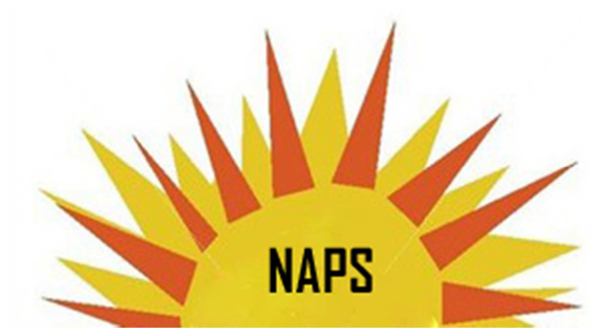
Recovery to Practice Situational Analysis

National Association of Peer Specialists



April 2011

Request for Input

This Situational Analysis for the Recovery to Practice project is intended to stimulate thought and discussion. This is an important planning document. Your input is highly valued and we encourage you to review this document carefully and thoroughly and provide suggestions, advice or information to help us. Although this is a “final” report, input is appreciated any time about issues raised here. We always welcome advice and suggestions from interested parties.

To contribute your thoughts, please use the following contact information:

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Overview of the RTP Project

On March 1, 2010, five mental health disciplines were awarded contracts to enhance recovery education. Those professions are: social workers, psychiatrists, psychiatric nurses, psychologists and peer specialists.

The first year of the five-year Recovery to Practice (RTP) project included the creation of a situational analysis based on efforts to understand the current status of the professions, identifying and marshalling recovery resources and identifying recovery knowledge gaps with the goal of creating a recovery curriculum for each discipline.

In addition to these efforts, the RTP project involved consultation with and collaboration among the disciplines and key experts in the recovery community. Involvement of persons in recovery from psychiatric disorders was deemed especially important. Also, the ten recovery components identified by the Substance Abuse and Mental Health Se3rvices Administration (SAMHSA) were to be used as a foundation for RTP efforts.

Subsequent years of the RTP project will involve the development of a recovery curriculum, testing of the curriculum, modifications resulting from pilot testing and distribution among the involved disciplines.

The NAPS RTP project manager is Steve Harrington, NAPS' executive director. He encourages input from all those interested in the important roles peer specialists can and do

play in bringing recovery practices to mental health systems. To ensure diverse sources of information and input, NAPS partnered with the Depression and Bipolar Support Alliance (DBSA), the country's largest consumer support organization, to conduct this project.

Recovery to Practice
Situational Analysis
National Association of Peer Specialists

Background

The contract award for the Recovery to Practice (RTP) initiative to the National Association of Peer Specialists (NAPS) was important for several reasons. First, it recognized the peer specialist* profession as a legitimate and important element of mental health services. The contract award placed the NAPS RTP team in the role of collaborator with the other mental health disciplines. This was important because it assured peer specialists across the country that their voices would be heard throughout the RTP project. This inclusion is supported by a quickly growing body of evidence that demonstrates the effectiveness of peer support and the peer specialist profession.

The contract award was also important because it recognized that while peer specialists are experts in their own recovery journeys, they are not necessarily recovery experts on a broader scale. Recovery can be "slippery" to define as it is a unique experience to the

*For the purposes of this document, "peer specialist" means one with a mental health recovery experience who helps others with a psychiatric condition on their recovery journeys in a formal manner and is paid for his/her services. The authors recognize that many other terms are used to describe this occupation. The term "peer support" is used as a more broad term and includes casual, intermittent, volunteer and informal support from one who has had the same or similar experiences in a broad range of settings including but not limited to psychiatric and general hospitals, correctional institutions, juvenile and geriatric residential facilities, substance use disorder treatment facilities, educational institutions and community and private mental health provider agencies.

individual and value based. The RTP contract award recognized that recovery is often complex and requires skills and knowledge far beyond those that can usually be acquired simply through one's own experience. Thus, the contract award will allow peer specialists to gain valuable, new recovery knowledge to use in their practices for the benefit of those they serve.

News of the RTP contract award spread quickly throughout the peer specialist community. The NAPS team had the "fortunate" problem of dealing with many phone calls and e-mails long before the actual start date. Perhaps the overwhelming response reflects a pent up desire to participate in a meaningful, national dialog and policy/education endeavor.

The sheer volume of unsolicited input and enthusiasm among peer specialists left little doubt that those working in the profession determined this initiative to be of great importance not only to the profession, but to a broad application of mental health services in the U.S. (Norcross, 2002; Liberman, 2008 & Townsend & Griffin, 2006).

Historical Overview

Because the peer specialist profession is a relatively new phenomenon in mental health services, it is often unknown or misunderstood by other mental health professionals, medical health professionals and the general public. Confusion and misunderstandings also exist in regard to the roles peer specialists can or should play in mental health services. A brief overview of the history and evolution of the peer specialist profession is likely to be helpful by providing valuable context.

Although peer support can be traced to the beginning of humanity, including the military operations of the ancient Greeks and Romans, it emerged as a powerful force in mental health in the early 1980s. The peer support outcomes, popularity of Alcoholics Anonymous and the reality of recovery from serious and persistent mental health problems combined to create an atmosphere ripe for the creation of a peer support movement in mental health. At this time, mental health institutions were closing across the U.S. in favor of community-based treatment where persons with psychiatric conditions could live and obtain support in the communities in which they lived.

As more and more people became well, they regained skills lost or developed new skills. These skills included leadership, engagement and communication and, when combined with a desire to "give back" to society, mental health systems were met with calls for peer involvement in the delivery of mental health services; often from former service users.

Some peer specialists report their interest in peer support as a profession was the result of participating (often facilitating) peer support groups on a volunteer basis. Organizations such as the Depression and Bipolar Support Alliance (DBSA), which sponsors more than 1,000 peer support groups in the U.S., Recovery International and the National Alliance on Mental Illness (NAMI).

What began as a whisper of isolated employment in mental health settings rose to a roar where peer providers are commonplace in some mental health systems. Factors driving this trend were: 1) the growing recognition of the reality of recovery from even severe and persistent psychiatric conditions, 2) a political climate that expected cost-effectiveness for public funds, 3) positive outcomes associated with peer support, 4) a ready labor force and 5) and the establishment of formal peer training and certification of peer specialists.

By the late 1990s, peer specialists[†] (persons with a lived history of mental illness and recovery journey who help others on their recovery journeys) emerged as a powerful force. In 2001, Georgia became the first state to obtain Medicaid reimbursement for peer support services (Salzer, Schwenk & Brusilovskiy, 2010). Since that time, 13 other states have followed. In addition to providing direct services to their peers, peer specialists were providing services in a variety of ways (one-on-one support, facilitating support groups, community resource connecting, education, etc.); peer specialists were acting as change agents. As employees of mental health providers, peer specialists found themselves in positions to influence organizational policies and practices to enhance service effectiveness (Fukul, Davidson, et al., 2010).

In 2004, the National Association of Peer Specialists was formed to promote the use of peer support in mental health settings by gathering and sharing information. NAPS soon became involved in advising policy makers about peer workforce issues. The organization quickly grew from a handful of dedicated peer specialists to more than 1,000 members representing every state, Australia, the United Kingdom, Japan, Guam, Canada and several other countries. The group has sponsored four successful national conferences where vital information has been shared. NAPS also publishes a quarterly newsletter for its members and back issues are available on its website: www.naops.org. The organization, primarily through e-mails and telephone calls, acts as a peer support information clearinghouse and frequently responds to inquiries from throughout the U.S.

As the peer specialist profession matured, changes in training naturally occurred. The number of training entities flourished but, in recent years, appears to have stabilized to a relative handful of highly competent entities including but not limited to: The Appalachian Consulting Group, DBSA, Recovery Innovations, The Aspin Group and the Institute for Recovery and Community Integration. Until recently, these training entities generally offered one-week training courses to satisfy state certification requirements. But training courses appear to be increasing in length and topics covered. A list of topics (competencies)

[†] Peer specialist may be also referred to as: "peer support specialists," "peer support technicians," "consumer advocates," "peer recovery support specialists," "recovery specialists," and a myriad of other titles. For a more detailed description of titles, see Salzer, Schwenk & Brusilovskity (2010).

frequently covered in training programs can be found in Appendix 2 and was compiled as part of this project.

Other peer support initiatives vary somewhat from this general model but nonetheless provide valuable services. These initiatives include Wellness Recovery Action Planning (WRAP™), Intentional Peer Support, Peer Bridger Programs, Crisis Intervention Teams, Recovery International and social-inclusion programs that involve peers as community, school, university and organizational educators.[‡]

Some states have developed their own peer specialist training curricula for use for certification purposes. A common feature among virtually all training programs is heavy reliance on peers as advisors in basic curriculum development and as instructors.

The number of states creating peer specialist initiatives with formal hiring of peer specialists has grown dramatically in the last five years. As of this writing, there are 14 states that tap Medicaid funds for peer support services in some manner. The number of states with employed peer specialists is somewhat higher (an estimate of 25 is not unreasonable) but the exact number is often difficult to determine as programs are sometimes small and/or isolated. At least two states, North Carolina and Texas, are working toward Medicaid reimbursement for peer support and have made much progress in that regard.

Each state with a formal peer specialist program exercises control over that program as it relates to certification, training, professional discipline and other operational issues. Despite efforts to foster training and certification reciprocity between states, those efforts have generally resulted in rejections to "outside" assistance or suggestions. Although Kansas, Missouri and Georgia permit a measure of reciprocity, most states do not and, at this time, appear unwilling to consider doing so.
In August 2007, the Centers for Medicare and Medicaid Services (CMS) issued guidelines to states wishing to use Medicaid funding for peer support services (Smith, 2007). For

[‡] Peer educators often perform their work in a variety of settings that often include peers. Through education of the community and peers, these educators are deemed to be helping others on their recovery journeys and, therefore, fall under the definition of "peer specialist."

delivery of peer support services, those guidelines addressed supervision, care-coordination and training and certification.

As a result of these guidelines and overall growth in the peer specialist workforce, the demand for continuing education opportunities has grown as well. The availability, protocol and requirements of continuing education among states with peer specialist certification programs is widely variable and difficult to determine. What we do know is that states have spent considerable time and effort to develop the basic certification procedure and requirements but many have yet to reach beyond that step to develop continuing education programs. State officials adamantly express their commitment to continuing education and it is reasonable to expect that state lacking such programs will strive to adopt successful models to address continuing education needs. Financial considerations may, however, affect the development of continuing education endeavors.

In recent years, the Department of Veterans Affairs (VA) has made great strides in the training, certification and hiring of peer specialists (often called "peer support technicians within its system) for its healthcare facilities. In some ways, that Department's successful efforts have encouraged states that once considered peer support meaningless or marginally meaningful, to reconsider their positions and, ultimately, create peer specialist programs. Today, the VA has a significant peer workforce that is well-trained, professional and contributing a wealth of positive outcomes (Salzer, 2011; Salzer, M.S., Schwenk, E., & Brusilovskity, E. (2010).

The diversity of the peer specialist workforce has been both challenging and rewarding. Each peer specialist brings a unique skill set to the mental health workplace. And because the profession is relatively new, there is often much flexibility in how and where those skills are used. In this way, the strengths of peer specialists have, to some extent, molded workplace roles. As a result, peer specialists are working in such settings as general hospital emergency rooms, psychiatric hospitals, jails and prisons, nursing homes, as educators in communities, drop-in centers, clubhouses, vocational placement agencies, etc.

The diversity of peer specialists is reflected by more than work setting. Tasks are also quite variable and include, but are not limited to: individual support, facilitating support groups, educating a variety of individuals and groups about recovery and the true nature of mental illnesses, helping people make the transition from hospital to community, housing and educational support, engagement, wellness coaching, resource connecting, advocacy, supervision, administration, teaching formal recovery courses (such as Wellness Recovery Action Planning™, Pathways to Recovery and courses created and taught by peer specialists) and transportation.[§]

On the other hand, there appears to be a great number of mental health provider agencies that are confused or misunderstand the valuable roles peer specialists can play. Reports from the field reveal that some peer specialists are relegated to roles in which they are unable to use their recovery experiences and knowledge for the benefit of those they serve (or should be serving). For example, there are reports that some peer specialists are providing parking lot security, medication monitoring, office support or other duties that do not present meaningful peer-to-peer contact.

Failure to understand the important roles peer specialists can play are detrimental to peer specialists, co-workers, persons served and mental health systems as a whole (Townsend & Griffin, 2006). Lack of understanding often leads to workplace conflicts. Although some authors have attempted to educate and teach both peer specialists and non-peer co-workers strategies for conflict resolution (Carlson, Rapp & McDiarmid, 2001), those strategies appear inadequate for effective application in many settings.

Despite the well-proven abilities of peer specialists to create positive outcomes in these many settings (Salzer, 2011, Salzer, M.S., Schwenk, E., & Brusilovskity, E., 2010, SAMHSA, 2009, Davidson, Chinman, Kloos, et al., 1999), the profession remains underpaid. Workers often feel disrespected and without a meaningful career ladder. A compensation and satisfaction survey was implemented nationally by NAPS in 2007 and the

[§] This list is far from exhaustive and more detail is found later in this report. Transportation is included here but is sometimes debated as to whether it is a “true” or “valid” peer support task. Transportation of peers can present meaningful opportunities for discussion and relationship building that supports a peer’s recovery.

results are compiled in a report found in Appendix 2. A similar survey will be implemented by NAPS in 2011.

Based on historical information, it seems a certainty that the peer specialist profession will enjoy considerable (and likely rapid) growth in the next decade. For example, as a result of budgetary constraints and a federal court order to revamp its mental health system, North Carolina has recently implemented changes that rely significantly more on peer specialist services. Why? One recent study has shown that peer support can reduce hospitalization by as much as 72 percent (OptumHealth, 2011). And it is clear the need for continuing education will be grow as a component of state-sanctioned peer specialist programs in line with the profession's growth and maturity and CMS guidelines. One Indiana state mental health official said distribution of this report will help him promote peer specialists in that state (VanDusen, 2011).

Assessment Methodology

In order to identify knowledge gaps and professional needs, the NAPS RTP project team used a multi-faceted approach to obtain input from the constituent group (peer specialists). This approach was used for approximately nine months with a multitude of assessment sources employed throughout this period simultaneously. Although the simultaneous use of assessment sources was not originally contemplated, circumstances (primarily the enthusiasm of peer specialists) made this approach necessary. This resulted in qualitative data acquired from a variety of peer support organizations and peer specialists.

It was the goal of the project team to obtain as much input from as many diverse sources as possible as quickly as possible and then summarize and evaluate that input. Input was sought from well beyond NAPS membership but came almost exclusively from peer specialists. The primary input sought related to the identification of recovery topics that, through further education, would enhance recovery knowledge among peer specialists. In addition, the NAPS RTP team explored the rationale for the identification of such topics and how information could best be conveyed (i.e. most effective instructional styles).

What follows is a summary of the assessment sources and how they were used to obtain input from the constituent group.

One-on-One Interviews

One-on-one interviews were conducted on an *ad hoc* basis by the NAPS RTP project team. Because the team is dispersed geographically and includes approximately 12 volunteers enthusiastic about the project, a set of questions was devised to guide interviewers. Most interviewers conducted a relatively small number of such contacts (about 2-3 each), although some volunteers were more engaged and conducted as many as 12 interviews.

Using the interview guide as a basis for reporting responses, the NAPS RTP project team received e-mails detailing input from those interviewed. All peer specialists were interviewed by project team members or project team leader, Steve Harrington. Harrington also interviewed mental health professionals from other disciplines (i.e. psychologists, psychiatrists, social workers and psychiatric nurses). Interviews with a small number of persons served by mental health agencies but not working as peer specialists, were also included.

Harrington also interviewed instructors of the most prominent peer specialist curricula currently in use. From these interviews, Harrington determined what students (current and former) felt were areas of greatest interest and value. Input regarding areas where more attention could be placed was also noted. For example, some instructors reported that students who completed a particular training course contacted instructors months later in an effort to secure additional information about a specific recovery topic.

Mental health government officials were consulted in the states of Indiana, California, Michigan, North Carolina and Wisconsin regarding capacity issues. Specifically, these officials—at varying levels of responsibility—were interviewed regarding government and

local agency ability to support continuing education or other venues for implementing the recovery curriculum for peer specialists. Other peer support experts (identified later in this report) were also consulted on capacity issues.

Interview responses were collected and summarized to identify key issues of concern/interest among interviewees and how recovery topics could be addressed in the new curriculum.

Listening Sessions

Groups of interested individuals (almost exclusively peer specialists) were presented with background regarding the RTP project and then asked, in an informal and open-ended manner, for suggestions regarding recovery knowledge gaps and how those gaps could be addressed in the recovery curriculum.

The listening sessions were generally conducted in conjunction with gatherings of peer specialists in diverse areas of the country. Such sessions were held in Chicago, Ill.; High Point, NC; Atlanta, GA; Anaheim, CA and Grand Rapids, Mich. The listening sessions were conducted by NAPS RTP project team members who were also NAPS or Depression and Bipolar Support Alliance (DBSA) staff. Volunteers were not used to facilitate these sessions but were used to record input through notes.

The following table identifies the listening session events and numbers of peer specialists and others [others in parentheses (n)] participating:

Location Or event	DBSA Conference	NAPS Conference	Alternatives Conference	High Point NC	Carter Summit	Recovery Academy
Number of Participants	8 (1)=9	75 (5)=80	22 (2)=24	15 (2)=17	8 (2)=10	8 (4)=12

The results of the listening sessions were summarized with an eye toward identifying recovery knowledge gaps among peer specialists and how those gaps could be addressed through the recovery curriculum. The NAPS RTP project team believed it was important to not only identify recovery knowledge gaps but the most effective learning and teaching methods. In some sessions, marketing issues were identified and discussed.

Despite geographic and cultural diversity among the groups, there were remarkably similar themes consistently identified. Those themes were:

- Holistic approach
- Conflicts in the workplace/intra-organizational advocacy
- Ethics and boundaries
- Peer support for peer supporters
- Co-occurring disorders
- Trauma-informed practices
- Cultural competency
- Building relationships/communication with peers

Expert Consultations

Although the NAPS RTP project team believed it vital to gain the bulk of input from peer specialists actually working in the field, the value of input from some who are recognized experts in various fields was also deemed important. It is important to note that nearly all experts are persons in recovery from a psychiatric condition. The following is a list that includes some, but not all, persons and organizations consulted during this phase of the project and experts who reviewed this situational analysis:

-Cathy Cave, National Center for Trauma-Informed Care, trauma and multi-cultural expertise

-Bill Anthony, Ph.D., Boston University's Center for Psychiatric Rehabilitation

-Jennifer Padron, GLBT advocate

-Jean Campbell, Ph.D., Mental Health Institute of Missouri

-Gayle Bluebird, National Association of State Mental Health Program Directors (NASMHPD) and peer support program consultant for Delaware
-Gladys Christian, NAPS president
-Antonio Lambert, Envisions of Life trainer
-Lisa Goodale, Depression and Bipolar Support Alliance
-Lyn Legere, The Transformation Center, director of training
-Beth Filson, National Center for Trauma-Informed Care
-Mike Roaleen, Recovery Academy Director
-Patrick Kaufmann, Power Branch Director
-Rita Cronise, Mental health education consultant
-Participants at the International Initiative for Mental Health Leadership
-Bruce VanDusen, Bureau Chief, Indiana Division of Mental Health and Addiction
-Staff of Mental Health America's National Technical Assistance Center
-Ed Knight, Vice President, ValueOptions
-Dan Fisher, Executive Director, National Empowerment Center
-Mark Davis, GLBT mental health service consultant
-Matt Federici, Director, Copeland Center
-Chacku Mathei, New York USPRA Chapter
-Andy Bernstein, Ph.D., psychologist
-Laurie Coker, Director, North Carolina Consumer/Survivor Organization

Newsletter, E-Mail and Website Solicitations

Solicitations for input from stakeholders regarding the identification of recovery knowledge gaps were made through the quarterly NAPS newsletter, by e-mails and on the NAPS website. Each solicitation resulted in a flurry of input. Input from these sources was primarily expected and received from NAPS members, with non-members providing additional suggestions. Input from supervisors of peer specialists, mental health administrators and others was received, summarized and cataloged for future reference.

Input was sent via e-mail to the NAPS RTP team; additional input regarding the project was received by letter and telephone.

Literature Search/Review

A search of professional literature was used to seek studies that identify: 1) current roles of peer specialists, 2) studies that relate to the ten recovery components identified by the Substance Abuse and Mental Health Services Administration (SAMHSA), 3) effective teaching methods for persons with psychiatric disorders, 4) recovery knowledge gaps among peer specialists and/or consumers in general. In addition to the resources listed below, professional journal articles were accessed through database searches and personal contacts with social science researchers.

Although the literature search yielded a variety of materials, it became apparent some areas had been researched in greater detail than others. Among the most valuable of the existing studies appears to be those conducted by Mark Salzer, Ph.D. of Temple University, Larry Davidson of Yale's Psychiatric Research Center and their colleagues. National surveys of peer specialists and studies of peer specialists working for the VA, specifically identified recovery knowledge gaps, particularly those relating to what he identified as "intimacy" skills. These skills included dating, spirituality and related topics (Salzer, Schwenk & Brusilovskity, 2010; Salzer, 2011).

In 2007, NAPS conducted a survey of peer specialists across the country (see Appendix 2) to identify recovery knowledge gaps. Responses were also useful for this project. A total of 173 respondents allowed NAPS to gather useful data. In 2011, the survey-based study is being repeated by the organization.

The literature search also involved consultation with staff of Boston University's Center for Psychiatric Rehabilitation and Moe Armstrong of the Vet-to-Vet program. Books and professional journal articles regarding a wide range of psychiatric rehabilitation issues were identified, obtained, read and reviewed by the NAPS RTP project team. For example, a new

book, *Self-Disclosure in Psychotherapy* (Forrest, 2010), was recommended by Larry Davidson, Ph.D., was obtained and found most useful in assessing important communication issues for peer specialists and other mental health disciplines. That book, in addition to professional journal articles on the topic, generated considerable discussion relating to identified recovery knowledge gaps as they relate to self-disclosure and the current and potential effects of self-disclosure by other mental health disciplines.

Relationship issues between peer staff and peers, non-peer staff, administrators, organizations and others were infrequently addressed in professional literature but some such literature does exist and provides valuable context (Townsend & Griffin, 2006; Carlson, Rapp & McDiarmid, 2001; Norcross, 2002). Additional research in these areas would be of great value as the peer specialist profession evolves and grows.

It appears the first generation of research regarding peer support was primarily exploratory and/or feasibility focused and involved pilot studies on various aspects of peer support (such as supported employment, education and housing) (See generally, Davidson, Chinman, Kloos, et al., 1999; Chinman, Hamilton, Butler, et al., 2008; Center for Psychiatric Rehabilitation, 2011). We are just now reaping the rewards of a second generation of research that focuses more on efficacy of peer support (Center for Psychiatric Rehabilitation, 2011). While that research is often qualitative in nature, studies currently underway hold the promise of quantitative analyses.

While professional journal articles had the benefit of peer review, one non-professional report widely circulated contained data that appeared somewhat unreliable. Pillars of Peer Support (Daniels, Grant, et. al, 2010) is the result of a meeting of peer support advocates and state and federal government officials. Data was obtained from state officials regarding numbers of peer specialists certified, employed and the length of training. This self-report may have been biased as the reporters knew their responses would be compared to other states.

Twenty-two states were represented at the meeting with 13 reporting a certification program.[**] Based on information obtained by NAPS through its normal course of business and empirical research, it is clear some state officials over-reported the number of certified peer specialists, number employed and length of training. For example, one state reported full employment of certified peer specialists but that contention is contrary to a number of reports from that state regarding peer specialist unemployment by peer specialists and data that showed that, nationally, 76 percent of peer specialists were working one year after training (Salzer, 2011).

Some state officials have opposed research involving their peer specialist programs, which presents a challenge to researchers to obtain data. To overcome this challenge, NAPS has cooperated with several researchers so they can directly access peer specialists across the country.

The issue of access to peer support research was identified by a group of peer specialists in North Carolina. When that state drafted a policy that would restrict peer specialists' activities and called for a Medicaid reimbursement rate for peer support at $5.50 per unit, the group seemed to become keenly aware of the value of peer-reviewed journal articles reporting the results of peer support studies. Through their advocacy, requests were made to NAPS by North Carolina state officials for the same studies.

The Center for Psychiatric Rehabilitation at Boston University has created a synthesis of some of the current research in this area and posted it on a website. This endeavor is part of a knowledge transfer project and NAPS will continue to consult with the center to explore how such initiatives may provide authoritative information to peer specialists and other stakeholders in a convenient and timely manner.

Although it was out of sequence for this project, the NAPS RTP project staff created a preliminary draft of guidelines specific to teaching groups of persons with psychiatric

[**] Since that meeting, Indiana has joined the ranks of states with Medicaid reimbursement for peer support services bringing the total to 14 as of this writing.

conditions. That draft was distributed to six persons experienced in instructing this population and extensive comments/suggestions were provided by Rita Cronise, a professional curriculum developer (and person in recovery) from Victor, N.Y., Lisa Goodale, vice president of training for DBSA and Mike Roaleen, director of the Recovery Academy in Grand Rapids, Mich. Because this aspect of the project was out of sequence, refinement of the guidelines was suspended until a more appropriate time.

The draft guidelines were created at this point in the project to stimulate discussion about how the resulting recovery curriculum would or could be implemented. It was deemed appropriate by a group within the advisory group to begin thinking about these considerations early in the RTP process. The primary issue of concern was ensuring that all persons with a variety of psychiatric challenges would be able to access, understand and use the resulting curriculum. Input from reviewers informed the NAPS RTP team's thinking about instructional quality and expectations regarding instructor competencies. Formal guideline development was postponed to allow time for opinions and thoughts regarding this issue to mature through further informal discussions.

Literature Search/Review Results

Despite a general lack of quantitative information available in professional literature, there is a wealth of qualitative literature regarding the importance of peer support and the peer specialist profession. The first generation of research was primarily focused on theory and implementation strategies. We are now beginning to see a new generation of research endeavors that focus more on outcomes in a quantitative fashion.

The "Reference" section at the end of this report identifies some of the most relevant and important research available regarding peer support and the peer specialist profession. It has been cited, where applicable, in this report. The references do not represent all of the research literature available (Center for Psychiatric Rehabilitation, 2011) and several important studies are currently underway which we expect to provide valuable data, analyses and conclusions.

Review of Existing Curricula

A review of several existing peer specialist training curricula was conducted and included curricula used by the Recovery Academy, DBSA, Appalachian Consulting Group, Shery Mead and the Recovery Opportunity Center (including that organization's advanced curriculum). Boston University and the Recovery Academy have produced curricula relating to vocational peer support and substance use disorders respectively and those curricula were included in the review.

In her role as a consultant for the Delaware Department of Mental Health, Gayle Bluebird is developing a curriculum designed for peer specialists working in in-patient settings (primarily psychiatric hospitals) and that curriculum will be reviewed when a draft is available. Bluebird did, however, provide valuable information regarding in-patient issues developed through her work with NASMHPD, which was reviewed for this project.

All curricula review resulted in summaries of key components for use in identifying recovery knowledge gaps and, for a later phase of this project, important instructional elements (such as teaching aids and methods).

Conference Workshop/Session Attendance

The NAPS RTP project team evaluated the relative popularity of workshops and other sessions at key conferences. These conferences included but were not limited to:

- DBSA's 2010 national conference
- NAPS's 2010 national conference
- Alternatives 2010 national conference
- Texas-USPRA 2010 conference

- Assertive Community Treatment Association's 2010 national conference
- Carter Center 2010 Mental Health Summit

A review and summary of the most popular workshop/session topics among consumers and peer specialists was thought to be one way to gain some measure of interest in topics where recovery knowledge is lacking. The observations were recorded and summarized although the exact content of the workshops/session was not detailed as the topics and conference programs provided sufficient information for the purposes of this project.

During the International Initiative for Mental Health Leadership (IIMHL) event in Ireland in 2010, a booklet entitled "My Sexual Health Matters: Advice for Persons with Mental Illness" was obtained and distributed to NAPS RTP advisory group members and selected consumers, mental health professionals from other disciplines and administrators. The response to this document was enthusiastic without exception. This response indicated the importance of this topic. The NAPS RTP project team was able to secure re-publication rights from the Australian group that created it and made arrangements to have the publication reproduced by a consumer micro-enterprise. Although this re-publication is independent of the RTP project this action is an example of how a public/private enterprise partnership can be used to foster distribution of important recovery-oriented materials.

Review of Existing Recovery Measures

The NAPS RTP project team gathered existing recovery measures and reviewed those measures (primarily survey instruments with explanatory material). The intent was to determine what recovery components had been identified by social science researchers and how they had explored those components in their work. This endeavor is uncompleted as of this writing but is expected to be finished early in the next phase of the RTP project. The results will be reported for the benefit of peer specialists and other mental health disciplines.

Marshalling and Evaluation of Existing Recovery Materials

In addition to identifying recovery knowledge gaps among peer support professionals, the first-year activities of the RTP project also included marshalling and evaluating existing recovery materials. To some, this may seem an entirely distinct activity from situational analysis. But, as the NAPS RTP team embarked on this endeavor, it quickly became clear these aspects are related.

Gathering and reviewing existing recovery materials enabled the team to: 1) learn what aspects of recovery had been the focus of professional and peer groups in the past (i.e. what recovery knowledge gaps had other groups identified and addressed historically), 2) learn what teaching/communication methods were used by other groups, 3) obtain a rough measure of what teaching/communication methods were especially meaningful to peer specialists and peers, and 4) learn the historical capacity of mental health organizations to create and develop recovery materials.

To marshal and evaluate existing recovery materials, the NAPS RTP team relied heavily on human resources provided by the Recovery Academy, a peer-run educational organization in Grand Rapids, Mich. The activities involved the following procedure:

- Publicize the need for recovery materials or information about them.
- Gather and organize recovery materials (13 large boxes).
- Establish a group of peers and peer specialists to examine the materials and make recommendations and suggestions regarding the meaningfulness of materials. The group met once a week for eight weeks and varied in size from four to 12. The group met for three to five hours during each session. Some individuals took materials home for a more extensive review and shared results with the group at the following meeting. This was particularly useful for comprehensive books, CDs and DVDs.
- Create and use a numeric evaluation code so each review group member could express his/her evaluation in a quantifiable way.
- Discuss materials of particular interest to the review group.

- Hire an administrative assistant to organize materials and create a filing and shelving system.
- Create summary documents of key recovery materials and the topics covered and why the review group felt they were especially meaningful.
- Create a "recovery resource center" at the Recovery Academy so the materials could be accessed by the NAPS RTP project team and interested peers and peer specialists.

In addition to lively and powerful discussions about the recovery materials (which later led to a peer support group at the Recovery Academy to continue such discussions), this activity successfully provided the information identified previously.

Situational Analysis Review

The first draft of this document was distributed directly to 48 individuals, primarily (41) peer specialists but also peers and other mental health professionals who expressed an interest in review. Some of these people further distributed this document so the exact number of those receiving this document for review is difficult to determine. The purpose of this review was to solicit comments and suggestions. This will serve as a way to increase reliability and validity of this situational analysis. Twenty copies were distributed in "hard copy" form. The NAPS RTP team is cognizant that many peers and peer specialists lack ready access to the computer technology necessary to receive e-mails and respond electronically.

In an effort to obtain as much feedback as possible, the availability of this document was promoted in the Winter 2011 issue of the NAPS newsletter and on the organization's website. This promotion led to the distribution of three copies. While this number is relatively small, the NAPS RTP team has received more than 20 previous requests for information about the RTP project and published regular updates in its newsletter.

Distribution of the first draft resulted in 18 responses. Five of those responses merely stated approval and gratitude for the document. The remaining 13 responses ranged from very

minor suggestions involving only a few word changes to very extensive input requesting significant additions to the document.

As a result of input, especially that from DSG, the NAPS RTP team will strive to create a "state of the profession" report annually. The work heretofore performed for the RTP project will provide an excellent foundation for such an annual report to all stakeholders. This endeavor holds the promise of advancing the profession in a variety of areas, including recovery knowledge transfer.

1) Target audience

The target audience for this project is employed peer specialists. Because some peer specialists are unpaid but receive training, an inclusive approach was used in gathering data. The vast majority of input (approximately 95 percent) was obtained from employed peer specialists. Additional efforts were made to include consumers, mental health professionals from other disciplines, administrators, educators and those who simply expressed keen interest in the project. For example, several parents of persons with psychiatric conditions contacted the NAPS RTP project team to obtain background information and then offered opinions and suggestions.

Specific groups, particularly groups that have been traditionally underserved, were contacted for input. These groups included those of ethnic minorities and gay, lesbian, bisexual, transgender and questioning (GLBTQ). Subgroups, particularly those with a history of trauma, were also specifically sought out for input for this project.

The recovery curriculum resulting from this project will be of greatest use and relevance for: 1) peer specialists, 2) those who instruct peer specialists, 3) those who supervise peer specialists and 4) those who use peer support services. By recognizing the interests and roles of these stakeholders and their relationships to working peer specialists, the NAPS RTP team expects to reach the primary target group—working peer specialists.

Because peer specialists are working in a great variety of settings with many different tasks and they are trained by instructors with different credentials, roles and experiences, the target group for this curriculum is amazingly diverse. Despite this diversity, there is a common goal of providing the highest quality of peer support possible. This goal will be the underlying principle for development of the curriculum and implementation.

Description of the Target Audience

The target audience, working peer specialists, can be described as having the following attributes:

- Living in poverty despite employment.
- Experience with a variety of training models and programs.
- Possessing a variety of skills.
- Diverse job tasks.
- High motivation to work and succeed at employment.
- High motivation to help others to begin or continue their recovery journeys.
- Subject to state rules/policies regarding certification that lack reciprocity.
- Subject to lack of national standards for professional qualifications and expectations.
- Frequently frustrated by workplace environment and/or workplace conflicts.
- Keenly interested in and willingness to obtain further education to enhance existing skills.
- Often supervised by non-peers who have no specific training about how to supervise peers in the workforce.
- Insightful regarding knowledge base and need for specific recovery skills.
- Mindful of the uniqueness of recovery journeys.
- Mindful and proud of their own recovery journeys.

- Often—but not always—work in an environment where co-workers 1) lack knowledge of the recovery paradigm and/or 2) feel confused or threatened by the presence of persons openly in recovery in the workplace.
- Largely lacking a meaningful career development path.
- Subject to lack of formal continuing education systems.

Peer specialists perform most of their tasks on a one-on-one basis with about two-thirds of their time spent at an agency; that amount of time depends on work setting. One national study reported that peer specialists were one-third male, 79 percent white or Caucasian, 12 percent black or African American, and 3 percent Hispanic or Latino. (Salzer, Schwenk & Brusilovskity, 2010).

> We also identified great variability overall in CPS activities. More frequent activities included the provision of peer support, understood as sharing of personal experiences and provision of mutual aid, encouragement of self-determination and personal responsibility; a focus on health and wellness; addressing hopelessness; assistance in communications with providers; education about illness management; and combating stigma in the community. These activities are all directly related to the recovery principles from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2005). Other activities were not address as often—employment, citizenship, spirituality and religion, developing psychiatric advance directives, parenting, and dating. These are areas in which CPSs are uniquely knowledgeable and qualified because of their own personal experience and understanding of the importance of these areas to recovery.
> (Salzer, Schwenk & Brusilovskity, 2010)

Contextual Conditions

2) Contextual Conditions for Discipline

Although some contextual conditions for peer specialists have already been detailed earlier in this assessment, some additional conditions warrant additional attention.

Distribution of Profession

The distribution of peer specialists in states using this form of peer support can be described as in "pockets." As of this writing, 14 states receive Medicaid reimbursement for peer support services in some manner. Some states have significant peer specialist programs but do not yet have Medicaid reimbursement.

For example, Colorado has a considerable number of well-trained peer specialists who are incorporating innovative activities in their practices such as outdoor adventure programs. But Colorado has no certification process or standardized training for peer specialists.

Within states there is often much variability in distribution. In some areas—often areas of high population density—peer specialists are found working in a variety of contexts. But in other areas (even an adjoining county), peer specialists are virtually unknown. Some peer specialists, because they may be the only such peer in the workforce of a particular organization, find themselves isolated from other peer specialists in the area.

Peer support for the peer supporter has emerged as an important and persistent issue. While this may be viewed strictly as a workplace issue, isolation can have detrimental effects on peer specialist practices. The use of communication technology, state and local peer specialist conferences and the emergence of state and local peer specialist organizations have evolved as ways to deal with isolation and the need for support.

Need for National Guidelines/Certification

Like the general population, peer specialists are dynamic. They move and change employers. Because there are no national guidelines or certification for the profession and an almost complete lack of reciprocity between states, moving one's residence or changing to a new workplace can pose significant difficulties and hardships. In some cases, there is a lack of consistency within states (examples include California and Colorado).

For example, a peer specialist living in one county in California may wish to move to a neighboring county but that county may not recognize the peer specialist's current certification. The neighboring county may not have any knowledge of peer specialists and, thus, no employment opportunities, training or certification procedures.

Although the organization for years has sought to work with various states to establish national standards and reciprocity, those efforts have yet to result in meaningful results. State officials have expressed a desire to retain control over peer specialist credentialing, practices and related issues.

NAPS will soon be addressing this issue in a limited fashion. The organization will be consulting with peer support leaders across the U.S. to formulate some basic standards regarding certification, practices and competencies. While this endeavor may not result in widespread acceptance of such standards, it is expected to have some effect on existing programs and those in development. These basic standards are likely to be dynamic as the profession continues to mature and evolve, but creating a "baseline" will likely stimulate thought, discussion and inform thinking about the value of some standardization.

The lack of consistency extends to certification initiatives in states with peer specialist programs. Some states only require training while others require training, work experience, successful completion of a comprehensive exam, character references, reference from a psychiatrist, an interview and background investigations.

The number of states with formal certification programs is growing. The creation of such programs is often driven by the CMS guidance letter of August 17, 2007, which called for certification and training standards by states seeking Medicaid reimbursement for peer support activities. These programs have taken many forms (Daniels, Grant, et al., 2010) and, of this writing, 14 states are receiving Medicaid reimbursement in some form. Some states without Medicaid reimbursement but with rapidly developing peer specialist programs (notably Texas and North Carolina) are certain to soon join these ranks.

Because each state enjoys autonomy in the way it develops training and certification programs, it is difficult to maintain an accurate record of the status of each state. This is especially true given the dynamic nature of this relatively new profession.

The Veterans Administration (VA) has established its own certification and training standards but those standards are expected to change relatively soon as that agency moves forward on initiatives to refine practices and policies to bring uniformity to peer specialists working in VA facilities.

In addition to curriculum development, investigations for this project have resulted in basic information about who, why, where and how peer specialists perform their work. This information will be a valuable aid in helping peer specialists, the peers they serve and co-workers about the roles of peer specialists and why they are important.

> What are not entirely clear, though, is how peer specialists view the central role for which they have been trained and hired (i.e. support provider) and how the system needs to change in response to this role. It is a beginning answer to this question to focus on the development of respectful and collaborative relationships, but that expectation should extend to all behavioral health practitioners and is not specific to the role of the peer specialist. It also has been noted that peer specialists tend to have greater credibility with persons with behavioral health conditions, and are more able to establish trusting relationships more quickly, because of their own first-hand experience. But to what ends is this first-hand experience being put to use? While these may seem like obvious questions to some, the answers to these questions are far from obvious to the typical non-peer behavioral health practitioner who most often views his or her clients as having organically based illnesses. To be fully prepared for their dual roles in integrated settings (i.e. provide support while acting as change agent), peer staff need to be able to clearly and persuasively articulate the purpose, nature and effectiveness of their work to others, including not only non-peer colleagues but also to the people they hope to serve. (Davidson, 2011)

NAPS will create a “fact sheet” detailing these areas in order to foster more consistency among the profession. The fact sheet will be published in NAPS publications and distributed as a handout at conferences, on the NAPS website and to those expressing an interest in the

document. It is anticipated that this fact sheet, carefully crafted, will address issues raised above by Davidson.

Financial Considerations

Money drives mental health innovation. The employment of peer specialists is often seen as an innovative practice and does not yet enjoy the status as a fully integrated profession. Peer specialists are often described as an "adjunct" to existing services rather than an integral component of meaningful and effective services. Thus, the availability of "extra" funds for the recruitment, training and hiring of peer specialists is often a critical factor.

Upon hiring, peer specialists often find themselves working part-time and for low wages. For example, the 2007 NAPS compensation and satisfaction survey revealed that the average work week was 32 hours at an average wage of $12 an hour.

Funding affects not only the training, hiring and use of peer specialists across the country; it has an important effect on continuing education. For example, NAPS has seen dramatic declines in its national peer specialist conference as peer specialists report budget cuts that prevent them from attending the conference. It is often the case that such budget cuts limiting continuing education opportunities are applied in a discriminatory fashion and do not affect other mental health disciplines in the same manner.

More and more, peer specialists are forming their own local (often state) organizations in order to connect with others in the profession and conduct their own conferences and similar events for continuing education purposes.

Many states have used federal Mental Health Development Block Grant funds to create and/or develop meaningful peer specialist programs. And, for the most part, such funding has been highly successful as "seed money" that results in viable and effective programs that continue after funding ends. These grant funds have most often been limited to support peer

specialist training but, in some cases, have also been used to provide short-term employment funding. In the case of the latter, it is often the case that mental health organizations discover the value of peer specialists and continue their employment after grant funds are no longer available.

The funding of continuing education activities is likely to be a capacity issue unless economic conditions improve and peer specialists enjoy equal status when it comes to access to training funds.

Early Evolution of Profession

It is important to remember that the peer specialist profession is a recent phenomenon in the provision of mental health services. It has only been in the last decade that peers in the workplace have moved from novelty to respected team member.

Because of the relative newness of the profession, there are a great many disparities in the areas of compensation, tasks, training and workplace environments. For a great many mental health organizations, peer workers are still "token" employees and have yet to move beyond the novelty status. In other organizations, peers are taking a true leadership role in not only providing services but creating and implementing policies.

Peer specialists themselves, because of the disparities identified previously, have diverse knowledge of recovery and recovery practices. While peer specialists are "experts" regarding their own recovery journeys, the uniqueness of such journeys to the individual make expanded recovery knowledge and practices vital to development of the profession.

It appears that the most successful peer specialist programs include supervisors who are especially supportive of a peer workforce (Chinman, Hamilton, et al., 2008). Some programs have specifically trained supervisors regarding appropriate tasks for peer specialists, how to integrate them into the workforce and how to deal with potential or existing conflicts in the workplace. Unfortunately, such supervisor training is the exception rather than the rule. This

type of training may be an issue for consideration by other mental health disciplines involved in this project.

Other important questions that frequently arise and are directly related to the freshness of the profession are:

- What if the peer specialist has a relapse?
- What if the peer specialist, outside the agency, participates in recovery events or activities (such as Alcoholics Anonymous meetings) with people they serve?
- Are peer specialists going to take the jobs of traditional mental health professionals such as case managers?
- Are peer specialists capable of respecting ethical standards and boundaries, especially when it comes to confidentiality?
- What if the peer specialist accesses his or her own mental health records or those of friends?
- Can peer specialists effectively work for a mental health organization from which they also receive services?
- Can non-peer co-workers socialize with peer specialists beyond the workplace? ("Should I invite the peer specialist on our team to our weekly gathering at a bar?")
- What are appropriate roles for a peer specialist?
- What if the peer specialist goes "bonkers" on the job?
- How or will the peer specialist be professionally disciplined?
- What, if any, are the legal liabilities of hiring a peer specialist?
- How can I hire a peer without violating anti-discrimination laws that prevent me from asking whether he or she has a psychiatric condition or history of one?
- Are peer specialists adequately trained? Will they know what to do if a client threatens harm to themselves or others?

These questions—the fact that they exist and the underlying meanings they convey—provide considerable context for the profession. As the profession matures, it is reasonable to expect these questions to be reduced in the frequency asked or disappear altogether.

It is interesting to consider anecdotal information that indicates that traditional mental health providers—particularly case managers, psychologists and social workers—have seen the "power" of peer support and effective and appropriate ways peer specialists have used disclosure to build effective relationships. As a result, it seems an increasing number of these traditional mental health professionals are finding their own meaningful and appropriate ways to use self disclosure of their own mental health histories to build effective therapeutic relationships with those they serve.

Training Capacity

Trainings are usually 80 hours or less and have been proven effective (Salzer & Katz, et al., 2009; Hutchinson, Anthony & Ashcraft, 2006; Ratzlaff, & McDiarmid, et al., 2006). But those trainings generally focus on the basic skills that can be universally applied to all settings (Salzer, Schwenk & Brusilvoskity, 2010).
Training capacity issues as they relate to funding have been addressed previously in this document. Other, sometimes related, training capacity issues remain.

Access to training presents challenges to the profession. Peers in rural areas often do not have the same access as those in urban areas. In rural areas, it is sometimes the case that there are not enough interested peers to be recruited to form a cost-effective class.

The length of training can pose barriers. While virtually all peer specialist training programs require at least a 40-hour commitment, some programs involve more than twice that time. The time barrier appears to be less for peers than it is for administrators. A 40-hour training is often a more convenient "fit" in the work schedule than an 80-hour or more training. If the peer is already employed by a mental health organization which is expected to compensate the peer for training time, the cost of wages may present a challenge to the organization's budget.

The cost of training is widely variable. Some states have used federal Community Development Block Grant funds to fully subsidize training—including compensation for the

trainee's time, transportation and training materials. Some training entities have been able to obtain full subsidies of training costs and trainee compensation through Ticket to Work and similar programs.

Some states have found training costs a major barrier as some training entities charge as much as $1,500 per student for a 40-hour course. Currently, one state is considering a training proposal that would cost $2,500 per student for a 40-hour course.

Another access issue relates to distribution of available training slots for interested peers. In some instances, particularly where state officials retain control of the selection process, some areas of a state have a large surplus of trained and certified peer specialists while other parts of the same state have a long list of peers waiting for training so they can be hired for one of many available jobs.

Training capacity may become a greater issue as "specialty" courses previously identified in this document become available. Such courses will require additional resources and time away from the workplace.

Contextual Conditions for the Target Audience

Peer specialists in the U.S. are subject to the rules, policies and practices for the mental health organizations for which they work. These rules, policies and practices, to a great extent, are driven by government rules, policies and practices. Funding is often tied to an organization's faithfulness to recognized practices and protocols and can vary significantly state-to-state or even within states.

While the peer specialist discipline may be described more generally as "peer support"—volunteer or paid, certified or not—the target audience is more specific and can be described as "working peer specialists." This subtle distinction is important only because the latter generally have greater access to training; especially continuing education. When it comes to

implementing the recovery curriculum, it appears most likely to be accomplished through core training courses and continuing education initiatives.

The curriculum will not address recovery knowledge gaps for peer specialists in all circumstances. Instead, the curriculum will supplement existing training curricula on the topics identified during Year 1 of this project and provide references and resource materials for more information on certain aspects. For example, the resulting recovery curriculum will include a list of additional resources and guidance about how to obtain these resources (such as professional journals and webinars).

A relatively new phenomenon has been observed in the last 18 months. Because peer specialists are working in increasingly diverse settings (psychiatric hospitals, general hospitals, correctional institutions, geriatric residential institutions, schools, colleges, and a variety of mental health provider settings) and performing equally diverse tasks, training needs have changed. It appears that peer specialists are increasingly expected to complete a core curriculum (ranging from 40 to 80 hours of instruction) and then offered opportunities to specialize with additional training (usually of a shorter duration) that better prepares them for particular work settings and tasks.

Although public funding is a major determinant of contextual conditions within this profession, it is not the only determinant. Funding from alternate sources and local priorities can have significant effects on how and where peer specialists practice.

The following are important contextual factors more relevant and applicable to the working peer specialist target:

Recruitment

Except in very rural areas and where the recovery paradigm does not exist, there is a large pool of willing and ready persons in recovery from which to recruit for the profession. In addition to income (which is often considered a secondary benefit), employment as a peer

specialist offers an opportunity to "give back." Also, the 2007 NAPS survey revealed that an important motivation for work in the profession was the opportunity to advance one's own recovery.

Peers often learn about the profession through their own experience with peer support. As the variety of job roles increases, it offers even greater opportunities for personal and professional growth.

One phenomenon observed after training is the desire among successful students to pursue more education to pursue other employment opportunities. For many peers, graduation from a peer specialist training program is a significant milestone and encourages them to investigate and pursue college degrees. Many who do so have the intent of working in the mental health system as members of other disciplines.

Once a peer engages in the profession, it is often seen as a life-long occupation. Only negative experiences in the workplace and low wages appear to dissuade peers from the profession.

Through training and work and personal experience, peer specialists usually develop a meaningful skill set that can be applied beyond mental health settings (Harrington, 2010). But anecdotal information tends to show little migration from the mental health workforce to other occupations and settings. Possible reasons for this apparent lack of movement are:

- Comfort within the mental health workforce
- Inertia ("Things are fine the way they are. Why change?")
- Lack of self-awareness of one's skill set
- Lack of awareness of the value of one's skill set
- Lack of employment opportunities outside the mental health workforce
- Credentialing barriers
- Self-stigma
- Hiring discrimination

- Employers’ fears of having to make “reasonable accommodations”
- Lack of employer awareness of skills and knowledge offered by persons in recovery
- Resume gaps for persons in recovery

Career development appears to largely remain in the domain of mental health and that development appears to be often inhibited by credential barriers. For many peer specialists, the only vertical movement available is to become a supervisor within peer specialist programs (Salzer, 2011).

Lack of career development within the mental health workforce can naturally impede the organizational culture change often required to adopt a true recovery orientation. Lack of movement outside the mental health workforce can impede social inclusion. Although these issues are, for the most part, beyond the scope of this project, they are important contextual considerations as the profession develops.

Continuing Education Requirements

As previously mentioned, continuing education is extremely important for professional development but most states—even those with well-developed certification programs—lack formal continuing education protocols. But, largely as a result of Medicaid guidelines and expectations by a variety of government entities, it appears as all states with certification programs are in the process of developing formal continuing education policies and protocols.

Some existing continuing education requirements are restrictive where state officials determine where and how continuing education activities and events are conducted. They may also determine what topics will be covered and by whom. Other programs are much more liberal and accept a great variety of continuing education opportunities for credit to maintain certification.

Roles/Tasks

As previously mentioned, the roles and tasks for peer specialists is growing rapidly. Where peers in the workplace were once relegated to mundane office duties (such as shredding paper, preparing mailings, scheduling appointments, etc.), there is a growing awareness that some job tasks are clearly inappropriate for peer specialists. Generally, peer specialists must be able to use their recovery experiences to encourage and inspire others on their recovery journeys.

The fact that roles and tasks are expanding means that training specific to these new "niches" will become increasingly important. In addition to the specialty areas identified in this document, it is reasonable to expect a growing need for other specialties.

Professional Oversight

Although instances requiring professional discipline are extremely rare, this issue is one often raised during peer specialist program development at the local and state levels. While most professional associations, certifying entities and local mental health organizations usually have well-established oversight practices and policies for dealing with professional discipline issues, there is often little or no guidance specifically for peer specialists at any level. Most states with organized peer specialist programs[††] appear to have ethical codes established specifically for peer specialists. Some organizations employing peers expect peer specialists to adhere to ethical codes and standards developed by that organization. Thus, there may be multiple layers of ethical standards by which peer specialists are expected to adhere.

Usually, professional infractions can be avoided through proper training that creates awareness of ethical and boundary issues. Driven by a desire to "fit in" or prove themselves, peer specialists generally respect these issues. Proper supervision and a good relationship

[††] The precise number of state or locally operated peer specialist programs is difficult to determine at this point because many entities define these roles differently and the number and nature of such programs is very dynamic at this stage of the profession's development.

with co-workers, supervisors and administrators helps peer specialists avoid such issues. Inherent in this issue is the possibility of peer specialists deferring on negotiations, assertions or advocacy that ought to occur. But peer specialists may lack the necessary support and knowledge to ensure they can adequately address culturally imbedded issues of discrimination, rights violations or simply encouraging a recovery orientation for the people they serve. This is referred to later in this report as an issue of "co-optation."

Peer specialists are usually subject to ethical standards and guidelines established for all employees at a particular workplace. These standards and guidelines are often derived from other disciplines and modified to apply to local work environments.

NAPS will be engaging in an effort to develop general "standards" for peer specialists and often distributes codes of ethics to those who inquire. Also, this topic is one that was identified during the first phase of the RTP project and will be covered in the resulting recovery curriculum.

Workplace Environments

Just as the occupational niches of peer specialists are diverse, so are workplace environments. Of greatest concern, however, are those environments where peers in the workplace are not fully accepted.

When peer specialists are not fully accepted as co-workers who perform valuable services and are not integrated fully in the workplace and treatment models, the results can be disastrous. Low morale and frustration among peer specialists in a negative work environment can affect the attitudes and performance of co-workers and, ultimately, the quality of services. Negative work environments are often the result of an incumbent staff with little or no preparation for the introduction of peers in the workplace. This often feeds fear among the incumbent staff, thus resulting in tension, conflicts and acrimony.

Proper preparation for the introduction of well-trained peer specialists can have the opposite effects. With such preparation the incumbent workforce is more likely to understand the unique role of peer specialists within the service delivery team and to be welcoming and open to working with and learning from peer specialists.

But the burden of creating a positive work environment does not exclusively fall on an incumbent workforce. Specific training in communication, problem-solving and conflicts in the workplace can contribute greatly to a positive attitude among all workers and, at the same time, help the peer specialist become a welcome change agent.

Throughout the first phase of this project, conflicts in the workplace was consistently the first issue identified by all those interviewed or offering input at listening sessions. The issue of sharing recovery practices and policies from the person in recovery perspective was seen as a vital component of all recovery efforts for peer specialists. Exploration of this issue resulted in a framework for curriculum development.

Co-Optation

A relatively recent phenomenon has been observed and appears to be fairly widespread. In some cases, peer specialists, for a variety of reasons, practice more like traditional, medical-model oriented clinicians as opposed to persons in recovery who focus on encouragement and inspiration. For example, a peer specialist may spend more time dealing with paperwork rather than building a meaningful relationship with a peer to explore barriers to recovery. There may also be a power differential perceived by the peer seeking support as opposed to being told what to do.

The reasons for this co-optation are many and include loyalty and a desire to fit in the workplace environment. We must remember that, for many, being hired as a peer specialist may be the first meaningful employment a person in recovery has had in a long time—or ever (see generally, Fiere, 1974). Thus, the desire to succeed may lead them to mimic

techniques and adopt attitudes of incumbent workers who are uninformed about the recovery paradigm and practices.

The existence of co-optation means recovery education is especially important for the profession. The education will introduce and encourage recovery practices and the setting in which the education occurs will provide a networking opportunity where peer specialists can share and inspire each other to adopt and maintain recovery practices.

Education for just peer specialists to avoid co-optation may be insufficient. Supervisors, administrators and co-workers may also benefit from education initiatives that address issues related to peers in the workforce (Carlson, Rapp & McDiarmid, 2001). Other strategies that may lessen the effects of co-optation include hiring multiple peer specialists at particular facilities and encouraging peer specialists to form local or state support and/or networking groups.

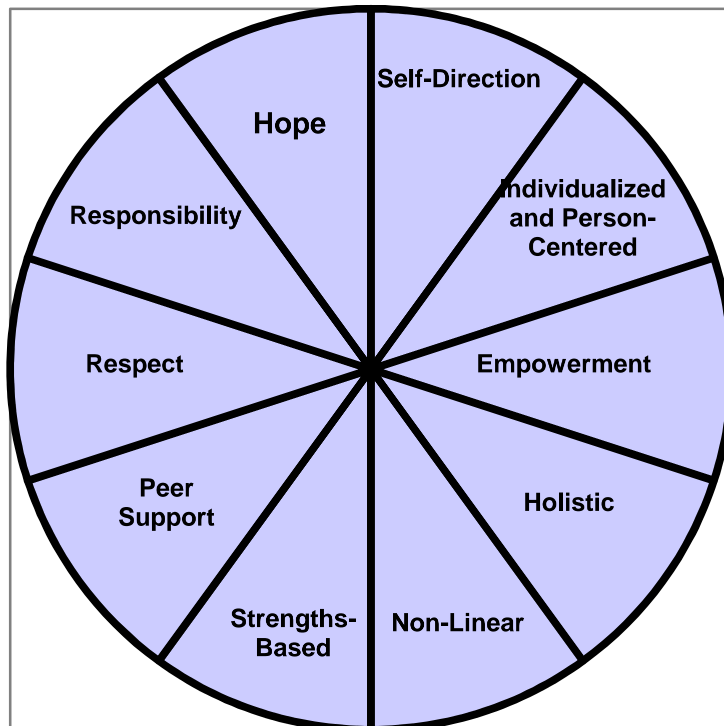
> Part of the mission of peer specialists is to help change the culture (lead the cultural change) of the mental health system from encouraging dependence to being recovery oriented. Part of the necessary skill set that will help set the stage for the shift to this new paradigm will be an understanding of power dynamics and how to use them in ways that will help lead the change from the old paradigm. Power differentials will always exist in systems, but those who understand power dynamics and how they are influenced by culture and thinking will be able to negotiate ways around the inevitable barriers caused by these power differentials.
>
> From a review of a draft of this report by James McNulty

Because conflicts in the workplace and co-optation involve all workers, collaboration between NAPS and the other RTP discipline partners will be especially important in the development of the recovery curriculum.

SAMHSA's Ten Recovery Components

The ten recovery components (graphically illustrated on the following page) identified by SAMHSA appear to be well-known among most peer specialists as these components are usually covered in some manner during training. But not all trainings specifically include these components and it would be a mistake to presume that all peer specialists are familiar with them. At the peer specialist listening session in Anaheim, Calif., the components were identified by one participant as fundamental to the recovery process. Indeed, these components have weathered well under the test of much scrutiny by the recovery community, according to input received from peer specialist trainers.

Recovery Components



How will these components be incorporated into the curriculum? Reviews of the first draft of this document reveal a preference for a module that covers "recovery basics." This would bring all students to the "same page" with a foundation of basic recovery knowledge upon which other curriculum topics can be built. The NAPS RTP team recognizes that the recovery components are often used in varying proportions during one's recovery journey. During this project, peer specialist trainers reported that when covering this topic, they often ask if students would add any other components. They report no such additions have been suggested over the course of teaching many such classes.

What follows is a summary of how each component is relevant to peer specialists and ideas about components may be incorporated into the curriculum. Again, it is anticipated that the first module will present these recovery components for examination and discussion. During the discussion, there will be links to trauma-informed practices and cultural considerations. All components are perceived subjectively by persons with psychiatric conditions and their perspectives must be considered in the contexts of trauma and culture. As Bill Anthony, founder and director of Boston University's Center for Psychiatric Rehabilitation once observed: "Recovery is not evidence based. It is value based."

Hope

It has been said, "Wherever there is a need for hope, there is a place for peer support." Inspiring hope has also been described as the primary function for peer specialists. Peer specialists inspire hope by modeling recovery and sharing their own mental health and recovery experiences. Hope can also be inspired through literature, films, music, spirituality, and interpersonal contact. But hope can also be diminished through oppression, the source of which can be personal social contacts, societal attitudes conveyed by entertainment and news media, organizational policies and practices, laws, and other means (see generally, Freire, 1974).

Hope is essential not only for those with a psychiatric condition but for all people. Peer specialists are uniquely qualified to inspire hope and usually have many workplace

opportunities to do so. The discussion outline regarding this component in the curriculum will stimulate thought about what hope is, how it can be diminished and how peer specialists can inspire it.

Self-Direction

Having control over one's life is vital to regaining skills and a position in one's community. For many persons with a history of severe psychiatric conditions, self-direction has often been subordinated to caregivers and service providers. While severe symptoms, on rare occasions, may necessitate such loss of control, it must be viewed as a temporary situation. When and how self-control is "returned" to an individual are issues of considerable debate. Many mental health professionals (including peer specialists) are reluctant to encourage self-direction as it may lead to "failure." This fear of failure on the part of clinicians can result in discouragement of dreams and prevent self-direction. The loss of self-direction is frequently part of the medical model of treatment where clinicians view their role as caretakers instead of partners with the individual.

Power differentials in relationships, organizations and systems runs contrary to trauma-informed practices and policies. During discussion of this component in the curriculum, students will examine their own attitudes toward self-direction (for themselves and those they serve) and how they can personally encourage self-direction among those they serve and their organizations.

Individualized and Person-Centered

The need for an individualized and person-centered approach to mental health services is often reflected through the use of person-centered recovery plans. It is not uncommon for peer specialists to be involved, at some level, with helping persons served with such plans. These plans are often form-driven and despite the form instructions and format, it sometimes the case that such plans reflect little input from the person served. When peer specialists are

involved in the creation of such plans, they can help ensure it is indeed individualized and person-centered.

Individualization and person-centeredness also has practice implications. Peer specialists are taught in every existing curriculum reviewed to remember their own recovery experiences and the importance of helping and empowering those they serve to self-advocate for individualized services that focus on the person's own-determined needs and desires.

During the discussion about this recovery component, the curriculum will encourage peer specialists to recall their own experiences and examine if their current practice is individualized and person-centered. They may also be asked to examine ways to foster individualization and person-centeredness in their organizations and among co-workers. The SAMHSA recovery components themselves can be used as an example of individualization as the "mix" of components must be crafted *by* the individual *for* the individual. Issues related to cultural competency and being non-judgmental are vital in this area if the peer specialist's practice is to have meaning.

Empowerment

It is indeed one thing to have choices in one's life and yet another to actually express and act upon those choices. Empowerment is a fundamental aspect of peer support as that support often enables and encourages those served to explore their options, make decisions and then express and follow up on those decisions (Layn & Hurdle, 2003).

Faced with a history of oppression, many of those served may feel helpless. That helplessness may be reflected in a virtual paralyzation when it comes to thinking about, expressing and acting on one's desires for services and outcomes. Such empowerment may be especially at risk when an individual has a history of trauma. The curriculum will encourage students to examine ways they can help empower another through advocacy.

Holistic

A growing body of professional literature supports what so many have known intuitively: the head and body are connected and each has an effect on the other. Our thoughts and feelings can have a profound effect on our physical well-being (Pressman, Matthews, et al., 2009).

With this realization, a holistic approach to mental health services has gained increasing attention in recent years. A study by the National Association of State Mental Health Program Directors (NASMHPD) found that people with psychiatric conditions have a greater mortality rate than the general population and, on average, die 25 years sooner than the general population. This study has sparked increased interest in a holistic approach to psychiatric services.

But a holistic approach involves much more than the mind-body connection. As Hippocrates observed: "The manner of the disease a person has is less important than the manner of the person with the disease." This means a broad view of an individual's lifestyle, culture, values, experiences, living conditions, financial status and desires are important to the recovery paradigm.

This curriculum will foster an understanding of holism by encouraging students to consider their own perspectives and how a broad view of the totality of their human experience affects not only their current status but future as well.

Non-Linear

Most peer specialist trainings use a phase or stage descriptions of the recovery process. Such approaches are generally based on a recovery from grief model. And while these descriptions can be useful in understanding another's recovery process and place in his or her recovery journey, there is a potential for misuse if phases and/or stages are assumed to be linear.

Those who have progressed on their recovery journeys, such as peer specialists, know well the ups and downs of recovery. But according to information obtained through listening sessions, some mental health administrators fail to appreciate the dynamic nature of recovery processes. As a result, some administrators expect clinicians (including peer specialists) to monitor the progress of those served in a linear fashion. In some cases, compensation may be tied to the rate at which a clinician reports linear progress with the assumption that one continually moves forward. If a person served fails to move forward in a linear fashion, it is assumed, and then it must be that the clinician is not effective.

The curriculum will address this phenomenon by encouraging students to recall their own recovery journeys and, where appropriate, identify both the ups and downs in that process. This type of activity must be presented carefully as recalling the "downs" of one's recovery journey could spark unpleasant memories that result in a setback. This consideration was identified at one listening session for this project. Students will be encouraged to consider the effects of a linear approach to recovery and how such an approach can affect those they serve.

Strengths-Based

Building on one's strengths is a fundamental aspect of psychiatric rehabilitation (Anthony, Cohen & Farkas, 2002). A focus on one's strengths enables a person to find hope, dream of a satisfying life and set recovery goals (Saleebey, 2002). A strengths-based approach is often reflected in the person-centered recovery plans mentioned previously. But putting that mindset into action can pose challenges to peer specialists who advocate change in their organizations.

Despite their own recovery experiences, peer specialists may "forget" the value of a strengths-based approach as they become "co-opted" in their work roles (co-optation is discussed later in this report). Thus, it will be important for a review of the importance of this approach and how peer specialists can use it to foster recovery for others. Again, culture

and a trauma history could have profound effects on how a person perceives their strengths (Saleebey, 2002).

Peer Support

Peer support is not the exclusive domain of peer specialists. Such support can be derived from others who have experience serious life challenges. Peer support involves mutuality, openness and lack of power differentials (Mead, 2009). Due to the rapid manner in which meaningful, trusting and therapeutic relationships can be formed through peer support, self-disclosure among all mental health professionals is attracting new attention (Forrest, 2010; MaAdame & Leitner, 2008).

In addition to a growing number of clinicians using self-disclosure to establish some sort of peer relationship, peer support can be derived from informal contacts at clubhouses, drop-in centers or even the lobbies of mental health agencies. Family, friends and community can be other sources of peer support. Peer specialists generally provide peer support in a formal manner as it is usually the recognized focus of contacts between them and those they serve.

Because other forms of meaningful peer support (usually informal) are available in most people's lives, it is incumbent upon peer specialists to help those they serve discover and use supports. Expanding one's support network (especially informal and in the community) can foster independence and broader social inclusion.

This curriculum will encourage peer specialists to recognize the various sources and forms of peer support they discovered in their own psychiatric experiences and how they can help those they serve discover and use such supports. Use of research and scales (Russinova, Rogers & Ellison, 2006) will be covered to demonstrate the value of supportive relationships in the recovery process. In addition to research report documents, a myriad of activities will be used to stimulate discussion thus making this topic presentation experiential, participatory and with very little didactic elements.

Respect

Respect is a critical component in any positive relationship—especially therapeutic relationships in mental health settings. It involves being non-judgmental and valuing another's culture, past experiences, thoughts, feelings, dreams and perspectives. Easily said but not always easily done (Harrington, 2009).

In many mental health settings, clinicians are viewed by consumers as "caregivers" who possess superior skills and education. This creates a power differential that can be disastrous in a therapeutic relationship. Instead, a relationship built upon mutual respect is viewed by all parties as a "partnership" working toward the same goal—well-being for the person served.

For many peer specialists—through training and/or personal experience—respect for those they serve has evolved into a "learning" approach to others. This means each person they encounter is a potential learning opportunity. This engenders honest, open discussions where judgments regarding another's perspectives and values have no place. Instead, differences in perspectives and values are embraced as they offer even greater learning opportunities. Thus, the more different the culture represented by the person served, the more welcome he or she may be by a recovery-informed peer specialist.

In this curriculum, peer specialists will be exposed to this learning approach as a means for their own personal growth and understanding of the human experience. Such growth and understanding will be explored as a means for personal life enrichment and growth. By relating to others in this way, students will learn the value—to themselves and all of society—by seeking not mere tolerance or acceptance of others' differences but an embracement of the diversity they represent.

Responsibility

Using a physical ailment or illness as a metaphor, Bill Anthony compares psychiatric support to that of a person using a crutch. While the person with an injured leg may use a crutch and become somewhat dependent upon it for a time, such support is ultimately temporary. In a psychiatric rehabilitation context, a person in recovery may become reliant on mental health services and support, but those elements should be considered temporary.

Moving from dependence to independence requires personal responsibility. Lest services and support become permanent, people must be committed to the work required to improve their lives. This commitment is often a function of all or most of the recovery components previously addressed in this report.

Consistent with the concept of self-direction, the peer specialist cannot take responsibility for others' decisions to be responsible for their recovery journeys. Instead, they can explore with those they serve who is in the best position to create dreams, goals and action plans and then act on them. While the peer specialist may support those they serve in this process, ultimately it is not their lives to craft.

This curriculum will demonstrate how all the other components may play a role in others' lives to foster responsibility. The curriculum will also help students examine issues of being non-judgmental and motivating through recovery education.

Assessment

1) Qualitative Measures/Indicators Used

This project, especially for the peer specialist discipline, is especially suited for qualitative data. Expressions collected during this phase of the project were many and varied. Of primary interest to the NAPS RTP project team related to:

- Recovery knowledge gaps.
- Why those gaps were deemed important.

- How those gaps affect the peer specialist practice.
- Why recovery knowledge gaps developed.
- How recovery knowledge gaps could be filled.
- How methods for filling gaps could be implemented.
- Barriers to addressing recovery knowledge gaps (capacity, workplace environment, policies, etc.).
- Expected outcomes resulting from this project to address recovery knowledge gaps.
- Other resources to consult regarding the goals of this project.
- How NAPS can—in the short and long-terms—facilitate the development and distribution of recovery knowledge among peer specialists.

2) Strategies for Data Collection and Analysis

Qualitative Data Collection

Methods used to obtain qualitative data were identified previously in this document. Those methods included:

- Listening sessions with groups of persons in recovery and, primarily, peer specialists.
- One-on-one interviews.
- Solicitation of suggestions/opinions/advice from peer specialists (and a limited number of persons outside the profession) via newsletter articles, website, conference presentations, and other means.
- Consultations with experts from the recovery community.
- Review of existing recovery measures.
- Literature search/review.
- Recovery materials evaluation by peer group.
- Recovery conference/workshop attendance patterns.

Qualitative Data Analysis

The analysis of qualitative data followed a general method that was modified as needed to ensure propriety to the data collection method used. That analytical method involved:

1. Development of a draft document identifying key questions/issues to be addressed during data collection.
2. Review of the draft document by peer specialist advisors.
3. Modification as necessary.
4. Data collection using the framework established in guidance document.
5. Data summarized from notes.
6. Key issues identified using SAMHSA recovery components as underlying guide.
7. Issues and key information reported to NAPS RTP project team, advisory group, NAPS membership and interested stakeholders.
8. Reviewers' comments/suggestions reported to project team.
9. Comments/suggestions incorporated into final summary document.

To foster data accuracy, reliability and validity, it was often the case that qualitative data collection and analytical activities involved multiple reporters. This approach seemed especially valuable as it 1) provided an opportunity for involvement by more people in the process, 2) acted as a "check" to ensure accuracy, and 3) increased personal "investment" in the project.

Trained volunteers with proven capabilities were used as reporters. Stipends were offered to volunteers, depending upon the level of contribution but, interestingly, the vast majority of volunteers were so enthusiastic about the project and their ability to use their involvement as a resume builder, that compensation of any sort was declined.

3) Quantitative Measures Used

The nature of this project does not lend itself well to quantitative measures. The first generation of peer support research focused on implementation issues (Davidson, Chinman, et al., 1999). The second, and most recent, generation of peer support research is focusing on outcomes and professional development (Davidson, Chinman, et al., 2006).

The number of peer specialists and states that use such services is one important measure of the status of the profession. The types of services provided is also a credible measure of the nature, capacity and development potential of the profession.

4) Strategies to Collect/Analyze Quantitative Measures/Indicators

To obtain and analyze quantitative measures, the NAPS RTP team relied heavily on three efforts: 1) the Pillars of Peer Support initiative and subsequent documentation (Daniels, Grant, el al, 2010), 2) a survey of the profession performed by staff of viaHope in Texas, and 3) national survey research performed and reported by Mark Salzer, Ph.D., of Temple University and his colleagues.

The Pillars of Peer Support initiative is a collaborative effort by SAMHSA/CMHS, Appalachian Consulting Group, NASMHPD, DBSA, and the Wichita State University Center for Community Support and Research, The Carter Center, OptumHealth and the Georgia Mental Health Consumer network. This collaboration brought together officials from states with existing or developing peer specialist programs. The 2009 Summit resulted in a comprehensive report that used both qualitative and quantitative data to examine the status of the peer specialist profession in the U.S. (Daniels, Grant, et al., 2010).

viaHope is a collaborative of several mental health advocacy organizations funded through a SAMHSA/CMHS state transformation grant. It is based in Austin, Texas and has been the primary force in establishing a peer specialist training and certification program in that state

and sponsoring educational conferences for persons in recovery and mental health professionals. The survey was performed by the organization as part of its peer specialist program development.

The results of these two endeavors were virtually identical as they collected almost exactly the same data. That data included 1) the number of states receiving Medicaid reimbursement in some fashion for peer support, and 2) the number of peer specialists certified in the 22 states that, at the time, had peer specialist programs.

Because the quantitative data was largely based on self-reports and the efforts did not include questions that would supplement—and therefore lead to a better understanding of the true status of the nature of the profession—the usefulness of such data is marginal for the purposes of this project. For example, some state officials reported a relatively large number (800 or more) certified peer specialists but no data was reported regarding the number of those who were actually working as peer specialists. Conversely, some states (both with and without peer specialist certification programs) have peer specialists working as volunteers or without Medicaid re-imbursement.

The most reliable and valid quantitative data regarding the profession appears to be that resulting from national survey research conducted by Mark Salzer, Ph.D., of Temple University. His data included number of hours peer specialists were spending with peers and analyses (based on coded analytical techniques) of the specific services provided by peer specialists.

Salzer's studies showed that peer specialists were spending the vast majority of their time with peers (as opposed to serving on committees and advisory groups) assisting them with community resource issues. Survey results also demonstrated a lack of attention to "intimacy" skills, which included dating, forming supportive relationships, sexual health and spirituality. Salzer notes that other survey research reveals that it is these intimacy skills that peers desire most.

Although the 2007 NAPS compensation/satisfaction survey provided some quantitative data, much had changed between the completion of that research and this project. General conclusions resulting from that research appear valid, such as the low wage peer specialists are paid, but it would not be reasonable to rely heavily on the quantitative data given the dynamics of the profession at this time.

Because of a relative lack of current and useful data, NAPS is engaged in survey research of the profession very similar to that performed in 2007. That survey research is entirely independent of the RTP project.

Vision and Goals

The vision derived from this project is a peer specialist workforce proficient in all aspects of recovery; both theory and practice.

To attain this vision, the following goals have been identified:

- Educate the peer workforce to increase recovery knowledge.
- Increase recovery knowledge and practices in the long term.
- Collaborate with other mental health professions to foster recovery knowledge and acceptance of recovery practices and policies.

Action Steps

Action steps can be roughly determined to attain the goals and serve the mission described above. Those steps include, but are not limited to:

- Continued information distribution through the NAPS newsletter, website and conferences.

- Development of a recovery-oriented curriculum that addresses the topics identified during the first phase of this project.
- Ensure that the curriculum is as participatory and experiential as possible.
- Develop, with advisory group review and input, a "fact sheet" that describes why, how, where and when peer specialists perform their work.
- Collaboration among peer specialists and peer specialist groups throughout the country.
- Collaboration with other mental health disciplines.
- Strategic planning to ensure efforts endure beyond the term of this project.
- Advocacy to increase funding and participation of peer specialists in continuing education activities.
- Communication with existing peer specialist training entities to encourage adoption of key topics identified during this phase of the RTP project in core trainings.
- "Marketing" efforts among a variety of stakeholders to ensure use of the recovery curriculum.
- Continued review of the curriculum (beyond the term of the project) to identify knowledge gaps and make modifications as necessary.
- Upgrade and maintenance of the NAPS website to provide key information in a comprehensive and timely manner.

Needs Assessment and Analysis

The following recovery knowledge needs identified most by stakeholders follow:

Conflicts in the Workplace

This issue was identified as the most important in virtually every setting and opportunity for input. Peer specialists are often viewed as change agents. As a result of their own mental

health treatment experiences, peer specialists often observe practices and are subject to policies that inhibit their ability to move service providers toward a recovery orientation.

Without a peer specialist workforce comfortable with expressing opinions and suggestions and co-workers and supervisors willing to listen and consider them, the recovery paradigm is inhibited. As a result, peer specialists may leave the workforce, become co-opted or simply lose their enthusiasm. All these results mean poorer quality services for persons in recovery who need them most.

The reasons for this frustration have already been addressed in this document. Input suggested that very practical skills focusing on communication, problem solving and conflict resolution would best address this issue.

Trauma-Informed Practices

In recent years, research has proven what persons in recovery have known for a long time: a great many persons with psychiatric conditions have experienced trauma at some time in their lives. Sometimes, that trauma has occurred by the hands of mental health systems.

Traumatic experiences are many and, often, the effects are long-term if left unaddressed. When mental health systems create or promote an environment rife with a power differential, the effects of trauma on the individual are left unabated or worsen.

Peer specialists, because of the nature of the relationship with those they serve and personal experiences, are in an ideal position to address trauma issues on a personal level of others and act as change agents to identify and modify practices in mental health organizations that exacerbate trauma effects (Harrington, 2009).

For the purposes of this project and the resulting recovery curriculum, stakeholders and experts in the recovery community felt it would be ineffective to address trauma-informed practices through a single chapter. A better approach would be to introduce trauma issues

early in the curriculum and use key concepts as an underlying foundation throughout the curriculum.

Consultation and collaboration with the other RTP disciplines will be especially important to the development of this portion of the recovery curriculum.

Holism

Many have long known intuitively that our minds affect our bodies and vice versa. Concern about this phenomenon as it relates to persons with psychiatric conditions has been raised recently by a series of studies that empirically confirm this link (Pressman & Matthews, 2009; Schulz, Zdaniuk, et al., 2008; Perham & Accordino, 2007; Husebye, Westlie, et al.,1987). Peer specialists, with appropriate training, can address this issue among peers. Although at least one curriculum developed by the Appalachian Group of Georgia (Personal Action Toward Health) exists and there are likely others, knowledge about the importance of holism and resources appears to be lacking among the peer specialist profession.

The curriculum resulting from this project will cover the importance of a holistic approach to practice and provide basic information, including ways to access existing curricula on this topic and other informational resources. It is not the intent of this recovery curriculum to duplicate existing curricula but, instead, create an awareness of such important issues, provide basic information about holism and provide references to additional resources for further education.

As described previously, the NAPS RTP team recognizes that holism involves more than psychological and psychological aspects of a person. It also involves considerations that include lifestyle, culture, personal experiences, financial status, recreation/capacity to enjoy life, housing and other factors that affect one's well-being.

Cultural Competency

Because trauma-informed practices frequently involve cultural considerations and minority cultures are frequently under-served by mental health systems, cultural competency was identified as an important issue to address in the recovery curriculum.

Those receiving mental health services are culturally diverse and that diversity may increase if efforts to reach out to under-served populations are successful. This diversity can present challenges for both peer specialists and those they serve. It is extremely difficult, for example, to have a person from an ethnic minority reach out and engage in services only to become frustrated when those services fail to address his or her needs because of lack of cultural sensitivity. Even more unfortunate is having that person share with his or her cultural community a negative experience that fosters even more reluctance to engage in services.

Add to this challenge the fact that peer specialists are frequently recruited from the pool of persons receiving services. When under-served populations are under-represented in that pool, the peer specialist workforce tends to become culturally homogeneous. As a result, it appears there are insufficient numbers of peer specialists from culturally diverse backgrounds to serve those seeking services in a culturally sensitive and knowledgeable manner. During the listening sessions, the lack of knowledge about culturally sensitive practices was identified repeatedly. Thus, it appears peer specialists recognize this knowledge gap and may be especially sensitive to lack of knowledge in this area as they often represent an oppressed group as they are persons labeled as “mentally ill” themselves and have experienced the effects of discrimination and stigma.

Using a variety of available resources, many of which have already been identified, and extensive review (Mount Sinai Hospital, 2009), the NAPS RTP project team will develop a cultural competency unit for inclusion in the recovery curriculum. Further literature search and review activities will be required and use of SAMHSA-developed materials will be

important. In addition, the NAPS RTP team will consult with Cathy Cave of the National Center for Trauma-Informed Care regarding this issue.[‡‡]

Meeting people "where they are" is fundamental to peer specialist training and practice. A review of existing peer specialist training curricula showed this principle is a universal foundation for instruction. While many of the curricula reviewed cover cultural competency as a separate topic, underlying principles are used and reinforced throughout trainings. Thus, infusing cultural competency throughout the recovery curriculum will be a logical approach. And, because this issue is often related to trauma-informed practices and policies, the two topics will make a natural pairing throughout the recovery curriculum.

For the purposes of this project, "cultures" mean ethnic minorities, those in specific socio-economic categories, GLBT individuals and others who share values, language, customs, rituals, dress and perspectives.

Ethics and Boundaries

Despite the fact that violations of ethical standards and appropriate boundaries are rare, ethics and boundaries was identified as a key topic for the recovery curriculum. One of the reasons may be the fact that the peer specialist profession is relatively new and, as a result, co-workers and supervisors are especially wary about peer specialists' conduct. Also, peer specialists themselves are aware that they are "under a microscope" at the workplace and failure to comply with professional standards may jeopardize not only their position, but the entire peer support movement.

It is impossible to incorporate the many codes of ethics under which peer specialists work. But it is entirely practical and possible to provide general background for the need for ethical behavior and codes. While it would be impossible to address every possible circumstance where ethical/boundary issues could arise, it is possible and meaningful to

[‡‡] Although the NAPS RTP team and advisory group is comprised of culturally diverse individuals, such diversity alone is inadequate to create a curriculum that addresses this issue sufficiently and effectively.

equip peer specialists with the knowledge and skills to help them make reasonable decisions whenever such situations arise.

Building Appropriate and Meaningful Relationships

This topic naturally flows from the previous one. A wealth of research—both within and beyond mental health—provides substantial and compelling evidence that the best, and perhaps only, positive treatment/service outcomes result from meaningful, collaborative relationships (Carkhuff, 1969; Norcross, 2002). These relationships include not only those with mental health professionals but friends, family and in the community.

Fortunately, recent research, publications and new resources are available that will be of great help in devising a highly interactive portion of the curriculum for this topic.

Building appropriate and meaningful relationships—especially in the context of ethical standards—is vital to a recovery-oriented practice by peer specialists. It is the trust, mutual respect, empathy, hope and compassion that peer specialists bring to a peer-to-peer relationship that encourages others to begin or continue on their recovery journeys (Norcross, 2002). Relationships between peers and peer specialists are frequently much different than those between traditional mental health disciplines and those they serve. Finding an appropriate balance is a challenge but one that can be overcome with training detailed in the recovery curriculum.

Intimacy Issues

This topic also flows naturally from the previous one. Intimacy issues, especially those relating to dating, sexual health and spirituality, were consistently identified as important during this phase of the project. Input from various stakeholders and interested parties confirm the results of survey research by Mark Salzer and his colleagues (Salzer, Schwenk & Brusilovskity, 2010, Salzer, 2011).

Some caution may be necessary to ensure that these issues are addressed in appropriate and culturally sensitive manners. Resources from a variety of sources, including international sources, have proven meaningful and effective. The NAPS RTP project team has collected a substantial number of such resources and expects more to emerge during subsequent phases of the project.

Considerable review by peers, peer specialists, supervisors, administrators and other mental health disciplines will be especially helpful as this portion of the recovery curriculum is developed.

Locating Recovery Resources

A great many useful recovery resources already exist and are available through computer technology. A vast amount of effort, time and money have already been expended to create and distribute these resources but, unfortunately, many of these resources remain unknown or inaccessible to peer specialists.

Access to existing recovery resources was deemed important as it is peer specialists who often refer—or have a need to refer—such resources to the persons they serve. While computer technology was once beyond the reach of many persons in recovery, public libraries, clubhouses, drop-in centers and recovery education centers offer computer use and sometimes instruction about how to use the technology.

The NAPS RTP project team is keen on using existing recovery resources whenever possible. It is a foolish waste of time, effort and scarce financial resources to attempt to duplicate the vast amount of excellent materials already available.

In addition to covering this topic in the recovery curriculum, the NAPS RTP team will forge collaborative relationships with organizations across the country to create depositories of evaluated and organized recovery materials. The team will also, of course, continue to contribute to and refer others to the RTP depository of recovery materials.

Necessary Changes in Practices and Policies

During this phase of the RTP project, certain changes in practices and policies were identified. While some of these changes relate directly to the RTP initiative, others may not but are identified here for planning and archival purposes. Those changes include, but are not limited to:

- Creation of collegial relationships among all workers in mental health systems.
- Full embracement of the recovery paradigm by all mental health service providers.
- Creation/development/maintenance of continuing education initiatives for peer specialists.
- Creation of professional peer specialist standards that can be applied nationally.
- Increased knowledge of and access to existing recovery resources through greater availability of computer technology among persons in recovery.
- More research emphasis on peer support outcomes and dissemination of results.
- More emphasis on real recovery practices by all mental health disciplines.
- Emphasis on recovery relationships.
- Greater understanding of what trauma-informed practices are and use of those practices.
- Increased compensation for peer specialists.
- Recognition of the value of a lived experience with mental illness.
- Less emphasis on academic credentials for mental health positions.
- More opportunities for continuing education and informal learning/networking opportunities among peer specialists.
- Greater collaboration among all mental health disciplines.
- Increased funding for training peer specialists and time-limited financial support for peer specialist employment.
- Ongoing effort by NAPS to obtain input from all peer specialists about the organization’s operations.

- Ongoing effort by NAPS to obtain input from all peer specialists about recovery knowledge gaps and how to address them.
- Creation of a formal leadership development initiative for peer specialists.
- More mental health advocacy and service organizations that are truly peer run.
- Action by all current mental health service providers to embrace and implement recovery practices to avoid the emergence of a parallel system of care (peer run vs. traditional, medical-model based).
- Elimination of practices and policies that create a power differential between clinicians and those they serve.
- Development of a national code of ethics.
- Development of national guidelines that describe fundamental competencies for peer specialists.

RTP Project Spin Offs

During the course of Year 1 of this project, input and suggestions from a variety of sources resulted in unexpected yet meaningful activities, endeavors and initiatives. These "spin offs" are distinct from the RTP project and are not funded by RTP contract funds but are the direct result of discussions and information derived from the project.

While not part of the project, it is useful to recognize these spin offs as they inform our thinking about the peer specialist movement and implementing recovery principles and practices. In some ways, these spin offs will complement curriculum implementation and often reflect the high level of enthusiasm for the project by the peer specialist workforce.

A brief description of spin offs is provided in Appendix 3.

Appendix 1—Common Training Topics

Although training entities have created their own peer specialist training curricula, there are common topics included in virtually all such curricula. Those topics include:

- Communication
- Ethics and/or Boundaries
- Recovery Principles
- Problem Solving
- Peer Specialists' Roles
- Supporting Peers
- Cultural Competency
- Stigma

Although some of these topics have been identified in this phase of the RTP project, those providing input expressed the feeling that these topics were often inadequately covered in core trainings.

Appendix 2—2007 NAPS Survey Report

Peer Specialist Compensation/Satisfaction 2007 Survey Report

National Association of Peer Specialists

While peer support has been common for many years in substance abuse treatment settings, it is a relatively new development for persons with psychiatric disorders. Some states, such as Georgia and Pennsylvania, have used peer specialists as a component in mental health treatment for many years. But, for the most part, peer specialists have emerged in significant number only in the last four years.

In order to gain an understanding of the status of peer specialists throughout the U.S., the National Association of Peer Specialists (NAPS), a non-profit organization dedicated to the promotion of peer support in mental health settings, initiated a survey to determine the nature of this occupation. Specifically, the survey was designed to determine the variety of tasks peer specialists perform, how satisfied they are with their work, compensation levels, outlook for the future and what motivates such workers.

This information can be valuable for both peer specialists and mental health administrators when designing and implementing peer specialist programs.

Methodology

A survey instrument was designed by an experienced social researcher and it was tested among a small group of peer specialists to identify problem areas that could affect reliability and validity of resulting data. The survey was distributed in several ways: 1) on the NAPS website, 2) at a national conference for peer specialists, and 3) by direct mail to NAPS members. Those distributed by mail to NAPS members included a self-addressed, stamped envelope to encourage response.

The survey was distributed July 15 through September 30, 2007. A total of 173 surveys were completed and returned representing 35 states. For the purpose of the survey, a "peer specialist" was defined as one with a history of or a current experience with a psychiatric disorder who helps others with psychiatric disorders.

The survey consisted of 18 questions, some of which offered multiple responses. Additional comments were sought in the survey instrument as a means of gaining detail about objective responses. Data was entered on an Excel spreadsheet for convenient processing.

Results

The data gathered reveals the following national information:

Average Hourly Wage*	Average Number of Weekly Hours	Average Years on the Job	Average Number of Peers Served Weekly**	Percent with Specific Job Training	Percent Interested in More Job Training
$12.13	29.5	2.8	16.7	82.7%	81.5%

*Salaries were converted to hourly rates based on 2,080 hours per year.

**This number reflects peer contacts in individual and group settings.

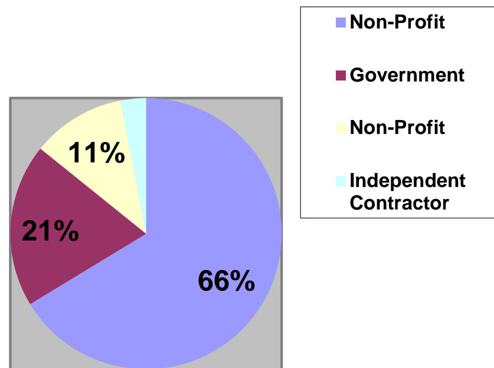
Respondents wanting additional training for their jobs listed the following as areas of particular interest: Wellness Recovery Action Planning (WRAP)™, public speaking, peer rights and legal issues, leadership, computer skills, boundaries and ethics, anti-stigma, trauma, diagnoses, benefits, motivational interviewing, conflict resolution and supervision skills.

Percent Working for Non-Profit Organization	Percent Working for Government	Percent Working for For-Profit Organization	Percent Working as an Independent Contractor
66.3%	19.5%	11.2%	3.0%

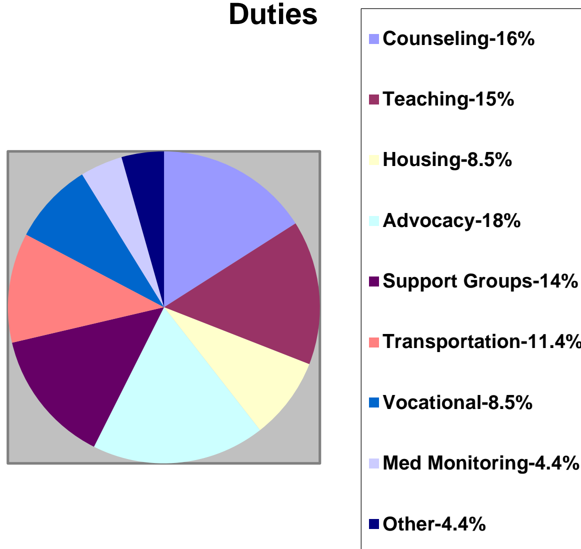
Peer specialists perform a diverse number of tasks. Respondents were asked to identify tasks (more than one response possible) from a checklist that included: one-on-one counseling, teaching, housing assistance, advocacy, facilitating support groups, transportation assistance, vocational assistance and medication monitoring. In addition, respondents were provided with an "other" option and asked to describe that task.

Those selecting the "other" option described such tasks as resource connecting; staff, family and community education; crisis intervention; jail diversion; administration; clubhouse supervision; coordinating appointments; research and reporting; serving on committees, benefits counseling and grant writing.

Percent Working for Organization Type



Percent Performing Various Job Duties



Why do peer specialists do what they do? That question was posed and the results are as follows:

Percentage Identifying Motivation to Work as a Peer Specialist

Money	Helping Others	Having Something to Do	Other
5.5%	73.5%	5.9%	16.7%

Nearly all those reporting "other" as a reason for their motivation identified "helping with my own recovery" as a reason for engaging in work as a peer specialist.

Are peer specialists satisfied with their work? The survey responses revealed the following:

Percentage of Persons Reporting Job Satisfaction

Always	Mostly	Somewhat	Not at all
31.5%	60.7%	7.1%	.6%

Related to job satisfaction is the frequency of conflicts in the workplace and whether peer specialists feel respected by co-workers. The results for these inquiries are below:

	Frequently	Sometimes	Rarely	Never
Percent with conflicts	4.9%	36.6%	45.7%	12.8%
Percent feeling respected	65.2%	30.5%	3%	1.2%

Another area of interest is the number of peer specialists who work full-time as opposed to part-time. Respondents were asked to report the number of weekly hours they worked on average. Those working 32 or more hours per week were considered full-time. Those working less than 32 hours per week were considered part-time. Of the 168 respondents to this inquiry, 48.9 percent reported they worked part-time.

The reasons for working part-time instead of full-time can be many. Respondents were asked to select from a list barriers that prevented them from working full-time. That list included: mental health reasons, lack of health benefits (including potential loss of SSI/SSDI benefits), administrators/managers, demand for services, physical health reasons, and low wages. Respondents were also invited to check "other" and then identify the barrier.

The results of this portion of the survey instrument are as follows:

Percent Identifying Barriers to Full-Time Employment

Mental Health	Benefit Loss	Administrators/ Managers	Demand for Services	Physical Health	Low Wages	Other
17%	36.7%	9.5%	4.1%	11.6%	6.8%	13.6%

Respondents who identified "other" as a barrier explained it was a personal preference to work part-time as opposed to full-time.

How long do peer specialists expect to remain in this occupation? The results of this inquiry may be interpreted as a measure of overall satisfaction and are detailed below.

Percentage Identifying Expected Duration in Occupation

Forever	At least 3 years	Until Something Else Comes Along	Next Year or so	Other
43.8%	27.8%	10.5%	6.8%	11.1%

Those identifying "other" exclusively said they were pursuing educational opportunities that would take them to a different career path.

At the end of the survey, respondents were asked to provide any additional comments they wished. The following is a sample of some of those comments.

- "Love the job but low pay is a real problem."
- "I am concerned that peer support and peer specialists will not last."
- "Mental health staff do not understand the role of peer specialists."
- "Stigma is a problem. The work environment is hostile."
- "More training would help us gain respect among mental health professionals."
- "Someone needs to train administrators about the roles of peer specialists and their value."
- "My agency is very supportive."
- "I love spreading hope around."

Analysis

Generally, the sample size is too small to provide statistical reliability on a state level. There are, however, a few exceptions. For example, 39 peer specialists from Michigan (22.5% of total responses) provide enough data to make reliable conclusions about that state. It is possible to determine with some accuracy, therefore, that Michigan peer specialists work about 5 fewer hours per week (25 versus 29.5 nationwide) and receive less average pay ($11.02 per hour versus $12.13). Satisfaction data also indicates Michigan peer specialists are somewhat less satisfied with their jobs than their counterparts in other states.

But enough data has been provided to make reasonable conclusions about peer specialists on a national level. One of the most obvious interests among peer specialists involves additional training for their positions. Respondents were asked to identify particular topics for further instruction and skill development but those responses were wide ranging. It can be said with some accuracy, however, that peer specialists want to know more about everything.

Looking at hourly wages, number of weekly hours worked and longevity, there is reason for concern about the level of integration of peer specialists in the mental health treatment workforce. The occupation is low paying with little apparent opportunity to create a meaningful career path that will enable peer specialists to move beyond dependence on entitlements, particularly Social Security disability benefits.

The majority (66.3%) of peer specialists work for non-profit organizations with almost 20 percent working for government agencies. If wages, work hours and working conditions are to change significantly, these employers must be the focal points for worker advocacy.

Although there are challenges facing the peer workforce in the future, there are bright spots. Peer specialists are generally very satisfied with their jobs, feel respected in the workplace and have relatively few conflicts among co-workers.

Clearly, the primary reward that motivates peer specialists is helping others. This is understandable as one who has survived and overcome the hardships of a psychiatric disorder often feels—with a fair measure of confidence—they are in a unique position to help others through the same or similar challenges.

Findings

The following findings can be reasonably made regarding the state of the peer specialist workforce in the U.S.:

- Peer specialists are paid relatively low wages, work fewer hours than mental health professionals and have few opportunities for career development in their current career path.
- Peer specialists are highly motivated and serve a significant number of peers.
- Peer specialists perform a variety of work duties and are not generally "locked" into a particular task.
- Peer specialists are generally highly satisfied with their job duties and work environment.
- Peer specialists are hungry for additional training in a variety of areas.
- Educating mental health administrators about the varied roles of peer specialists and their value could improve the work environment.
- Additional satisfaction/compensation survey research would be useful.
- Survey research among state mental health administrators would be a logical "next step" in determining the status of peer support in U.S. mental health systems.
- The National Association of Peer Specialists should use data gathered from survey research to advocate for more peer support initiatives, higher wages, more work hours and a greater understanding of peer specialist roles.

Future Plans

The National Association of Peer Specialists will distribute this report via direct mail to its members. Others who have requested this report will receive it by postal mail or e-mail. Survey results will be shared with mental health professionals, administrators and peer specialists at conferences, meetings and other events whenever possible.

Additional survey research directed to state mental health administrators will determine: 1) the number of working peer specialists in each state, 2) training/certification requirements, 3) future plans for peer specialist program creation and/or development.

Survey research will be implemented on an annual basis to measure changes in the peer specialist workforce. Experience will be useful in refining survey instrument design.

The National Association of Peer Specialists will consult with mental health advocacy organizations and government agencies to determine how it can best advocate for an enduring, well-trained and satisfied workforce.

Appendix 3
RTP Project Spin Offs

Spin offs reflect the effectiveness of project design and provide a broader view of the project's impact. Spin offs are frequently an important part of grant-funded project evaluation and the NAPS project team felt it timely to examine some of those spin offs even though it is still relatively early in project implementation.

Collaboration

The energy and enthusiasm of this project among peers and peer organizations was almost palpable. That led to extensive communications about the project between NAPS and other organizations and individual peers. Other organizations particularly interested in the project and the NAPS role include: The Transformation Center, National Empowerment Center, U.S. Psychiatric Rehabilitation Association (USPRA), the Recovery Academy, Jefferson Mental Health Center, Council on Quality and Leadership, Depression and Bipolar Support Alliance, University of North Carolina-Chapel Hill, The Copeland Center, Assertive Community Treatment Association, Via Hope, Mental Health America (MHA) and a host of local and state chapters of the National Alliance on Mental Illness.

The list above is not complete as many small peer-run organizations and individuals have expressed great interest in the project. This interest has been converted into new and meaningful collaborations that hold much promise. For example, MHA's consumer technical assistance center and USPRA have both tapped NAPS for webinar presentations that, at least to some extent, focus on recovery education issues identified as a result of this project.

A group of peer specialists in King County, Washington (Seattle area) contacted NAPS leadership about a variety of issues relating to peer specialists' practices and a strong relationship has evolved. Other groups in Wisconsin, California and Pennsylvania have

formed close ties with NAPS as a result of their interest in the RTP project. These relationships will for collaborative conduits for not only "marketing" the resulting RTP recovery curriculum, but dissemination of other information as well.

Interest in the project has expanded NAPS' network and the prospect of much more collaboration is real and will benefit many organizations and individuals.

Private Sector Partnership

Early in the project, peer specialists identified sexual health as an important topic. An Australian publication, *My Sexual Health Matters: Advice for Persons with Mental Illness*, addresses this topic in a meaningful and appropriate manner. Peer specialists expressed the belief that sexual dysfunction is a leading cause of medication non-compliance yet is rarely addressed by any mental health professionals.

The RTP team learned that this publication could be reprinted at a relatively low cost for a copyright license. Instead of pursuing republication as part of the RTP project, the team shared the information with a consumer owned/operated micro-enterprise. That business has decided to pursue republication, reprint the booklet and market it to mental health providers across the country. The business hopes to reap a modest profit and at the same time serve an apparent need for all mental health professionals. Hard copies of the booklet will be sold and the business will make downloadable, online copies available to NAPS and, hopefully, other mental health information distribution websites.

The NAPS RTP team will examine other potential opportunities for nonprofit-for profit collaborations.

Organizational Leadership Lessons

As part of the RTP project, NAPS engaged in a multi-faceted endeavor to obtain information from peer specialists and peers across the U.S. The result was a wide array of perspectives that reflect cultural, geographic, organizational and governmental issues. The value of this

input is immense as it allows NAPS to evaluate how it can best serve peer specialists in a diverse workforce.

NAPS leadership has determined that this outreach must become an integral part of the organization's operations. Through newsletters, e-mails, phone calls and personal contacts, NAPS will continue to seek out opinions, suggestions and advice on specific issues.

The RTP project has also allowed individuals to come forward with important leadership and related skills. For example, one long-time member from New York extensively edited the draft guidelines for peer instruction. She spent considerable time reviewing the document and her contributions were extremely helpful. As a result, her comments, which were based on many years of personal teaching experience and curricula design, will contribute greatly to the development of a meaningful tool. On a personal level, she has offered to become more involved with NAPS and her efforts to form a statewide peer specialist organization were boosted because of this involvement.

Several others from across the country have also expressed interest in becoming more involved in the national organization and their participation is certain to strengthen NAPS. As reported in previous months, the enthusiasm for this project has been tremendous and the current NAPS leadership is turning that enthusiasm into opportunities for personal and organizational growth.

Special Resource Publication

As peer specialists across the country were interviewed for the RTP project, it quickly became apparent that a great many were unaware of existing information resources. A considerable number also appeared unaware of the value of webinars and how to access them.

To respond to the growing need for information from professional journals, magazines, webinars, newsletters and other sources, NAPS will be publishing and distributing in late 2010, a newsletter-format publication that will identify key resources and explain how to obtain them. The publication will also describe why and how to participate in webinars.

Information resources developed and/or collected by DSG as part of the RTP project (such as Larry Davidson's work) and the Substance Abuse and Mental Health Services Administration's (SAMHSA) valuable collection of publications, will be featured.

Specialty Development

The peer specialist profession is relatively new. The RTP project has spawned conversations among many interest groups/stakeholders, including instructors of peer specialist certification trainings. One area of development is that of specialties.

It appears as though the profession is quickly headed to a system where peer specialists are offered a "core" curriculum that teaches basic skills for state certification purposes. After completing basic training, peer specialists will options to continue their education through specialty curricula. Examples of such specialties include: forensic and in-patient settings, substance abuse/co-occurring, whole health, vocational support, housing, stigma busting and leadership/advocacy.

Curricula for some topic areas have already been developed are in process. For example, Boston University's Center for Psychiatric Rehabilitation is near completion of a curriculum for vocational peer support. Curricula for supporting peers with whole health issues has been developed in Georgia (and is now offered throughout much of the U.S.) and curricula for recovery coaching for those with substance use disorders and those working in in-patient settings are also near completion.

For the RTP project, developing a single curriculum that covers all these areas would be duplicative and result in an unwieldy training manual. Instead, the NAPS RTP team believes it will be more practical to cover such specialties (as many have been identified as key recovery knowledge gaps) in a cursory fashion so as to accommodate most continuing education formats. Information about further training in these areas will be provided. In this way, peer specialists will be able to obtain an awareness of specialty areas and basic information as well as how they may pursue further education in these areas.

There are, of course, many recovery topics that will be covered in the NAPS RTP curriculum in total. It is expected that such topics (remember we are still in the process of obtaining input to identify recovery knowledge gaps) as cultural competency, relationship building and advocacy in the workplace will be among those topics that will be covered thoroughly in the NAPS RTP curriculum.

Competency Dialog

A dialog about the role of NAPS in creating and implementing national competency standards began almost from the moment of inception of the organization six years ago. A variety of approaches and the insistence of states for autonomy in setting certification standards have burdened the conversation. Some have advocated for a national job description for peer specialists while others have sought a national certification.

As a result of the RTP project, new energy and perspectives have emerged regarding national standards/guidelines. It appears as though the time is "right" for a fresh approach to the dialog that will address a variety of issues raised as a result of the RTP project. NAPS leadership has begun discussions with SAMHSA staff regarding ways to develop general peer support principles that can be adopted by NAPS with national implications.

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