forensic/Corrections
- Homeless
- Crisis Intervention Teams (CIT)
- Peer Trainer
- Elderly
CONTINUING EDUCATION

Below is a list of pre-approved continuing education course and workshops for peer support. It is broken out to match the peer support scope of practice for easy reference. In no way is this list complete. We anticipate regular additions to the list by the oversight council.

Level I = 5 hours
Level II and III = 20 hours every 2 years

Recovery Support

- Alternatives Conference (largest peer conference in the US)
- Depression Bipolar Alliance various trainings
- eCPR – National Empowerment Center
- Illness Management and Recovery (16 hrs)
- Intentional Peer Support (40hrs)
- Living Well
- Magellan E-courses (free for peer supporters)
- Montana Mental Health Conference
- Peer to Peer
- Recovery International online training
- SAMHSA – various web based trainings throughout the year
- SMART Facilitator Training
- Wraparound
- Wellness Recovery Action Planning (16-21hrs)

Professional Responsibilities:

- Applied Suicide Intervention Skills Training - ASIST (16hrs)
- Compassion Fatigue
- Crisis Intervention Training (40hrs)
- Dialectical Behavioral Therapy 101
- HIPAA Training
- Illness Management and Recovery (16 hrs)
- Montana Workers with Disability Training
- Motivational Interviewing
- QPR – Suicide prevention training
- Supervisor training
- Values and Ethics – Copeland Center
- Work Incentive Plan Training
- Wraparound
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Advocacy:
- In Our Own Voice
- Alternatives Conference (largest peer conference in the US)
- Peer Leadership Training (12hrs)
- Recovery Talks (2 hrs)
- Trauma Informed Care

Mentoring:
- Intentional Peer Support (40hrs)
- Living Well
- Illness Management and Recovery (16 hrs)
- eCPR – National Empowerment Center
- Life Coaching Training (60hrs)
- Recovery Coaching
- Warm line Responder Training

CODE OF ETHICS AND STANDARDS FOR PEER SUPPORTERS

This Code of Ethics and Standards was developed by the Montana Peer Support Task Force and is the accepted standard for all levels of peer supporters in Montana.

1. Peer Supporters act in a way that encourages and promotes recovery for themselves and those they serve without placing judgment on the recovery path of others
2. Peer Supporters share their own recovery story in a manner that promotes recovery, instills hope and is a benefit to those they are serving
3. Peer Supporters always use person first or recovery language and encourage this practice in others
4. Peer Supporters maintain high standards of personal and professional conduct; always acting in a way that represents peer support in a positive and beneficial light
5. Peer Supporters act as a positive role model in recovery
6. Peer Supporters conduct themselves in way that fosters their own recovery. Peer Supporters will take personal responsibility to seek support and manage their wellness
7. Peer Supporters respect and protect the confidentiality, rights and dignity of those they serve
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8. Peer Supporters advocate for those they serve unless it would threaten the safety, security or recovery of others
9. Peer Supporters shall not engage in disputes between colleagues and those they serve or engage in inappropriate conversations with those they serve
10. Peer Supporters take proper and adequate measures to prevent, report and correct unethical conduct
11. Peer Supporters follow all State and Federal laws including Health Insurance Portability and Accountability Act (HIPAA)
12. Peer Supporters are mandatory reporters of elder abuse and child abuse to appropriate authorities and supervisor
13. Peer Supporters shall report risk of imminent harm to self or others to their proper authorities and to their supervisor. When reporting, the minimum amount of information necessary will be given to maintain confidentiality
14. Peer Supporters shall not enter into sexual or personal relationships with an individual they are providing services to or their immediate family member
15. Peer Supporters shall disclose any pre-existing relationships, sexual or otherwise to immediate supervisor prior to providing services to that individual
16. Peer Supporters shall not accept receive or exchange gifts of value over $5 from those they serve
17. Peer Supporters shall not loan, give, lend or borrow money to or from those they serve
18. Peer Supporters shall not engage in or promote behaviors or activities that would jeopardize their own recovery or the recovery of those they serve
19. Peer Supporters act in a way which does not exploit those they serve
20. Peer Supporters shall not engage or offer advice on the matters of diagnosis, treatment, medications
21. Peer Supporters shall not abuse, harass, demean or discriminate against others based on race, culture, religion, age, gender, gender identity, disability, nationality, sexual orientation, or economic condition
22. Peer Supporters meet the requirements for training, continuing education, clinical supervision, support and recertification
The work that we do in the world of mental health is incredible. Think about what we do for a moment. We are given the great honor of interacting with fellow humans who are walking a path on which they are experiencing pain, disillusionment, hopelessness, and even suffering to varying degrees. We are invited into their worlds, into their pain and stories, and they allow us to offer whatever strength and encouragement we have. This is amazing. It’s awe-inspiring! What a gift.

At the same time, our work is stressful, frustrating, overwhelming, demanding, and sometimes downright heartbreaking. Too many of us get driven to the brink of despair. We can feel helpless, hopeless, or worse…apathetic. We need support and guidance. We need mentorship. We need to know we’re not alone.

Here’s the good news: there are ways for us to get exactly what we need. One of those platforms is clinical supervision. Too often, even when supervision is provided, many entities are providing a “check the box” kind of supervision that doesn’t meet the needs of those it serves. Many times this happens because clinical supervisors are given the title, but not offered the support they need in knowing what supervision is and how to provide quality clinical supervision. This chapter outlines the importance of quality supervision and offers some guidelines for providing it effectively.

WHAT IS CLINICAL SUPERVISION? (AND WHAT IT’S NOT)

I like to think of supervision as just what the word implies: extra (super) sight (vision). Supervision is, in its most basic form, an extra pair of eyes seeing a person/situation/issue from a different vantage point. It is a dynamic, reflective, and in-the-moment process. A good supervisor helps his/her supervisees make the best use of the knowledge and skills they already have to perform to the best of their abilities. Good supervision also provides the opportunity for the peer supporter to examine his/her own performance to further develop and refine his/her abilities. This process is most helpful when approached “in the moment.” In other words, the supervisor’s interventions become about what is going on in the consultation room at this moment, including what the peer supporter is discussing, needing, and wanting for guidance. In this, the supervisor creates an environment that is open, respectful, non-judgmental, and focused on the peer supporter.

While having a solid understanding of clinical supervision is important, we also need to know what supervision is not. Clinical supervision is not support. Clinical supervision should be offered in a supportive manner, but it is not support. Clinical supervision is not therapy. Clinical supervision is a safe, confidential, healthy, open, non-judgmental place to share personal triumphs, difficulties, and questions in the workplace. It is not a place to work on greater
underlying issues that arise. Nor is it a place for simply “airing complaints.” These lines can get blurry and it is important to spend the time necessary to establish a healthy, supervisor-supervisee relationship with clear expectations and boundaries.

In many places, supervisors play multiple roles. It is important to understand the difference between a clinical supervisor and an administrative supervisor. Administrative supervisors are concerned with the organizational efficiency of a program, while clinical supervisors are concerned with the support of the peer supporter as they relate to the person receiving services from the program. These two roles are certainly interrelated and can sometimes be in conflict with one another. When at all possible, it is helpful to have different professionals providing these equally important and often conflicting roles. When the roles are separate, the administrator doesn’t have to concern him/herself with the clinical issues that the peer supporter is practicing. Likewise, the clinical supervisor doesn’t have to be concerned with the more practical aspects of the peer supporter’s performance at work, which can sometimes get in the way of a positive therapeutic relationship.

WHY IS CLINICAL SUPERVISION IMPORTANT?

There are many valid reasons that clinical supervision is important. The first is that in order to receive funding for a peer support program in most states, clinical supervision is strongly recommended, if not required. In its first letter of guidance to State Medicaid Directors interested in “peer support services under the Medicaid program,” the Department of Health & Human Services Centers for Medicare & Medicaid Services listed Supervision as the first core component of peer support services. The letter detailed the “minimum requirements that should be addressed for supervision,” stating “supervision must be provided by a competent mental health professional.” As the necessity of peer services gains acceptance nationally, most states have either already implemented or are working on certification processes for peer supporters. This process includes clinical supervision of peer supporters.

Another important reason clinical supervision is important has to do with liability. Peer supporters should receive extensive training in laws and guidelines in the mental health world. However, they will not have the same level of required training as a licensed mental health professional. Having someone with the highest level of training possible overseeing employees in direct contact with consumers of the mental health industry is critical to avoiding liability issues. From a practical level, this may be the most important administrative reason to have a well-trained clinical supervisor in a peer support program. It will help protect your agency or organization as well as the people it serves.

Quality clinical supervision fosters the growth, development, and professional competence of supervisees. With the focus on offering the peer supporter an avenue for discussing triumphs as well as difficulties, supervision can be a place to refine skills, offer education, encourage positive interventions, and identify areas which require further training.
All of these lend themselves to increasing competence, confidence, and quality care for the consumer.

Finally, clinical supervision is an essential ingredient in helping the peer supporter develop and maintain resilience to burnout and compassion fatigue. In the difficult work that a peer supporter carries out, s/he will inevitably be exposed to others’ trauma. When this vicarious trauma happens in an ongoing way and without the professional support of a supervisor, the person is more prone to develop symptoms of compassion fatigue. One of the pioneers of treatment for compassion fatigue, Dr. Eric Gentry, identifies “connection and support” as one of the five necessary areas to avoid developing compassion fatigue. He asserts that, “[o]ne way trauma seems to affect us all, caregivers included, is to leave us with a sense of disconnected isolation… We have seen that a warm, supportive environment in which caregivers are able to discuss intrusive traumatic material, difficult clients, symptoms, fears, shame, and secrets… to be one of the most critical ingredients in the resolution and continued prevention of compassion fatigue.”

COMPONENTS OF CLINICAL SUPERVISION

There are many ways to consider the scope of issues a clinical supervisor is responsible for and how to address these in clinical supervision meetings. It is helpful to conduct your own research and get sound training in this area, and then develop your own ideas about what should be included in effective supervision. The National Association of State Mental Health Program Directors published the *Supervisor Guide: Peer Support Whole Health and Wellness* in 2013 and cites these areas as a helpful guideline:

- Performance – how things are going, what is working well and what’s not
- Education/Growth – skill development and training opportunities
- Relationships – with co-workers
- Management Issues – Policies and Procedures
- Personal Wellness – how self-care is being addressed and any challenges to wellness on the job

CHARACTERISTICS OF AN EFFECTIVE CLINICAL SUPERVISOR

Supervisors are not simply good clinicians. Supervisors have a host of responsibilities and skills that are quite different from those of clinicians. Supervisors should, at a minimum, be curious, non-judgmental, good leaders, eager to learn, willing to not be “the expert,” able to foster an open and encouraging atmosphere and have strong ethics. It is important to note that some of the best clinicians may not make the best supervisors. Quality training is necessary to build on already-established clinical skills and learn tools specific to supervision.
BOUNDARIES

As with any work that we do in this field, it is necessary to address boundaries. Having a solid understanding of and practice in good, healthy boundaries is paramount to the success of clinical supervision. It is important for the clinical supervisor and the supervisee to understand what their relationship is, and what it isn’t. It is equally important for this topic to be directly addressed by the clinical supervisor with the supervisee early in the relationship in order to avoid any confusion. Boundaries can sometimes become blurry. An open and ongoing dialogue about these issues helps maintain crisp boundaries.

The clinical supervisor and the supervisee need to have a clear idea about what is within the supervisor’s scope of practice and what is not. This will largely be impacted by whether or not the clinical supervisor is also in an administrative supervisor’s role (for situations like disciplinary issues, etc.). When issues arise that are outside of the scope of the clinical supervisor’s work, there should be policies in place that allow for referral to outside sources, such as an Employee Assistance Program, for additional work. Clear procedures regarding this are necessary so that the clinical supervisor knows when and how to recommend this.

(Written by Lynette Rodi, LCPC, LAC)

The guidelines contained herein are just that: guidelines. They are based on my study of others’ research and my own experience in this area. For further information, consultation, and training on Clinical Supervision for Peer Supporters and/or Compassion Fatigue, please contact Lynette Rodi, LCPC, LAC at lynette@journeys-consulting.com.

1 Letter to State Medicaid Directors
1 Gentry training
1 GA Supervisor Guide
1 GA Guide, p 27

HOW TO GET STARTED

Once you have made the decision to include (or improve) clinical supervision in your peer support program, there are a number of necessary things to consider:

- What are the Policies and Procedures of the program in general and for clinical supervision within the program?
- What is the program’s Code of Ethics and how does this apply in clinical supervision?
- What are the protocols for addressing high-crisis situations (suicidal ideations/threats, self-harm, violence, etc.)?
- What are the on-call parameters, both for peer supporters and their supervisors?
- What form of documentation will be required and how is that completed?
- How will the clinical supervisor understand the certification process for peer supporters and participate in ongoing assessment of peer supporters’ skills and training?
TASK SUPERVISION

Task Supervision is non-clinical. It provides the Peer Supporter with support, coaching, direction for interacting with their peers, and how to do non-clinical tasks such as documentation.

Winds of Change uses task supervision for additional supports in learning the job through working in our Recovery Mall. This provides the Peer Supporter with a direct task supervisor who can assist them with interacting with peers. Our project focuses on healthy living so the Peer Supporters are trained to use the exercise equipment, encourage participation, and healthy lifestyle changes. These are non-clinical tasks which can utilize a supervisor who is not a clinician.

Clinical Supervision is also provided in how to work with peers, communication, motivation, and mental health issues. However, for our program, we rely more heavily on Task Supervision.

A PEER COACH'S VIEW OF SUPERVISION

I have been working as a peer supporter for just over a year. The organization that I work for has provided clinical supervision for me from the beginning. It has been beneficial in good times as well as challenging times. During a period of working with a few individuals who were suicidal, clinical supervision was essential. I was able to explore how it was all affecting me and how to lessen the effects of secondary trauma. I have learned through talking and learning skills with my clinical supervisor how to identify signs in myself for when I am getting too emotionally involved in an individual’s story. This is helpful for my own well-being, alleviating job burnout, and making me better able to support the individual. Now when I notice these signs, I can step back from the situation, center myself, and determine how to move forward in the healthiest way.

One of my favorite things about clinical supervision is sharing success stories. It is so beneficial to have someone there to share in the excitement of my work and to point out areas where I did a great job. It is easy for me to forget to give myself credit or to notice my own strengths. I can also get wrapped up in learning how to deal with a situation better and not celebrate when it all turned out great. Also, sharing the good times gives strength and motivation for when things are not going that well.

Another area where clinical supervision helps is feeling connected. I am the only peer supporter within my organization other than the executive director. This can make me feel isolated in my work at times. The executive director and I meet with our clinical supervisor together once a month, as well as individually. This gives us a set time to just be coworkers and share our positive and challenging experiences together. We learn from each other’s experiences and get
valuable feedback from our clinical supervisor. I feel clinical supervision is a necessary part of any helping profession and therefore a necessary part of peer support.

Michelle Jermunson
Recovery Coach
Montana’s Peer Network

SUMMARY

Peer Supporters and Coaches need a regularly scheduled Clinical Supervision for a successful program. Task supervision may be utilized for additional supports based on the program but is not a substitute for clinical supervision. We recommend that each Peer Coach be provided at minimum an hour of Clinical Supervision every two weeks. The importance of Clinical Supervision cannot be stressed enough.
CHAPTER 10: EVALUATION AND DATA COLLECTION

Evaluation and data collection are essential components to assess how a service works. In this day and age we know that if you can’t measure what you are doing then you will be limited in what you can accomplish. We see evaluation in all forms of practice today and it is important that for peer services to be recognized as a sustainable service then we must start with a thorough evaluation process.

The pilot projects were charged with using tools that were suggested by Helena College and these tools helped shape our practices and it is our hope that any provider of peer services will recognize the value of measurement and ensure that each participant has an opportunity to reflect back on the progress made as well as for the programs to evaluate their effectiveness. The evaluation instruments can be found in the Appendix starting on page 77:

- Meaning of Life Questionnaire
- The Quality of Life Scale
- Mental Health Recovery Measure
- DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure- Adult
- Health and Well Being

These five instruments give us the ability to see improvement in functioning over time for the participants as well as the effectiveness of the support. We also found that we were able to see co-occurring issues more clearly giving us a holistic view of how, overall the obstacles that each person faces in recovery may have an impact and a direct correlation to a co-occurring issue.

To use these effectively we recommend that each program introduces the evaluations when first meeting a new participant to get a baseline of where he/she is at and then follow up every three months. At the minimum having a start-up evaluation and a transition evaluation as the participant is leaving the service is also beneficial.

*Meaning of Life Questionnaire*

Scores on the 10 MLQ items range from 1= absolutely untrue to 7 = absolutely true and questions include items such as “I understand my life meaning; I am looking for something that makes my life meaningful; I am always looking to find my life's purpose.” The higher the score, the more meaning the individual finds in life. The question posed for evaluation is: are consumers finding life more meaningful after participating in the Peer Recovery Support program? The scale totals can range from 7 to 70.
**Quality of Life Scale**

The quality of life scale has 16 questions listed on a scale of 1-7. This questionnaire asks about the overall quality of life from needs to relationships and how the person feels about him/herself. Total scores can range from 16 to 112 with higher scores indicating higher QOL. Looked at another way, on a scale where 1 equals “Terrible” and 7 equals “Delighted”.

**Mental Health Recovery Measure**

As used in this evaluation, total Recovery Measure scores can range from 30 to 150. Higher scores indicate a higher self-reported level of mental health recovery.

**DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult**

Scores on the DSM-5 measure may range from 0 to 92. The higher the score, the more severe a level of symptomatology being reported by the client.

**Health and Well Being**

This instrument looks at what other possible issues from diabetes to smoking may also be occurring for this individual in recovery. This instrument will give us an ability to cross check different co-occurring issues with addiction and mental health.
CONCLUSION

When we first convened the Peer Support Task Force on January 26, 2012, Beki Brandenborg our facilitator had us make a list of “our ideal future or what we want to achieve together”. This list included:

- A curriculum for people interested to learn how best to provide peer support.
- Legitimization of peer support as a vital field of work.
- A certification process, credentials that indicate successful and thorough education, accompanied by a perception of high value of this profession.
- An equality of services by peer support providers, a consistency in training so everyone doing it is very well equipped.
- The availability of reasonably priced and easily accessible training for peer support providers.
- A mentoring system where work experience between new and experienced peer recovery specialists is shared and enhanced.
- Standards, guidelines and best practices for peer support work are in place.
- Workforce development takes place; employers value peer support providers, know how to hire peers, and encourage people to pursue this career.
- Decisions about where to house or who to sponsor our efforts.
- No re-inventing of the wheel, utilization of all the good work already done by other states.
- A common understanding of what peer support means, and a common language to refer to it.

Today, when I look at that list I am proud to say we have achieved each and every one of these items. These visions, for what the Peer Support Task Force could achieve together, are quite amazing. Over the last three and half years the Peer Support Task Force has successfully brought together peer supporters, providers, state officials and advocates to achieve this list of dreams, this list of needs for peer services in Montana. This guide is the culmination of all the work countless individuals have contributed to the task force. This toolkit contains information, resources and best practices for peer services in Montana regardless of the field of work. This will conclude the Peer Support Task Force as we have achieved our mission. We sincerely hope you find this toolkit of great value. The next phase for peer services in Montana will be the formation of the Peer Services Oversight Council which will begin the process of certifying peer supporters and overseeing training standards. We anticipate this council getting started by the end of 2015.

“The friend who can be silent with us in a moment of despair or confusion, who can stay with us in an hour of grief and bereavement, who can tolerate not knowing…not healing, not curing…that is a friend who cares.” Henri Nouwen. Dutch writer 1932-1996
MONTANA PEER SUPPORT TOOLKIT

Employer Readiness Self-Assessment

This Employer Readiness Self-Assessment tool was designed by the Peer Support Task Force to assist organizations in the creation, development and/or enhancement of peer services in their organization. In order to ensure success of peer services in an organization, vital components are needed to facilitate a recovery oriented culture. Please answer yes or no to the following questions:

1. Our organization engages in regular community mental health education activities around wellness and recovery. Yes____ No____

2. Our organization promotes the 10 components of recovery with every client. Yes___ No___

3. Our organization believes peer support staff would be an added benefit to our treatment team. Yes___ No___

4. Our organization promotes recovery and wellness to the best of our ability with clients. Yes___ No____

5. Our organization routinely offers peer support at every level of service to our clients. Yes___ No____

6. Our organization offers flexible hours for clients in recovery. Yes___ No____

7. Our organization uses recovery oriented language when interacting with our clients. Yes___ No____

8. Trauma informed care is an integral part of our delivery of services. Yes___ No____

9. Management of our agency routinely provides learning opportunities around wellness and recovery for staff. Yes___ No____

10. The wellness of staff is strongly supported in our organization. Yes___ No____

We would recommend that an employer be at an 80% or above (8 questions answered yes) before utilizing Peer Supporters or have a plan on how you are going to reach 80% or above in the next year.
# Matrix for Training, Supervision and Continuing Education for Peer Supporters

<table>
<thead>
<tr>
<th>Possible Job Titles</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>TOTAL TRAINING REQUIRED</th>
<th>CONTINUING EDUCATION CREDITS (2 YRS)</th>
<th>Work Experience</th>
<th>Time in Recovery</th>
<th>Description</th>
<th>Clinical Supervision</th>
<th>RATE OF PAY</th>
<th>Current Examples</th>
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<tr>
<td><strong>LEVEL 1</strong></td>
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<td></td>
<td>Informal Structure</td>
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<td>volunteer</td>
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<td>Moderate Structure</td>
<td>Y</td>
<td>$9-12/HR</td>
<td>Montana State Hospital peer support staff (2), Drop in Center staff, Peer to Peer (wraparound)</td>
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<td>PEER SUPPORT</td>
<td>10</td>
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<td>Peer Mentor</td>
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<td>Formal Structure Complementary to Clinical Team</td>
<td>Y</td>
<td>$12-15/HR</td>
<td>Recovery Coaches, PACT, Waiver, Peer to Peer Coach (wraparound), Drop in Center Staff</td>
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<td>CERTIFIED PEER</td>
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<td>Yes</td>
<td>Formal Structure Specialized Setting</td>
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<td>$12-?</td>
<td>Veteran, Youth, Family, Coach, Corrections, Addictions, Homeless, CIT, Peer Trainer, etc</td>
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<tr>
<td>SUPPORTER</td>
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Montana Peer Support Task Force
EMPLOYEE READINESS SCALE
This self-assessment is a readiness tool to help you determine if you are ready to become a peer supporter. Please answer yes or no to the following questions.

Yes or No

1. Are you willing to disclose to your peers, clients, staff and the general public that you have been diagnosed with a mental illness, substance abuse and or addiction diagnosis?

2. Can you describe in detail the type of supports you have found helpful to move from where you were to where you are now in recovery?

3. Can you describe what you have had to overcome to get where you are today?

4. Can you describe what you have learned about yourself in recovery?

5. Can you describe some of the things that you do daily to keep yourself on the path of recovery?

6. Can you describe what having a diagnosis means, how it impacted your life?

7. Can you describe some of the strengths you have developed your recovery?

8. Can you describe the role that a sense of hope played in your life?

9. Can you describe some of the community supports you currently use or have used in the past?

10. Have you ever lead a support group?

11. Do you have any experience with advocacy organizations in Montana?

12. Do you have any experience volunteering or serving on boards or committees?

Each question you answer yes to please write a detailed answer on a separate piece of paper to help you further determine your readiness. Some employers may utilize this assessment as interview questions. Being prepared ahead of time will give you an advantage.

*It is preferred by the Montana Peer Task Force that a Peer score at least 9 out of 12 on this questionnaire before being hired as a Peer Support.*
SAMPLE PEER SUPPORT JOB POSTINGS:

**Consumer Direct Personal Care:**
Consumer Direct Personal Care, LLC is currently hiring for a Peer Recovery Coach in Missoula, MT. This position supports adults in the community in their recovery process regarding mental health and addiction concerns. A successful candidate will be able to share his/her experience with recovery, be able to inspire and motivate others, be flexible with scheduling, and be able to model and empower individuals in their own recovery process. The candidate must be at least two years in his/her own recovery and have an understanding of the recovery community in Missoula. It is important to be a team player, have strong communication skills, and knowledge of Microsoft office. There is extensive ongoing training and coaching available to build skills for the Peer Recovery Coach.

**Montana Peer Network:**
Recovery Coach needed in Bozeman for community based peer support recovery pilot project. Candidate should be willing to self identify as a person in recovery from a mental health and or substance abuse diagnosis. Candidate should be willing to share their own recovery journey with others and provide whole health peer support. Candidate should have a working knowledge of recovery concepts, wellness tools and peer support. Candidate should be able to work as part of a team, be organized, have good communication and computer skills and have a positive attitude. This position requires on call rotating work schedule, clean driving record and reliable transportation. This position also requires completion of extensive training that is contingent on employment.
Winds of Change:

PEER SUPPORT
JOB ANNOUNCEMENT

Winds of Change has job openings for Peer Support Staff as part of our Wellness Grant.

Requirements:

1) Must be in recovery from a SDMI and/or Co-occurring Disorder.
2) Must have, or be able to obtain within six months of hire, a high school diploma or GED.
3) Must be able to work a minimum of 1 hour/week.
4) Must have a clean background check for violent crimes, crimes against persons, and/or others crimes which would be detrimental in providing services to a SDMI/Co-occurring peer population.
5) Must have experience in wellness issues by training, education, and / or personal experience.
6) Prefer completion / participation in WRAP, IMR, NAMI’s Peer-to-Peer Program, Montana Peer Network, Local Advisory Council, Service Area Authority, or others which demonstrate involvement in their personal recovery and willingness to share their experience and knowledge with peers.

Description: The PRSC will work to provide services of assistance, support, coaching, and teaching to peers. This will include both mental and physical health issues. PRSC may facilitate or co-facilitate groups, work individually, or in small groups with peers. PRSC may do physical activity with peers to improve their health. The PRSC will work directly with the Wellness Coach on any physical activities peers are participating in.
INTERVIEW QUESTIONS FOR PEER SUPPORT CANDIDATES (EXAMPLE)

1. **Please tell us about your experience with recovery and why you are interested in this position?**
   The successful candidate will be able to give detailed information about his/her journey with recovery and be able to identify his/her individual pathways to recovery that worked for them. The successful candidate will demonstrate passion and dedication for those actively pursuing recovery. Listen for length of time in recovery (must be at least two years to meet the requirements for employment). Key terms to listen for will be holistic approach, positive recovery identity, individualization, supporting others. A candidate who talks about fixing problems, or seems rigid in his/her recovery perspective may not be the best fit for this position.

2. **(assuming personal experience) As a person with direct experience with recovery please tell us how you are able to maintain stability and balance in your own life, including any support systems you have developed?**
   If the candidate cannot provide a clear answer to this question, then it probably means that there is no clear plan to maintain stability, and therefore be considered a negative response.
   
   If the candidate has self-identified themselves as a person in recovery, it is perfectly acceptable to ask how they maintain their stability. If their answer includes physician prescribed medication and treatment, you can ask further if they have a recovery wellness plan to augment their stability.

3. **Would you please tell us about a person that you have helped, and how you helped them?**
   The answer to this question will point to whether your candidate is a nurturer or enabler. If he/she is a nurturer, the answer will revolve around how the candidate helped another person to help themselves, or how the candidate discovered resources that could be utilized to support self-efficacy. If the candidate is an enabler, the answer will revolve around what the candidate did personally for another person.
   
   This question can be tricky. For example, if the candidate took another person to a team meeting that could be construed as a nurturing act. If the candidate made the appointment, arranged transportation, gathered all the necessary documents etc. rather than use this as an opportunity to teach a person the skills needed to do this for themselves the candidate leans more towards an enabler.
4. Can you describe a time that you taught, modeled and/or coached another person in developing a skill?
A successful candidate will walk you through a step by step process of how they taught a specific skill. Key terms to listen for are; modeling, breaking down action steps, encouraging strengths, seeing another person’s potential etc.

5. Would you please tell how you go about planning your day’s activities?
Look for a response that involves the use of a calendar or a list of activities. If the candidate states something to the effect that they would be lost without their calendar, that they carry it everywhere, or that they being each morning with a list of things they need to get done that day, those would be considered positive responses.

Follow up question: Would your friends say that you are usually early for appointments, on time for appointments, or late for appointments?
If the response is “usually early” or “usually on time”, there will probably be included a philosophical statement on time management. If the response is “usually late”, the candidate will usually list excuses for that behavior, or simply laugh it off.

6. Would you please tell us what it is about people that bugs you the most?
While the responses to this can vary greatly, by the time the response is completed there should be no doubt whether you are dealing with a judgmental or non-judgmental person.

7. Would you please tell us about the most frustrating thing that has happened to you this week, why it was frustrating, and how you reacted to whatever it was that frustrated you?
An inflexible candidate will take delight in telling you about details of the frustrating event, and who to blame for the event. A flexible candidate will focus on how he/she overcame the event, and possibly what they learned in the process.

8. Let me give you a hypothetical scenario, and tell us how you would react:

You are working with a person in recovery where a therapist and a case manager are also involved. You overhear the therapist explaining to the case manager that he is thinking that the client needs to be in a higher level of care. You know the person you are working with wants to stay in his home and community and you personally think the needs of the person in recovery would be better met in the community. What do you do?
You are looking for evidence that the candidate is a team player. If the candidate responds that he/she would warn the client so that the client could fire his team members, or that the candidate would go directly to the therapist or case manager’s supervisor for an intervention, those would be considered negative responses. The responses we are looking for is an action that would create a dialogue with the case manager and therapist and the person in recovery, to discuss why the therapist thinks this person needs a higher level of care, and what could be done by all parties to deter or delay this higher level of care.
9. Give the candidate a blank piece of paper and a pen. State this: “please write down a time you had a conflict with someone and what you did to resolve it. Take 5 minutes to complete this”. A successful candidate will be able to describe the intervention used and you should be able to tell if he/she was proactive and assertive or passive and unable to communicate. This also gives you an opportunity to observe the candidate under stress. When the time is up ask the candidate to read what they have written. This should lead to further discussion and further opportunity to observe the candidate’s communication skills.

10. Please rate your proficiency on each component of Microsoft office on a scale of 1-5?
   Microsoft word:
   Microsoft Excel:
   Microsoft PowerPoint:
   Microsoft outlook:

   Follow up question: Were you required to use these programs for other employers and what did you find beneficial about using these programs? What did you not like about using these programs? The interviewer should look for at least a 3 on the above programs and be listening after the follow up question regarding likes and dislikes. This will give you more information about how comfortable the candidate is using software required for the position.

11. Do you have 24/7 access to a reliable, safe vehicle and insurance?
   This is a straightforward question requiring a yes or no answer. The position requires the Peer Support to be able to flexibly navigate the area without relying on friends or family for transport. Insurance is a must for this position.

12. Please tell me about what you like to do in your spare time away from work?
   A successful candidate will be able to explain how he/she takes care of themselves and hopefully reflects on the importance of wellness through mind, body and soul. Listen for how he/she explains to you what interests he/she has and how he/she takes care of themselves.

   Someone who presents as rushed or stress may not be ready to commit themselves to supporting others in a recovery environment. If well versed in recovery, he/she will have an understanding of balance and self-care.
INTERVIEW SHEET FOR PEER SUPPORT (EXAMPLE CONSUMER DIRECT)

For the interviewer:

Name of candidate
Date of interview
Cover letter
Resume
References

Welcome and brief description of agency.

1. Please tell us about your experience with recovery and why you are interested in this position?

   Rate on a scale of 1-7 with 4 being an average response

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

   Notes:

2. (assuming personal experience) As a person with direct experience with recovery please tell us how you are able to maintain stability and balance in your own life, including any support systems you have developed?

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

   Notes:

3. Would you please tell us about a person that you have helped, and how you helped them?

   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
4. Can you describe a time that you taught, modeled and/or coached another person in developing a skill?

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Notes:

5. Would you please tell how you go about planning your day’s activities?
Follow up question: Would your friends say that you are usually early for appointments, on time for appointments, or late for appointments?

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Notes:

6. Would you please tell us what it is about people that bugs you the most?

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Notes:

7. Would you please tell us about the most frustrating thing that has happened to you this week, why it was frustrating, and how you reacted to whatever it was that frustrated you?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
8. Let me give you a hypothetical scenario, and tell us how you would react:

You are working with a person in recovery where a therapist and a case manager are also involved. You overhear the therapist explaining to the case manager that he is thinking that the client needs to be in an inpatient facility. You know the person you are working with wants to stay in his home and community and you personally think the needs of the person in recovery would be better met in the community. What do you do?

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Notes:

9. Give the candidate a blank piece of paper and a pen. State this: “Please write down a time you had a conflict with someone and what you did to resolve it. Take 5 minutes to complete this”.

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Notes:

10. Please rate your proficiency on each component of Microsoft office on a scale of 1-5?

- Microsoft word:
- Microsoft Excel:
- Microsoft PowerPoint:
- Microsoft outlook:
Follow up question: Were you required to use these programs for other employers and what did you find beneficial about using these programs? What did you not like about using these programs?

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Notes:

11. Do you have 24/7 access to a reliable, safe vehicle and insurance?

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Notes:

12. Please tell me about what you like to do in your spare time away from work?

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Notes:

**Scoring**

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</table>

Total score

- **excellent** 75-84
- **Very good** 60-75
- **average** 42-60
- **Below average** 30-42
- **Poor** 1-30
<table>
<thead>
<tr>
<th>Positives about candidate</th>
<th>Concerns about candidate</th>
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</table>

Employ candidate? | YES | NO
PEER SUPPORT JOB DESCRIPTIONS (SAMPLES)

Consumer Direct Personal Care:

Position Title/ Location: Peer Recovery Coach/ Missoula, MT
Reports to: Program Manager
FLSA Status: Exempt
Position Status: Core

GENERAL PURPOSE OF JOB: Support, advocate and facilitate access to recovery oriented programs, develop wellness recovery plans with participants, and work collaboratively with community resources in a manner that support individualized holistic interventions for adults in recovery. The Peer Recovery Coach is responsible for developing and maintaining relationships with participants in recovery.

ESSENTIAL DUTIES AND RESPONSIBILITIES:
Other duties may be assigned.

- Work directly with clients developing a wellness recovery plan and supporting implementation of that plan
- Advocate for clients actively working in recovery that are developing life skills and building confidence to attain their personal goals.
- Maintain compliance with CDMT policy and procedures.
- Join the Montana Peer Task Force and Peer Support Network.
- Complete training curriculum as Peer Recovery Coach specified by Consumer Direct.
- Support community development in Missoula.
- Ensure that all required documentation is completed and submitted in a timely manner to CDMT administration.
- Interact with key referral points within the community.
- Interact with community resources, state agencies and providers in a collaborative team-based approach.
- Link participants to resources identified within the wellness recovery plan.
- Assist participants in finding, organizing, and scheduling recovery-oriented, pro-social activities.
- Attend educational meetings, training sessions, and other meetings as needed.
- Act as a resource for and coordinate continuously with the Program Manager of CDMT and the parent company CDMS on all mental health development.
- Travel within the assigned geographic area as required.
- Manage workload of up to 15 participants that support wellness recovery through direct service.
- Communicate regularly with admin support, Peer support workforce, identified wraparound coach, and clinical supervisor as required.
Report all safety concerns to appropriate authorities and staff immediately including:

- 911
- CDMT Program Manager
- Clinical Supervisor
- Other identified crisis responders detailed in wellness recovery plan

Provide peer recovery leadership throughout the community of Missoula

SUPERVISORY RESPONSIBILITIES: None.

QUALIFICATIONS: To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION and EXPERIENCE:

- In recovery for a minimum of 2 years
- Knowledge of community resources and recovery process
- High school diploma
- Computer skills including word, excel, power point.
- Experience with mental health and addictions recovery services.
- Experience working in a team-based approach
- Experience with High Fidelity Wraparound preferred.
- Experience working within a cultural responsive atmosphere.

LANGUAGE SKILLS: Ability to accurately read and interpret documents such as safety rules, operating and maintenance instructions, procedure manuals, and business communication. Ability to accurately write routine reports and professional business correspondence. Ability to speak effectively before groups. Some ability to speak effectively in impromptu situations is expected.

MATHEMATICAL SKILLS: Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and to draw and interpret bar graphs.

REASONING ABILITY: Ability to solve practical problems and effectively deal with a variety of concrete variables in situations where only limited standardization exists. Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form. Ability to prioritize tasks and to handle multiple tasks. Ability to maintain problem solving ability during participant’s perceived crisis.

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is regularly required to use hands to finger, handle, or feel; reach with hands and arms; and talk and hear. The employee frequently is required to stand, walk, and sit. The employee is occasionally required to stoop, kneel, or crouch. The employee must frequently lift and/or move up to 10 pounds and occasionally lift and/or move up to 25 pounds. Specific vision abilities required by this job include close vision, and distance vision.
WORK ENVIRONMENT: The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. The noise level in the work environment is usually moderate. In conducting home visits, the employee will be exposed to a variety of sights, sounds, and smells while maintaining a professional demeanor.

PERSONAL ATTRIBUTES: It is essential for this position to be represented by a people-oriented person, pleasant, professional, and gracious in manner. Open-mindedness and flexibility with regard to work to be performed and work schedule. Must be willing to step in and assist other co-workers as needed without direction to do so; e.g., be self-initiating. Teamwork is a must in this position; must be receptive to receiving job training and coaching (as needed) from Program Manager. Working with the public, vendors, co-workers and consumers is integral to this position. This person reflects the CDMT attitude and workplace culture and must always present a positive image within the community in terms of appearance, comportment, social interaction, knowledge of job duties and program information.

The above information, in conjunction with the Specific Physical and Sensory Requirements, is intended to describe the general content of and requirements for performance of this job. It is not to be considered as an exhaustive statement of duties, responsibilities, or requirements and does not limit the assignment of additional duties at the discretion of the supervisor.

SPECIFIC PHYSICAL AND SENSORY REQUIREMENTS (Job Safety Analysis)

<table>
<thead>
<tr>
<th>Physical Activity</th>
<th>R</th>
<th>O</th>
<th>F</th>
<th>C</th>
<th>NA</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Stationary standing</td>
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<tr>
<td>Walking</td>
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<tr>
<td>Ability to be mobile</td>
<td></td>
<td></td>
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<tr>
<td>Crouching (bend at knee)</td>
<td>√</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Kneeling/Crawling</td>
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<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Stooping (bend at waist)</td>
<td>√</td>
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</tr>
<tr>
<td>Twisting (knees/waist/neck)</td>
<td></td>
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<tr>
<td>Turning/Pivoting</td>
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</tbody>
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Training Record and Proficiency Demonstration
Emp. Initial Eval. Initial
| Physical Activities | | | | | |
|---|---|---|---|---|
| Climbing | ✓ | | | |
| Balancing | ✓ | | | |
| Reaching overhead | ✓ | | | |
| Reaching extension | ✓ | | | |
| Grasping | ✓ | | | |
| Pinching | ✓ | | | |
| Pushing/Pulling | ✓ | | | |
| Typical weight: | 10 | | | |
| Maximum weight: | 50 | | | |
| Lifting/Carrying | ✓ | | | |
| Typical weight: | 10 | | | |
| Maximum weight: | 50 | | | |
| Other physical activities | | | | |

<table>
<thead>
<tr>
<th>Sensory Activities</th>
<th>R</th>
<th>O</th>
<th>F</th>
<th>C</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking in person</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Talking on telephone</td>
<td>✓</td>
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<td></td>
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<tr>
<td>Hearing in person</td>
<td>✓</td>
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<tr>
<td>Hearing on telephone</td>
<td>✓</td>
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</tr>
<tr>
<td>Vision for close work</td>
<td>✓</td>
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<tr>
<td>Other sensory requirements</td>
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</table>

*Evaluation in the following section to be completed by representative from Employee Health and Safety Division*

<table>
<thead>
<tr>
<th>Environmental Factors</th>
<th>Occasionally in clients homes</th>
<th>Emp. Initial</th>
<th>Rep. EHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Requirement (i.e., clothing, required safety equipment, activities performed)</td>
<td>Hazard Communication Program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Exposures (i.e., fumes, chemicals, vibrations, humidity, cold, heat, dust, blood and other body fluids) | Internal building heating/cooling
Weather elements
May be required to operate vehicle in inclement weather
Communicable diseases | | |
| Operation of equipment, vehicles, tools | Standard office equipment-typewriter, fax machine, computer, photocopier, shredder. Educational equipment-VCR, video camera, overhead projector, chalk board, grease board, Automobile | | |
Winds of Change
CBPRS - Peer Support Specialist II (PSS-II)
Job Description

Requirements:

1) Must be 18 years of age or older.
2) Must be in recovery from a SDMI and/or Co-occurring Disorder.
3) Must have a high school diploma or GED.
4) Must be able to work full time (32 hours).
5) Must have a valid Montana Driver’s License.
6) Must have a clean background check for violent crimes, crimes against persons, and/or others which would be detrimental in providing services to a SDMI/Co-occurring population.
7) Prefer completion of WRAP.

Description:
The PSS-II will be employed to provide peer support services to other Wind of Change clients. The service may be provided in the clinic, at a group home site, or in the community.
The PSS-II will spend time with clients to do recovery oriented activities, engage in social interactions/outing, problem solve situations, and other tasks as assigned.
The PSS-II will be responsible for documenting and billing each client contact and other duties required for the CBPRS position.

Supervision:
Direct supervisor is the Program Administrator or their designee.
Wind of Change
Peer Recovery Support Coach (PRSC)
Job Description

Requirements:
1) Must be in recovery from a SDMI and/or Co-occurring Disorder.
2) Must have, or be able to obtain within six months of hire, a high school diploma or GED.
3) Must be able to work a minimum of 1 hour/week.
4) Must have a clean background check for violent crimes, crimes against persons, and/or others crimes which would be detrimental in providing services to a SDMI/Co-occurring peer population.
5) Prefer completion / participation in WRAP, IMR, NAMI’s Peer-to-Peer Program, Montana Peer Network, Local Advisory Committee, Service Area Authority, or others which demonstrate involvement in their personal recovery and willingness to share their experience and knowledge with peers.

Description:
The PRSC will work to provide services of assistance, support, coaching, and teaching to peers. This will include both mental and physical health issues. PRSC may facilitate or co-facilitate groups, work individually, or in small groups with peers. PRSC will do physical activity with peers to improve their health. PRSC will work directly with the Wellness Coach on any physical activities peers are participating in.

Supervision:
Direct supervisor is the Program Administrator.
OSHA Category Classification:
II: Potential for exposure to blood-borne pathogen.

I have read and understand the above job description.

______________________________________________  __________
Employee Signature                          Date

Montana’s Peer Network
103 South Main Street Suite 7
Livingston, MT 59047
406-551-1058
www.mtpeernetwork.org

Job Description: Recovery Coach (community based peer supporter)

The work schedule for this position will be a mixture of on call and flexible work hours

The Recovery Coach must be willing to self-identify as a client of mental health and or substance abuse services who is well established in a recovery program

The candidate should be able to take direction, be prompt, complete tasks as assigned, and be able to work effectively as part of a team including various community stakeholders

The candidate should be articulate, and have good communication skills

The Recovery Coach will act as a role model for wellness and recovery
Recovery Coach must be willing to share his/her own story of recovery as an inspiration to others.

The candidate should have at minimum a basic understanding of recovery concepts and peer support as they relate to supporting individuals in crisis, wellness and recovery planning.

The candidate must complete and pass Peer Support 101 40 hour training.

Duties of the recovery coach will include working as part of the mobile crisis response team for Gallatin and Park County Montana, working one on one with individuals in the community, participating in emergency services meeting and community presentations, presenting educational material, facilitating a support group, collecting data, completing reports and other assigned tasks.

The Recovery Coach must have good computer skills (e.g. Word, Excel, Outlook, video conferencing) and have home access to high speed internet.

The Recovery Coach will be required to collect data and submit reports in a timely manner.

Travel will be required for this position. Candidate should have a reliable vehicle and a clean driving record. Mileage is reimbursed by MPN.

Candidate must be willing to submit to and pass a background check.

Candidate will participate in clinical supervision.

The Recovery Coach will report to the Executive Director.
Montana Peer Supporter Scope of Practice

Recovery Support

Knowledge, Skills and Abilities

- Be able to share their own recovery story in a meaningful and hopeful way
- Provide peer support that is mutual and respectful
- Be able to assist others in developing their own wellness or recovery plan
- Understand the key components of the recovery process
- Be able to facilitate a peer support group
- Be able to connect others to community resources
- Have a working knowledge of the mind body connection and its relation to recovery
- Provide education around wellness and recovery
- Be able to listen and be present in the moment

Mentoring

Knowledge, Skills and Abilities

- Act as a role model for wellness and recovery
- Assist in others in recognizing and building natural supports
- Be able to support others in planning and achieving their own goals at their own pace
- Utilize a strength based approach

Professional Responsibility

Knowledge, Skills and Abilities

- Fulfill necessary training and continuing education requirements
- Understand the role of peer support in the system
- Understand and abide by a code of ethics and standards
- Be able to work as part of a treatment team
- Understand the importance of confidentiality and HIPAA
- Understand mandatory reporting and why this is necessary
- Participate in clinical supervision
- Understand risk factors for suicide

Advocacy

Knowledge, Skills and Abilities

- Provide education around self-advocacy
- Assure those they work with know their rights and responsibilities
- Provide referrals to other community supports
- Advocate for those we work with when necessary
CODE OF ETHICS AND STANDARDS

This Code of Ethics and Standards was developed by the Montana Peer Support Task Force and is the accepted standard for all levels of peer supporters in Montana.

1. Peer Supporters act in a way that encourages and promotes recovery for themselves and those they serve without placing judgment on the recovery path of others
2. Peer Supporters share their own recovery story in a manner that promotes recovery, instills hope and is a benefit to those they are serving
3. Peer Supporters always use person first or recovery language and encourage this practice in others
4. Peer Supporters maintain high standards of personal and professional conduct; always acting in a way that represents peer support in a positive and beneficial light
5. Peer Supporters act as a positive role model in recovery
6. Peer Supporters conduct themselves in a way that fosters their own recovery. Peer Supporters will take personal responsibility to seek support and manage their wellness
7. Peer Supporters respect and protect the confidentiality, rights and dignity of those they serve
8. Peer Supporters advocate for those they serve unless it would threaten the safety, security or recovery of others
9. Peer Supporters shall not engage in disputes between colleagues and those they serve or engage in inappropriate conversations with those they serve
10. Peer Supporters take proper and adequate measures to prevent, report and correct unethical conduct
11. Peer Supporters follow all State and Federal laws including Health Insurance Portability and Accountability Act (HIPAA)
12. Peer Supporters are mandatory reporters of elder abuse and child abuse to appropriate authorities and supervisor
13. Peer Supporters shall report risk of imminent harm to self or others to their proper authorities and to their supervisor. When reporting, the minimum amount of information necessary will be given to maintain confidentiality
14. Peer Supporters shall not enter into sexual or personal relationships with an individual they are providing services to or their immediate family member
15. Peer Supporters shall disclose any pre-existing relationships, sexual or otherwise to immediate supervisor prior to providing services to that individual
16. Peer Supporters shall not accept receive or exchange gifts of value over $5 from those they serve
17. Peer Supporters shall not loan, give, lend or borrow money to or from those they serve
18. Peer Supporters shall not engage in or promote behaviors or activities that would jeopardize their own recovery or the recovery of those they serve
19. Peer Supporters act in a way which does not exploit those they serve
20. Peer Supporters shall not engage or offer advice on the matters of diagnosis, treatment, medications
21. Peer Supporters shall not abuse, harass, demean or discriminate against others based on race, culture, religion, age, gender, gender identity, disability, nationality, sexual orientation, or economic condition
22. Peer Supporters meet the requirements for training, continuing education, clinical supervision, support and recertification
Health and Well-Being

In this section you will be asked questions on your general health and well-being.

1. Overall would you say your health is:
   a. Excellent _____
   b. Very Good _____
   c. Good _____
   d. Fair _____
   e. Poor _____

2. Have you ever been told by a doctor/health professional that you have any of the following?
   a. Hypertension (High Blood Pressure) _____
   b. Diabetes _____
   c. High Cholesterol _____
   d. Angina or Coronary Heart Disease _____
   e. Heart Attack or Myocardial Infarction _____
   f. COPD (Chronic Obstructive Pulmonary Disease) _____
   g. Chronic Pain and/or Fibromyalgia _____
   h. Asthma _____
   i. Other (please indicate) ________________________________

3. What is your exact height? _____ feet _____ inches

4. What is your exact weight today (please weigh yourself if possible)? _____ pounds

5. If you are taking medications for mental health purposes how well are they helping you?
   a. Very well, I have few if any symptoms _____
   b. Well, I have some symptoms but I can tolerate them _____
   c. The medications help some but I still have many symptoms _____
   d. The medications I take really are not reducing my symptoms _____
   e. I am not taking medications for mental health purposes _____
6. Concerning smoking cigarettes or using other forms of tobacco, which of the following is true for you?
   a. I do not use any tobacco products ____
   b. I smoke cigarettes on occasion ____
   c. I smoke less than a pack of cigarettes a day ____
   d. I smoke up to one pack of cigarettes a day ____
   e. I smoke up to two packs of cigarettes a day ____
   f. I smoke more than two packs of cigarettes a day ____
   g. I use chewing tobacco ____
Recovery Markers

For the next questionnaire you are asked to rate your current recovery. First please note your current employment and housing status, and your level of symptom interference.

Which of the following most accurately describes your employment situation during the last 3 months?

Caregiver or homemaker ___
Student ___
Retired ___
Non-paid work or volunteering ___
Supported employment ___
Full-time competitive employment ___
Part-time competitive employment ___
Unemployed but desiring and able to work ___
No interest in work ___
Disabled ___
Other ___

Which of the following most accurately describes your housing situation during the last 3 months?

Jail/Correctional Facility ___
Hospital ___
Other ___
Single room occupancy/transient/hotel ___
Nursing Home ___
Foster home ___
Homeless/Shelter ___
Personal care home ___
Mental health group home ___
Living with others (in their care) ___
Supported independent living ___
Living independently with others ___
Montana Peer Support Toolkit

Living independently ___

Which of the following most accurately describes your experiences with mental illness symptoms during the last 3 months?

Very High (significant difficulties on daily living) ___
High (symptoms have serious impact on daily living) ___
Moderate (symptoms have moderate impact on daily living) ___
Low (symptoms have mild impact on daily living) ___
Very Low (symptoms have minimal impact on daily living) ___

________________________________________________________________________________________
The goal of this next questionnaire is to find out how you view your own current recovery process. The mental health recovery process is complex and is different for each individual. There are no right or wrong answers. Please read each statement carefully, with regard to your own current recovery process, and indicate how much you agree or disagree with each item by filling in the appropriate circle.

**SD = Strongly Disagree  D = Disagree  NS = Neutral  A = Agree  SA = Strongly Agree**

1. I work hard towards my mental health recovery.

2. Even though there are hard days, things are improving for me.

3. I ask for help when I am not feeling well.

4. I take risks to move forward with my recovery.

5. I believe in myself.

6. I have control over my mental health problems.

7. I am in control of my life.

8. I socialize and make friends.

9. Every day is a new opportunity for learning.

10. I still grow and change in positive ways despite my mental health problems.

11. Even though I may still have problems, I value myself as a person of worth.
12. I understand myself and have a good sense of who I am. 
13. I eat nutritious meals every day. 
14. I go out and participate in enjoyable activities every week. 
15. I make the effort to get to know other people. 
16. I am comfortable with my use of prescribed medications. 
17. I feel good about myself. 
18. The way I think about things helps me to achieve my goals. 
19. My life is pretty normal. 
20. I feel at peace with myself. 
21. I maintain a positive attitude for weeks at a time. 
22. My quality of life will get better in the future. 
23. Every day that I get up, I do something productive. 
24. I am making progress towards my goals. 
25. When I am feeling low, my religious faith or spirituality helps me feel better. 
26. My religious faith or spirituality supports my recovery. 
27. I advocate for the rights of myself and others with mental health problems. 
28. I engage in work or other activities that
enrich myself and the world around me.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>N</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. I cope effectively with stigma associated with having a mental health problem.</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>30. I have enough money to spend on extra things or activities that enrich my life.</td>
<td>o</td>
<td>o</td>
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</tr>
</tbody>
</table>
QUALITY OF LIFE SCALE (QOL)

This questionnaire asks about your overall quality of life. Please read each item and circle the number that best describes how satisfied you are at this time. Please answer each item even if you do not currently participate in an activity or have a relationship. You can be satisfied or dissatisfied with not doing the activity or having the relationship.

Delighted = 7, Pleased = 6, Mostly Satisfied = 5, Mixed = 4, Mostly Dissatisfied = 3, Unhappy = 2, Terrible = 1

1. Material comforts home, food, conveniences, financial security ............ 7 6 5 4 3 2 1
2. Health - being physically fit and vigorous ........................................... 7 6 5 4 3 2 1
3. Relationships with parents, siblings & other relatives-
   communicating, visiting, helping ..................................................... 7 6 5 4 3 2 1
4. Having and rearing children ................................................................. 7 6 5 4 3 2 1
5. Close relationships with spouse or significant other.............................. 7 6 5 4 3 2 1
6. Close friends .......................................................................................... 7 6 5 4 3 2 1
7. Helping and encouraging others, volunteering, giving advice .............. 7 6 5 4 3 2 1
8. Participating in organizations and public affairs .................................... 7 6 5 4 3 2 1
9. Learning- attending school, improving understanding,
   getting additional knowledge ............................................................... 7 6 5 4 3 2 1
10. Understanding yourself - knowing your assets and limitations
    - knowing what life is about .............................................................. 7 6 5 4 3 2 1
11. Work - job or in home ........................................................................... 7 6 5 4 3 2 1
12. Expressing yourself creatively ............................................................. 7 6 5 4 3 2 1
13. Socializing - meeting other people, doing things, parties, etc............ 7 6 5 4 3 2 1
Delighted =7, Pleased = 6, Mostly Satisfied = 5, Mixed = 4, Mostly Dissatisfied = 3, Unhappy = 2, Terrible = 1

14. Reading, listening to music, or observing entertainment .......................... 7 6 5 4 3 2 1

15. Participating in active recreation ............................................................... 7 6 5 4 3 2 1

16. Independence, doing for yourself ............................................................. 7 6 5 4 3 2 1
The Meaning in Life Questionnaire

For this questionnaire, please take a moment to think about what makes your life feel important to you. Please respond to the following statements as truthfully and accurately as you can, and also please remember that these are very subjective questions and that there are no right or wrong answers. Please answer according to the scale below.

<table>
<thead>
<tr>
<th>Absolutely Untrue</th>
<th>Mostly Untrue</th>
<th>Somewhat Untrue</th>
<th>Can’t Say True or False</th>
<th>Somewhat True</th>
<th>Mostly True</th>
<th>Absolutely True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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</tbody>
</table>

1. I understand my life’s meaning. _______
2. I am looking for something that makes my life feel meaningful. _______
3. I am always looking to find my life’s purpose. _______
4. My life has a clear sense of purpose. _______
5. I have a good sense of what makes my life meaningful. _______
6. I have discovered a satisfying life purpose. _______
7. I am always searching for something that makes my life feel significant. _______
8. I am seeking a purpose or mission for my life. _______
9. My life has no clear purpose. _______
10. I am searching for meaning in my life. _______
# Cross-Cutting Symptom Scale

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past two (2) weeks**.

<table>
<thead>
<tr>
<th></th>
<th>None None at all</th>
<th>Slight Rare, less than a day or two</th>
<th>Mild Several days</th>
<th>Moderate More than half the days</th>
<th>Severe Nearly every day</th>
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<td>I.</td>
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<td>VII.</td>
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<td>VIII.</td>
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<td>X.</td>
<td>16. Unpleasant thoughts, urges, or images that repeatedly entered your mind?</td>
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<td>17. Feeling driven to perform certain behaviors or mental acts over and over again?</td>
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<td>XI.</td>
<td>18. Feeling detached or distant from yourself, your body, your physical surroundings or your memories?</td>
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<td>XII.</td>
<td>19. Not knowing who you really are or what you want out of life?</td>
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<td>20. Not feeling close to other people or enjoying your relationships with them?</td>
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<td>XIII.</td>
<td>21. Drinking at least 4 drinks of any kind of alcohol in a single day?</td>
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<td>22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?</td>
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<td>23. Using any of the following medicines ON YOUR OWN, that is, without a doctor’s prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?</td>
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