PeerTAC
PEER SUPPORT SERVICES
TECHNICAL ASSISTANCE CENTER

The Supervision of Peer Support Specialists

CONTENTS

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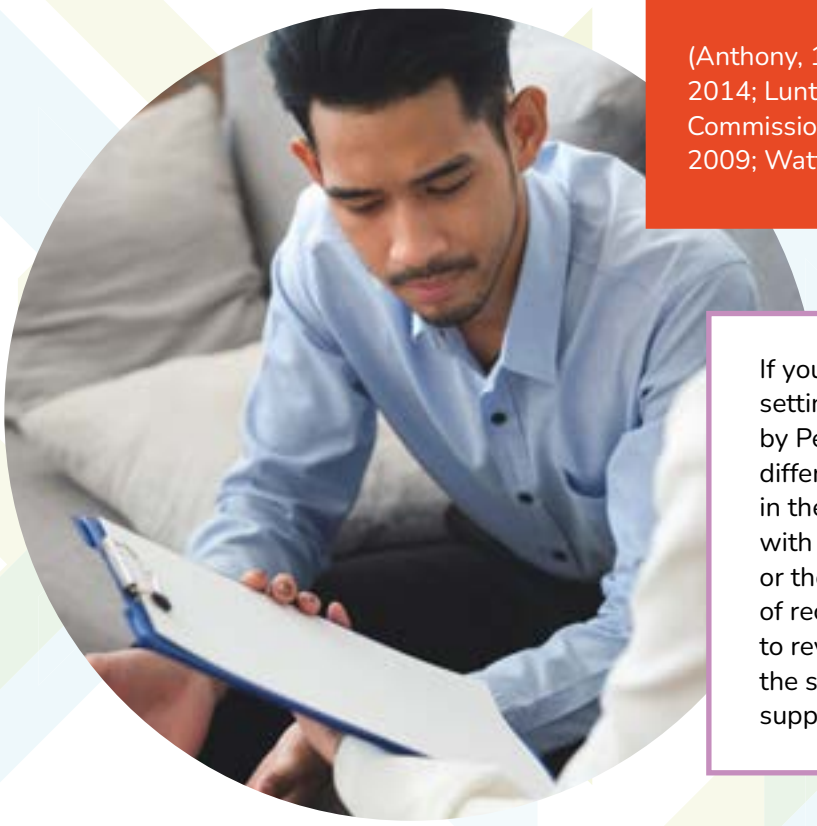
The goal of this training workbook is to provide a brief overview of supervision in general and more specifically supervision for Peer Support Specialists. At the end of this self-directed workbook, the learner will understand what peer support is, and how that translates into peer support services, and what peer supervision is, the context within which it thrives, how it may be performed, the myths and reality of supervising peers, the necessary knowledge and resources when acting as a peer supervisor and finally the unique challenges of peer supervision in multi-professional behavioral health settings.

According to William Anthony (1993)" Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness".

Peer support is most successful when it is provided in an organization or environment that is recovery-oriented. It is widely accepted that peer support is a critical element of a recovery-oriented system of care.

(Anthony, 1993; Deegan, 1988; Drake & Whitley, 2014; Lunt, 2002; President's New Freedom Commission, 2003; Ralph, 2000, Slade, 2009; Watts & Higgins, 2016.)



If you work in a traditional treatment setting, the term "recovery" as it is used by Peer Support Specialists may be different from what you have learned in the past. If you are not familiar with the SAMHSA working definition or the peer specialist/advocate view of recovery it is worth taking the time to review Appendix 1 so that you have the same understanding as your peer support staff.

LEARNING 1

Peer Support and Peer Support Services

What is Peer Support?

Peer support occurs naturally as individuals with common situations find each other and provide support for life's challenges.

Peer support is also known as self-help (Mead, S.,2003, Mead, S., & McNeil, C. 2006). For this training we are speaking specifically about the profession of peer support. "Those in peer roles have experiential knowledge as someone who can either use what they've learned through their personal process of recovery and resilience (or as the parent of a child that is receiving services in one or more of the systems of care) to offer program participants practical assistance with their challenges of life." For more information on these distinctions, visit https://peertac.org/2023/10/12/peer-specialists-are-not-clinicians/.

Peer support is generally defined as a way of giving and receiving help from people who have similar experiences (Davidson, Bellamy, Guy, & Miller, 2012; Lammers & Happell, 2003; Mead, 2003; President's New Freedom Commission, 2003; Repper & Carter, 2011). PSS, using their lives as a primary experience-based intervention, function in ways that are distinct from mental health professionals. These experience-based interventions differ from professional interventions as they may involve dual relationships, personal self-disclosure, a focus on empowerment, and role modeling hope and recovery (Davidson et al., 2012; Lammers & Happell, 2003; Mead, 2003).

Exercise:

Think about times in your own life when you have reached out to someone in a similar situation. List two times when you have reached out to someone in a similar situation, or someone in a similar situation has reached out to you. Did you find this helpful? If so, in what way and why?

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Understanding Peer Support Services

The International Association of Peer Supporters (iNAPS, 2015) in its video entitled "What is a peer supporter?" defines peer supporters broadly as providers with "a personal experience of recovery from mental health, substance use, or trauma conditions who receive specialized training and supervision to guide and support others." To view the video, visit this link: https://peertac.org/2023/07/07/peer-support-vs-peer-support-services/.

N.A.P.S. (2023) has recently updated the definition as part of a proposed Occupational Classification for professional peer support providers as follows:

A Peer Support Specialist may:

- Provide non-clinical support services that align with "SAMHSA's 10 Guiding Principles of Recovery" https://store.samhsa.gov/product/samhsas-working-definition-recovery/pep12-recdef and "SAMHSA's Core Competencies for Peer Support Specialists" https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers to individuals and/or groups.
- Disclose personal experiences of overcoming challenges in ways that inspire hope, empowerment, and positive action.
- Engage individuals in personalized, peer-to-peer relationships that support development and use of skills to manage crises and achieve recovery, wellness, and life goals.
- Use personal knowledge to navigate systems and link individuals to resources and services including education, employment and social activities that can help them to achieve their goals.
- Educate individuals and/or groups, as well as their family members, about health, wellness, and recovery.
- Use lived experience to educate colleagues on using person-centered, recovery-oriented practices when interacting with individuals and/or groups to enhance the provision of services and supports.
- Engage in facilitating individual rights and systems advocacy.

Exercise:

Chose one of these Peer Support Specialist functions listed above. List the strengths and challenges of the function.

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New York Peer Specialist Certification Board (NYPSCB) definition of peer support and services

NYCPS – NEW YORK CERTIFIED PEER SPECIALIST The New York Peer Specialist Certification Board defines a NYCPS - New York Certified Peer Specialist as a person who, by virtue of special knowledge, training, and experience, is uniquely able to inform, motivate, guide, and support persons in recovery from a mental health condition, diagnosis or major life disruption.

In order to become certified as a NYCPS, a candidate must demonstrate they have completed appropriate education and training, relevant to the work of a peer specialist and endorse the NYCPS Code of Ethical Conduct and Disciplinary Procedures.

New York Certified Peer Specialist - Scope of Activities (2015).

The scope of activities outlines the range of peer recovery services that a New York Certified Peer Specialist can provide to assist others in living their lives based on the principles of recovery and resiliency.

1 Utilizing unique recovery experiences, the New York Certified Peer Specialist shall:

- Teach and model the value of every individual's recovery experience
- Model effective coping techniques and self-help strategies
- Encourage peers to develop a healthy independence
- Establish and maintain a peer relationship rather than a hierarchical relationship

2 Utilizing direct peer-to-peer interaction and a goal-setting process, the New York Certified Peer Specialist shall:

- Understand and utilize specific interactions to assist peers in meeting their individualized recovery goals
- Demonstrate and impart how to facilitate recovery dialogues through the use of active listening and other best practice methods
- Demonstrate and impart relevant skills needed for self-management of symptoms, relapse
- Demonstrate and impart how to overcome personal fears, anxieties, urges, and triggers
- Assist individuals in recovery in articulating their personal goals and objectives for recovery
- Assist individuals in recovery in creating their personal recovery plans (e.g., WRAP®, crisis plan, etc.)
- Appropriately document activities provided to peers in either their individual records or program records

3 The New York Certified Peer Specialist shall maintain a working knowledge of current trends and developments in the fields of mental health, substance use disorders, co- occurring disorders, and peer recovery services by:

- Reading books, current journals, and other relevant material
- Developing and sharing recovery-oriented material with other Certified Peer Specialists
- Attending authorized or recognized seminars, workshops, and educational trainings

4 The New York Certified Peer Specialist shall serve as a recovery agent by:

- Providing and promoting recovery-based services (e.g., WRAP®, IPS, etc.)
- Assisting individuals in recovery in obtaining services that suit each peer's individual recovery needs;
- Assisting individuals in recovery in developing empowerment skills through self-advocacy
- Assisting individuals in recovery in developing problem-solving skills so they can respond to challenges to their recovery
- When appropriate, sharing his or her unique perspective on recovery from mental illness and cooccurring disorders with non-peer staff
- Assisting non-peer staff in a collaborative process in identifying programs and environments that are conducive to recovery

In all activities, the peer specialist must demonstrate consistent adherence to the NYPSCB Code of Ethical Conduct & Disciplinary Procedures and agree to continue their professional development with ongoing education, training and maintain a working knowledge of current best practices and developments in the field of peer support.

The values and expectations of peer support

Peer support has its roots in what was known in the 1970's and 1980's as the consumer/survivor movement. Former patients of the mental health system (known as ex-patients) came together for mutual support and self-help (Borkman, 1990, Mead, S. 2003). A lot of what peers attempt to do is based on the concepts of empowerment and social inclusion.

Alternatives to the mental health system such as the Wellness Recovery Action Plan (WRAP) drop-in centers, club houses, community residences, and peer-run organizations were developed and suggested (Chamberlin, 1977).

What is important here is that the beginnings of peer support were built upon the foundations of values shared by those offering or accepting mutual aid or peer support. Lived experience and mutual support are the foundation upon which the rest of the peer values are built.

Initially, the basis of this movement was represented by a few shared values, like those currently mentioned in Intentional Peer Support (Mead, Kuno, & Knutson, 2013).

- **Connection.** We pay attention to "magical moments" when we seem to "get" each other. We look for areas of shared energy, interest, and engagement. ...
- **Worldview.** We listen to understand and explore how we have come to believe what we believe.
- **Mutuality.** We share power and responsibility.
- **Moving Toward.** We focus on what we can create together.

"Intentional Peer Support is a way of thinking about and inviting transformative relationships. Practitioners learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and support and challenge each other in trying new things."

(https://www.intentionalpeersupport.org/).

Exercise:

What do you know about the more recent origins of peer support?

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What surprised you to learn?

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Principles of Core Competencies for Peer Support Specialists

Core competencies for Peer Support Specialists reflect certain foundational principles identified by members of the mental health consumer and substance use disorder recovery communities. SAMHSA has listed these competencies or expectations as:

Recovery-oriented:

Peer Support Specialists hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer Support Specialists help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.

Person-centered:

Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the people served and to respond to specific needs the people has identified to the Peer Support Specialist.

Voluntary:

Peer Support Specialists are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.

Relationship-focused:

The relationship between the Peer Support Specialist and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the Peer Support Specialist and peer is respectful, trusting, empathetic, collaborative, and mutual.

Trauma-informed:

Peer recovery support utilizes a strength-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment (SAMHSA, 2015).

Most recently, the National Association of Peer Supporters (NAPS) identified twelve values after an extensive consensus building process. These values are:

- Peer support is voluntary
- Peer supporters are honest and direct
- Peer supporters are hopeful
- Peer support is mutual and reciprocal
- Peer supporters are open minded
- Peer support is equally shared power
- Peer supporters are empathetic
- Peer support is strengths focused
- Peer supporters are respectful
- Peer support is transparent
- Peer supporters facilitatechange
- Peer support is person-driven

Source: National Practice Guidelines for Peer Supporters, Washington, DC, National Association of Peer Supporters, 2013. https://www.peersupportworks.org/wp-content/uploads/2021/02/nationalguidelines_updated.pdf

Exercise:

List the values or competencies that are the same as those upheld by your profession.

Use the Supervision Self-Reflection Tool to explore how well your practice of supervision supports the ability for your staff to provide peer support with fidelity to the core values.

Read through each of the statements associated with "As a supervisor, how often do you..." Choose a frequency that matches your practice of supervision and then review the information about the National Practice Guidelines (NPG) that comes up based on your responses. If you are supervising in alignment with the NPG, you will be commended for the amount that you know and things that you do as a supervisor to support your staff. If you are less knowledgeable, you will be provided with more information about the NPG that you can use to improve the way in which you supervise to be more in alignment with the NPG values.

For the Supervision Self-Reflection Tool, visit https://rutgers.ca1.qualtrics.com/jfe/form/SV_8AKyyl53xllRJIy.

The basis of peer support and peer support services is often referred to as LIVED EXPERIENCE

- Lived experience is what we have learned after reflecting on an experience.
- Lived experience offers a different kind of knowledge (wisdom) than academic knowledge.
- Self Help: You alone can do it, but you cannot do it alone.
- Mutual Support: giving and receiving support in the form of lived experience.

(Borkman, 2021)

Exercise:

Think again about the times you were able to help someone because you had been through something similar (noted above). Jot down how your own experience made a difference to the other person.

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Or, can you remember a time when someone reached out to help you because of something you were going through that they had also been through? Jot down how this experience made an impact on you.

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Another way to think about and appreciate the differences in perspective is from the viewpoints of non-peer professionals and Peer Support Specialists:

Clinical practice	Lived experience
✔ book knowledge	✔ experiential knowledge
✔ expertise defined by formal education	✔ expertise defined by lived experience
✔ uni-directional accountability	✔ bi-directional accountability
✔ clear boundaries and fixed roles	✔ flexible boundaries and complementary roles
✔ power rigidly defined a priori	✔ power situationally defined
✔ externally regulated	✔ un-regulated

Credit: Andy Bernstein; (Borkman, 1990).

Exercise:

What might you add to these distinctions?

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What aspects need more explanation?

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Which might you disagree with?

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In 2007, the Centers for Medicare & Medicaid Services (CMS) acknowledged peer support as an evidence-based practice and peer support services became a Medicaid-reimbursable service.

This recognition also required that peer support specialists be trained, certified, and supervised as determined by each state. In New York, the online Academy of Peer Services (APS) https://www.academyofpeerservices.org/ provides the necessary training to apply to become a certified peer specialist.

Exercise:

You can go to the APS website to open a free account and browse through the courses peers are required to take. Or review the list to the right: List three that might interest you as a supervisor.

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Name something you might add to the training

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Name something about the training that surprised you.

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Courses required for certification as a peer specialist:

- ☐ Action Planning for Prevention and Recovery
- ☐ Creating Person-Centered Service Plans
- ☐ Documentation for Peer Support Services
- ☐ Essential Communication Skills (Active Listening and Reflective Responding)
- ☐ Human and Patient Rights in New York
- ☐ Introduction to Person-Centered Principles
- ☐ Olmstead: The Continued Mandate of De-Institutionalization
- ☐ The Goal Is Recovery
- ☐ The Historical Roots of the Peer Support Services
- ☐ The Importance of Advocacy
- ☐ Trauma-Informed Peer Support
- ☐ The Rehabilitation Act and the Americans with Disabilities Act (ADA)

Once an applicant passes all thirteen core courses, they are eligible to apply for certification through The New York State Peer Certification Board. https://nypscb.org/.

Certified Peer Specialists are required to adhere to a code of ethical conduct.

The NYPSCB Code of Ethical Conduct contains sections on:

- ☐ Professional Standards
- ☐ Confidentiality
- ☐ Sexual Misconduct
- ☐ Exploitation of Persons Supported
- ☐ Fraud-Related Misconduct
- ☐ Disciplinary Procedures
- ☐ Benefits of Certification/Who Benefits

From New York Peer Specialist Certification Board Code of Ethical Conduct & Disciplinary Procedures (2023)

Exercise:

Review the most current version of the Code of Ethical Conduct from the Certification Board website. https://nypscb.org/

If you are part of a non-peer profession, in what ways does this code of conduct differ from the code of conduct of your profession? Note parts of the code, and the difference from that of your profession, below.

LEARNING 2

What is Supervision?

Introduction

The idea of supervision is both commonly understood and commonly misunderstood. How it is understood and how it is both experienced and practiced can differ from one setting to another. For the purposes of this lesson, supervision will be defined in the context of behavioral health care.

However supervision is defined, please be mindful that supervisors are powerful influences on work performance, task understanding, and overall work experience.

Supervision has been described as an event that involves an ongoing professional relationship, between two and more professional members with different levels of knowledge or expertise, to support professional development and to enhance knowledge and skills.

(Nancarrow, Wade, & Moran, 2014).

Questions for reflection: Who supervises your work?

Exercise:

What would you add or change to the above definition of supervision?

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Name three qualities that you feel a good supervisor would have? We will revisit this later in the text.

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Organizational benefits of supervision

Although the practice of supervision may have begun as an apprenticeship model with the purpose of teaching a beginner a certain profession, supervision took on other purposes as time went on. (Feeney & Lamparelli, 2002)

Other purposes of supervision are reflected in how it serves the institution where it takes place. In this regard, the literature on supervision suggests that supervision can be divided into three main purposes: administrative/managerial, educational, and restorative (supportive) (Goodyear & Bernard, 1998). Administrative or managerial supervision is understood to focus on ensuring that the rules and regulations, licensure requirements and other agency initiatives are followed by the supervisee (Karpenko & Gidycz, 2012; Spence, et al., 2001). Educational supervision encompasses the notion that there are skills and understandings to be transmitted from a more experienced supervisor to a less experienced supervisee (Kavanagh, et al., 2002; Kilminster & Jolly, 2000). Restorative or supportive supervision is frequently cited as those aspects of supervision which prevent job burnout and improve job satisfaction and retention (Kavanagh, et al., 2002).

Exercise:

As you think of your experience in supervision, what purpose of supervision seems to take up most of your supervisory time? Rank the importance of the above aspects of supervision as you understand them.

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As a supervisee, what were you looking for from supervision? Rank the importance of the above aspects of supervision from the supervisee's point of view.

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What are the basics of good supervision?

There is not a full understanding about what makes supervision effective and directly linked to positive outcomes for clients. (Allen, Szollos, & Williams, 1986; Barnett, Erickson, Goodyear, & Lichtenberg, 2007; Kavanagh et al., 2002; Spence et al., 2001)

However, there is some consensus that effective supervision includes characteristics such as trustworthiness, good people skills, ability to listen, open mindedness, flexibility, and supportive of personal growth (Allen, Szollos, & Williams, 1986; Falender et al.). The literature pertaining to clinical supervision further suggests that the supervisory relationship itself is an essential component to effective supervision" (Jones, 2006; Ladany, Mori, & Mehr, 2013, 2004; Manthorpe, et al., 2015)

Exercise:

List the three things you liked most about your favorite supervisor. What did your supervisor do that you felt was most helpful.... Least helpful

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What affect do you think supervision can have on the experience of work and/or job performance?

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OR What do you think is the connection between effective supervision and someone's experience of their work or job performance?

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Peer Support Supervision

Chinman (2014) defined peer support supervision in the following way: Peer Support Supervision occurs when a peer support supervisor and Peer Support Specialist supervisee(s) formally meet to discuss and review the work and experience of the peer provider, with the aim of supporting the peer in their professional role.

Clinical supervision versus peer supervision

For those Peer Support Specialists however, who are supervised by a non-peer supervisor, it is important to understand that there may be a difference in understanding about supervision.

What is clinical supervision?

"The broadest definition of supervision refers to "a working alliance between two or more professional members where the intention of the interaction is to enhance the knowledge, skills, and attitudes of at least one staff member." (Spence et al., 2001, p. 141). According to Bernard and Goodyear's (2004) definition, clinical supervision is generally understood in the traditional mental health milieu as occurring between a senior member and a junior member of a certain profession or between an expert in the profession and its unlicensed allied health professionals. When viewed as an intervention provided by a more senior member of a profession to a more junior member, supervision has the purposes of enhancing professional functioning of the more junior person, monitoring the quality of professional services offered to clients, and serving as a gatekeeper to those seeking to enter a particular profession (Bernard & Goodyear, 2004; Milne, 2007; Milne et al, 2008). A more progressive understanding includes the idea that supervision advances professional and personal development in a supportive relationship among equals (Butterworth, Bishop, & Carson, 1996). (Forbes and Pratt, 2019).

Exercise:

How would you define supervision?

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Supervision for Peer Support Specialists

As noted earlier, in 2007, the Centers for Medicaid and Medicare Services (CMS) recognized peer support as an evidenced based practice. Such a ruling allowed states to adopt waivers to allow organizations to bill for peer support services. These waivers required that peer supporters have training, care coordination, and supervision by a mental health professional as determined by each state. Most states interpreted that guidance to mean a mental health professional would be a licensed mental health professional recognized by that state. What has followed is a continued effort to understand peer supervision and to provide guidance that points to best practices.

How might peer supervision differ?

It is important to understand that clinical supervision generally reflects the clinical practice of the supervisor.

There are differences between the practice of a licensed clinician and the practice of a trained Peer Support Specialist which could create confusion and conflict in supervision. Inherent in clinical supervision is the task of role-modeling practice behaviors for the less experienced supervisee, thus assisting the supervisee to increase their expertise (Goodyear & Bernard, 1998).

Practice behaviors of Peer Support Specialists differ in many ways. Sharing one's personal recovery story is a different skill than maintaining professional distance. And empathy based on experience is likely different and differently conveyed than empathy based on knowledge. The National Practice Guidelines for Peer Supporters (iNAPS, 2013) identify peer support as voluntary, mutual, and reciprocal; and as representing equally shared power. Expert knowledge is not generally viewed as mutual, reciprocal, and based on equally shared power. These differences often contribute to role confusion as non-peer supervisors may not be knowledgeable about how to support these distinct skills (Delman & Klodnick, 2016).

IT IS NOT	THE ROLE IS NOT
• Hiring a clinician with lived experience and saying the are "a peer" • Simply hiring someone with a diagnosis • Rehabilitation for a person with lived experience	• A case manager • A medication or compliance monitor • An extension of systems or clinical services • A friend • A sponsor • Parental

Caraco, 2024

Some non-peer supervisors may understand part of their role with a Peer Support Specialist as being an "adjunct therapist," or being willing to help and support the Peer Support Specialist with mental health interventions (Swarbrick & Nemec, 2010). Peer core competencies reflected by mutuality and reciprocity may create concerns for professionals concerned about boundary setting or ethical issues stemming from power differentials.

Given these factors, supervision of a peer by a non-peer supervisor is different than typical clinical supervision in several ways. Peer supervision as recommended by CMS does not fit the criteria of occurring within an explicit professional practice domain, nor is the supervisor delegating job duties of a profession to be carried out by the peer support worker as a junior member of the profession, paraprofessional or allied professional. Additionally, while the supervisor may understand the role of the peer, they typically have no direct experience performing the tasks required. For these reasons, clinical supervision of a peer support worker by a non-peer supervisor may not fit well with generally accepted clinical supervision models.

"For these front-line workers who typically lack academic training and credentials, supervision is a primary source of on-the-job education and training. In many cases the supervision of peer support specialists is required to be carried out by licensed mental health workers, who for the most part are non-peers. So, supervisors are assessing and guiding persons in carrying out a role of which they themselves have had no experience. This mismatch may create issues that need to be addressed to improve the effectiveness of Peer Support Specialists." (Forbes & Pratt, 2019.)

Exercise:

If you are in the role of a clinical supervisor, what do you do to adjust your supervision to accommodate the needs of a peer support provider?

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What are some of your thoughts on addressing the differences between clinical supervision and peer supervision? Name three differences between clinical supervision and peer supervision.

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LEARNING 3

Pillars of Peer Support and Supervision

In November 2009, the Pillars of Peer Support Services Summit was convened at the Carter Center in Atlanta, GA. The intent of the Summit was to bring together those states that were providing formal training and certification for peer providers working in a mental health system (Daniels, et al., 2010). Twenty-five pillars were identified at that summit and meant to guide the continued development of peer support as a growing profession.

Later, peer leaders would get together again to address peer supervision specifically. The recommendations were reached by a consensus process based on discussion among those who were actively trying to address the issue of peer supervision either within their agencies or within their states. The recommendations from the Pillars were intended to provide guidance to states and other entities asking how best to provide supervision for the peer support workforce. The Pillars were widely distributed by the National Association of State Mental Health Program Directors (NASMHPD) and thus served as a valuable tool (Forbes, Pratt, & Cronise, 2022). This endorsement by NASMHPD was important as they are one of those national organizations with the political power to promote changes throughout the system.

There are many concerns non-peer professionals have about peer staff. Below is a short summary of some of those concerns and what almost two decades of peers in the workforce demonstrate as fact.

Myths and Facts

MYTH/CONCERN	FACT
Aren't peer staff too "fragile" to handle the stress of the job?	• Self-care is importan for all staff, not just peer staff • Peer's history of handling illness is indicative of persistence and reslience, not weakness • Focus should be on whether or not the peer staff is able to perform the essentail functions of the job
Don't peer staff relapse?	• All employees, including peer staff take time off because of illness, including mental health issues • Role modeling includes working through advesrity and resturning to work even flollowing health challenges
Can peer staff handle the administrative demands of the job?	• Despite possible prolonged periods of unemployment or limited educational opportunities, supervision and specific job-skills training can support peer staff in managing these tasks
Won't peer staff cause harm to clients by breaking confidentiality or by saying "the wrong" things?	• Given their own experiences, peer staff may in fact be more sensitive around issues of participant confidentiality
Won't peer staff make my job harder instead of easier?	• Peer support provides an important and useful complement to existing mental health services; when well trained and supervised peer supporters can enrich participants' lives while other staff focus on their own roles

Davidson, L. & Harrington, S. (2011). Common Practitioner Concerns and Myths About Peer Support. Recovery to Practice Weekly Newsletter, 2(10), 3/18/2011

Pillars of Peer Support Supervision

The result of the facilitated dialogue groups was the development of a set of core principles for supervision. These concepts were then reviewed and distilled into five key themes. Based on these principles and themes, a set of five pillars were generated.

1 Peer Specialist Supervisors are Trained in Quality Supervisory Skills.

Exercise:

What would you identify as quality supervisory skills. Name two or three skills you would identify as contributing to quality supervision,

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This recommendation would seem unnecessary. However, a review of the literature and strong anecdotal information suggests that most supervisors are not trained in how to be a supervisor. Becoming a supervisor is often based on strong clinical/work skills that seem to indicate mastery in the profession. Similarly, many supervisors are not compensated for the additional responsibilities inherent in supervision. There is emerging evidence about what is valued by supervisees – specifically availability, positive relationships, mutual communication, support and delegating responsibility. Carpenter, et al. (2012) also suggest supervision works best when it focuses on task assistance, social and emotional support and building a positive relationship with supervisors.

Exercise:

Based on what peer specialists say is important to them, what kinds of things do you do in supervision to provide a quality supervisory experience?

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2 Peer Specialist Supervisors Understand and Support the Role of the Peer Specialist.

Exercise:

Given the setting you work in, how do you see the role of the peer specialist? Write a brief job description.

Supervision is best understood as a structured relationship between a senior member and a junior member of a profession with the goal of developing the professional skills of the junior member. This is a difficult task if the supervisor has never worked as a Peer Support Specialist and as a result does not understand the skills, attitudes and knowledge required to be a Peer Support Specialist. At the very least, this pillar recommended that a supervisor recognize this knowledge gap and make an effort to understand the role. Research suggests that those supervisors who had respect for the peer role along with a positive, non-judgmental attitude, were able to support the autonomous functioning of the Peer Support Specialist (Forbes, Pratt, & Cronise, 2022). This practice allowed the supervisor an additional source of understanding of the peer role.

Exercise:

How would you go about learning more about the role of the peer specialist? Where would you look for information about the role of the peer specialist?

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What do you see as the core values of that profession? Please list.

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What are the core values of your profession? Please list.

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A good supervisor champions that a peer supporter utilizes and does not stray from peer values in the work. National Guidelines of Peer Support Values are available at the National Association of Peer Supporters website https://www.peersupportworks.org/national-practice-guidelines/. If interested, the story of their development is available at https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000901.

For Family Peer Advocates (FPA) and Youth Peer Advocates (YPA), the core values are expressed on the Families Together website under The Guiding Principles: https://www.ftnys.org/our-policy-priorities/#:~:text=OUR%20GUIDING%20PRINCIPLES&-text=All%20children%2C%20youth%20and%20their%20families%20must%20have%20timely%2C%20affordable,integrated%20and%20appropriate%20setting%20possible.

Supporting the peer role includes continued focus on several areas which have been identified as challenges when peers join multi-disciplinary teams. One area is role clarification. This may take the form of working with the Peer Support Specialists to provide educational talks to other members of the organization which helps to explain what a Peer Support Specialist does and does not do, perhaps, in traditional settings, in the form of in-service training or grand rounds.
A helpful exercise is spending some time in training on role reversals, role playing what it is like to be in another's role - the challenges and the rewards.

Another area is addressing any stigmatizing behaviors which continue in the workplace. The supervisor functions as an advocate and role model in this regard, responding to microaggressions as they occur with corrective language and welcoming behaviors.
A good supervisor champions having more than one peer on a team.

3 Peer Specialist Supervisors Understand and Promote Recovery in their Supervisory Roles.

Spend a few minutes reviewing the Recovery Context chapter at the end of this workbook.

After your review, decide where you think your supervision skills match the core values of peer support through the Supervision Self-Reflection Tool: https://rutgers.ca1.qualtrics.com/jfe/form/SV_8AKyyl53xllRJIy.

You might want to have the Peer Support Specialists you are supervising fill out the scale as well. Take time to discuss with each other the results of both efforts.

Peer Support Specialists are integrating into a mental health service system transitioning from a medical model to a recovery-oriented model of care. PSSs are the embodiment of recovery. It is widely accepted that peer support is a critical element of a recovery-oriented system of care (Hogan, 2003, 2 Harding, et al. 1987). "The mental health recovery paradigm has become a significant philosophical influence on the delivery of mental health services; however, the use of the term recovery has varied widely. As the possibility of recovery was introduced into mental health systems through the writings of proponents and through documents such as the President's New Freedom Commission (2003), mental health service providers slowly began to incorporate the language and tools of recovery into mental health settings. The term recovery is used differently in different settings. There is a perspective on recovery in the clinical sense which focuses largely on symptom remission. There is also the perspective of personal recovery which focuses on creating a life with personal meaning. For some mental health practitioners, the term may refer to expected clinical outcomes or for other practitioners, it may refer to a philosophy or attitude that casts doubt about viewing all serious mental illness as a chronic condition (Forbes, Pratt, & Cronise, 2022).

Exercise:

What is your personal view of the possibility of recovery from a mental health challenge? In what ways could you promote the idea of recovery?

4 Peer Specialist Supervisors Advocate for the Peer Specialist and Peer Specialist Services Across the Organization and in the Community.

Exercise:

What is your understanding of advocacy? What have you advocated for in the past?

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Have you participated in advocacy efforts in your profession? Yes No

What prompted you to participate, and what did you do to advocate?

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Daniels, et al (2015) state strongly that peer specialist supervisors are responsible to be advocates for the role of peer support services not only in the organizations where they work but also in the community. They suggest this effort fosters a relationship of trust and support between the supervisor and supervisee. Such a strong partnership promotes the value of these services, and educates everyone about peer support services. For both this could be done in any number of ways: promoting team building exercises; creating organizational and community educational events; attending conferences that focus on peer services as well as advocating for policies and procedures in the organization that promote and foster recovery. Be mindful that many of these advocacy goals will require support and participation from upper management/leadership.

5 Peer Specialist Supervisors Promote both the Professional and Personal Growth of the Peer Specialist within Established Human Resource Standards

Exercise:

Think about your own personal and professional growth. Name three goals that you have you set for yourself:

_____

_____

_____

Has your organization supported achievement of those goals? Yes No

In what venture have you failed to receive such support?

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One of the challenges facing Peer Support Specialists is the lack of adequate compensation and often the absence of a meaningful career ladder. Most organizations' compensation policies recognize education as a standard. Such a standard is a barrier for Peer Support Specialists and is in all likelihood the issue behind the high turnover rates among those employed as Peer Support Specialists. Daniels, et al (2015) suggest peer specialist supervisors are a key link between the peer staff and the organization's leadership. Both supervisors and peer support specialists have a responsibility to advocate for equitable compensation and benefits for the peer workforce. How this is done will differ from organization to organization. However, in New York State, The Alliance for Rights and Recovery (formerly NYAPRS) often takes the lead around compensation issues. The website can be reached at https://rightsandrecovery.org/. Promoting professional and job-related personal growth is a shared task as well, but is often very powerful when suggestions for professional development come from a supervisor. These suggestions can include access to training and continuing education, evolving peer specialist role opportunities, and appropriate career ladders. Encouraging participation in peer networks outside of the organization is also useful.

Personal growth can be modeled by a supervisor and may include maintaining a safe work environment, personal wellness, and individual goal attainment. Dual supervision also provides an opportunity for growth both personally and professionally. There are other resources for personal growth included in the following website Solution Suites at UIC: https://www.center4healthandsdc.org/solutions-suite.html. In addition, The Philadelphia Peer Support Toolkit addresses professional growth issues here: https://dbhids.org/wp-content/uploads/1970/01/PCCI_Peer-Support-Toolkit.pdf. (Access to the entire toolkit is included under resources for further study).

Steps that address the most common barriers and challenges to include peer supporters on a multi-disciplinary team.

What do peers say about good supervision?

Peer Support Specialists noted that supervisors who were respectful, nonjudgmental, and open minded were perceived as supportive and more aligned with peer values.

One PSS noted

"But our supervisor is a non- peer, but they're open to suggestions. They listen to anything that … the peers have to say, and will work on it, whatever… we need and are very open… they ask me for my advice. They …truly accept things that I can say." M028 White female, PSS over 10 years, very satisfied, bachelor's degree (Forbes, et al., 2022).

Activity:

Assuming the Characteristics of a Good Supervisor (Based on What's Important to my Staff) – create a checklist of the characteristics in the area to the right.

Ask peer staff to choose the top 5 most important characteristics. Incorporate a "How Am I Doing" rating in your supervision sessions, so that peer staff rate how well you're supervising as a regular basis as part of a co-supervision process. If they want to be anonymous, ask other members of the staff and your own supervisor or manager to provide the How You're Doing rating every month (or more frequently, if you're open to more feedback). If you're getting top ratings in those first five, move on to five more. Keep working toward incorporating those desirable characteristics in your practice of supervision.

Exercise

Create a checklist of the characteristics of a good supervisor here:

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LEARNING 4

Models of Supervision and How Supervision Is Performed

There is not a lot of consensuses about supervision and how it is performed. As a refresher let us review some differences between what you might have been taught as clinical supervision and what a Peer Support Specialist might expect from peer supervision.

Clinical supervision versus Peer Supervision

CLINICAL SUPERVISION	PEER SUPPORT SUPERVISION
About educating a junior member of a profession to meet the standards to be competent in that practice	Mutuality and self-help are the values and practice of the profession
Focus primarily on education and support	Focuses on education, support, and advocacy
Administrative functions such as following policies and procedures	Administrative functions such as following policies and procedures
Part of a professional developmental model	Employs an apprenticeship model

The Five Critical Functions of Supervision Model developed by Dr. Jonathan P. Edwards (2016) provides a framework that highlights some of the nuances that address the unique concerns of peer support workers

Grid with the Five Critical Functions of Supervision (Jonathan Edwards)

ADMINISTRATE	SUPPORT	EDUCATE	ADVOCATE	EVALUATE
Hire peer supporters who meet job qualifications	Build rapport by providing constructive feedback	Offer relevant training and conference attendance opportunities	Build good morale and a respectful work environment	Conduct performance evaluations in the same manner as any other staff
Orient peer supporters to organizational structure	Utilize a strengths-based approach to help a peer supporter problem-solve	Coach peer supporters on engaging service recipients	Strengthen the discipline of peer support	Manage expectations with respect to job performance
Help peer supporters understand practices, policies, and procedures	Promote wellness and self-care	Explain the big picture, put their work in perspective and provide context	Negotiate reasonable work accommodations	Address areas needing improvement; progressive discipline

Exercise:

Compare the functions in this model to your own experience in supervision? Select two functions from the model to your supervision practice, and note what differs from your own experience, and what is the same.

There is not a universally accepted model of supervision and often what is said anecdotally by supervisors is that their supervisory practice is modelled after their own experience in being supervised. For Peer Support Specialists, the issue of supervision has been given a lot of attention. As a new profession there has not been a history of experienced peer supervisors to draw upon. Additionally, the CMS guidance of 2007 suggesting that Peer Support Specialists be supervised by competent mental health professionals was largely interpreted to mean licensed professionals. As a result, many peer supervisors (social workers, psychologists, nurses, mental health counselors) found themselves supervising someone from an entirely different profession (peer support). Recent research suggests that Peer Support Specialists want to be supervised by a more experienced Peer Support Specialist-by someone who has actually done the work (Forbes, et al, 2022). One way many organizations have accomplished this is dual supervision, i.e. having an experienced peer specialist as a supervisor as well as a clinician.

The peer community and its allies have continued to make recommendations to improve peer supervision. SAMHSA's Supervision of Peer Workers (2018) can be found here and is a handy resource. Here are a couple of examples of the content:

Supervisors Have a Recovery Orientation and Model Recovery-Oriented Practices

- Supervisors endorse and enact recovery-oriented practices and values
- Supervisors believe in the capacity of peer workers to grow and develop professionally
- Supervisors frame difficulties as learning opportunities and structure learning opportunities to help the worker grow
- Supervisors support the development of individualized professional goals
- Supervisors support the integration of peer workers and recovery values (SAMHSA's Supervision of Peer Workers (2018) p 18.

Supervisors Use Strengths-based Supervision

- Strengths-based supervision is a collaborative process between the worker and supervisor enabling them to deliver quality services and supports that draws on the person's strengths and assets
- Seek to discover and amplify the workers' strengths and competencies
- Intentionally identify and amplify the workers' success
- Encourage learning and share responsibility for setting learning goals Focusing on strengths does not mean ignoring problems, but rather means that the supervision frames problems as learning opportunities
- Feedback and self-assessment are tools in strengths-based supervision (SAMHSA's Supervision of Peer Workers (2018) pp 22-23.

Exercise:

Pick one recommendation from the Supervision of Peer Workers or from the content examples above and add it to your practice. Which one did you choose? How come?

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There is a need for supervisors to be aware of the necessity of employing trauma informed supervisory techniques. Supervisors need to be aware of the toll PSS work takes on them due to their constant use of self and their often-deep sharing of lived experiences when working with other peers.

Trauma sensitive supervision includes encouraging self-care, recognizing compassion fatigue or moral injury, and preventing re-traumatization. A good practice is to include regular training with all team members to empower them to personally recognize signs and symptoms of compassion fatigue, etc. as well.

One of the components of trauma sensitive care for all supervisees is recognizing that the need for self-care is universal.

Those employed in behavioral health systems of care benefit from a workplace emphasis that freely encourages and even incorporates self-care. In fact, Lori Ashcraft (2007) suggests that 1 in 4 providers have lived experience, even if this is not widely discussed. It does support the wisdom that all workplaces benefit from an emphasis on self-care and wellness.

Most PSS welcome a supervisor's concern about them as a whole person. Questions from supervisor about their well-being is often expected and interpreted as recognition that their needs for support on the job may be different from non-peer colleagues. Supervisors who communicate sensitivity without judgement and stigma are well received.

Exercise:

What is your organizations stance on self-care? How is it communicated?
What would you like to see in place?

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For example, does your organization offer periodic trainings on wellness habits?
Do they offer a discount to a local gym? Is self-care clearly targeted at all levels of staff?

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"And peer support supervisors should understand that we, as peer supports have got our own problems That's why we're here. So, we have a unique set of circumstances that all other employees don't have. So, we, we need somebody that is compassionate and understanding. Somebody we can trust (R021 White male, PSS6-9 yrs., satisfied, high school degree)" (Forbes, et al., 2022).

The second component of trauma sensitive supervision for PSS is recognizing compassion fatigue and the possibility of experiences of moral injury.

Compassion fatigue may occur quickly in PSS, as a result of their own status and identification with the people they serve. Supervision can be very helpful when compassion fatigue is recognized early. Be mindful and recognize that diagnostic overshadowing can happen when we look at a person's diagnosis and behavior as symptoms rather than realizing that vicarious/secondary trauma can also trigger what would appear to be symptoms. Symptoms of compassion fatigue include work behaviors like irritability, apathy, loss of motivation, fatigue, feeling overwhelmed, loss of interest in things one enjoys. Sometimes these signs look like bad work behaviors but they may be signs of burnout or compassion fatigue.

Possible solution: Support and frequent debriefings can be helpful. An offer to provide regular opportunities to talk through stressful or traumatic experiences can lessen their impact.

Exercise:

Think about your own professional work. How do you avoid burn out or compassion fatigue? What do you wish was available to you? Name two strategies that help you avoid burnout or compassion fatigue. What could your agency offer as well?

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"That supervision time and being able to have that good discussion is important. It's crucial because I think I would find myself getting into that empathy burnout. Because I would still think about them (clients), I would still go, Hmm, I wonder how they're doing? Or I wonder how this situation was or how that turned out. And I don't think I'd ever be able to shut that off, if I didn't have that supervision piece of that, to have someone to talk through it would affect me very negatively in that that I would just never let those things go. I would constantly be in that cycle of thinking about it and then I would burn myself out (T004 Indian female, PSS 3-6 yrs., very satisfied, High school)" (Forbes, et al., 2022).

Moral injury is an experience associated with peer work reported by Peer Support Specialists.

It may occur when PSS are witnessing situations that were unacceptable to them as peers; situations where they felt anger and helpless to intervene on behalf of a service user. The idea of moral injury is often associated with military service but as health care and behavioral health care has encountered extreme demands it is a concept that is just being recognized as applicable outside the battlefield (Dean, Talbot, & Dean, 2019).

Exercise:

What do you know about moral injury? Have you witnessed or participated in activities that are in conflict with your moral beliefs? Express your understanding of the term "moral injury. What activities have you participated in that are in conflict with your moral beliefs? Who do you think should set the standard of morality with regard to peer-informed interventions?

"I think it's especially harder for somebody that has their own mental health struggles, and I think making sure that when there is like a crises or secondary trauma or something going on…making sure that that support from the supervisor is available. I think that is really, really crucial. There was times that I felt like, okay, I'm doing something like kicking someone outside at five o'clock because we're closing the doors and they're homeless and have nowhere to go but I can't let them stay here and I have to sit there and kick them out the door and close the door. And now what do I do with that? Yeah, that was extremely hard and I had nowhere to go with that (J046 White female, PSS 3-6 years, moderately satisfied, Bachelor's degree)" (Forbes, et al., 2022).

The third component of trauma sensitive supervision is prevention of re-traumatization.

There is a need to recognize situations that may be retraumatizing for PSS. Often participants encounter situations on the job that remind them of traumatizing situations they experienced as a service user, for example like team discussions about involuntary hospitalizations which may trigger a painful memory. PSS can be retraumatized during the normal course of their work, but it is also important to recall that triggers are very individual and not always recognized by the person experiencing re-traumatization.

"I remember…this is my supervisor…. He is very, very supportive and going through that … listen to me, let me go through the things that I was going through and the feelings that it caused cuz …I got some PTSD from the past and stuff. And it kind of flared that up a little bit …he just talked me through it and …I mean he's not a peer supervisor… just feel overwhelmed or whatever, having a safe place to be able to go talk... let some stuff out in a safe environment.…just so that I can continue to do my job and stuff through these situations (D017 Pacific Islander male, PSS 1-5 years, very satisfied, Bachelor's degree)" (Forbes, et al., 2022).

"We're going into situations where we could be triggered. And I think the clinicians are trying to be… I see that … the majority of them are trying to be sensitive to that and at the same time, if they do not have their own lived experience, they don't understand that. They're coming from their clinical experience and they actually have a much more protected environment, working with individuals than we do, where they have you know a controlled environment in their clinical office. They have certain guidelines and frameworks that they have to work within and around. They have their own set of rules as do we, however, ours is just more open to, so to speak, where we go into individual homes. We're working with them in the community, we're faced in different physical environments that could put us at risk to the way that people act, so we see things more, we are exposed to more and we're already a high-risk vulnerable population so that needs to be addressed. When we are inevitably faced with something that could be triggering to us- we have the understanding and support of our supervisors that know what we are facing, know who we are as individuals and what our triggers are and how they can be supportive to us and what we need to navigate those potentially hot crisis and dangerous situations (C044 White female, PSS 1-5 years, dissatisfied, Associates degree)" (Forbes, et al., 2022).

Exercise:

Most professions have been educated about the impact of trauma on the populations they work with. Sometimes it is difficult to think about the work as a source of trauma. What are your thoughts and experiences with trauma on and off the job? Has work you have done been a source of re-traumatization? If so, what have you done to cope or self-soothe as a response?

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In summary:

The Top Supervisory Best Practices for Peer Supervision include:

- Provide a clear functional job description.
- Prepare the way (organizational readiness).
- Treat a Peer Specialist like any other employee.
- Be familiar with your agency's Human Resources policies, and refer the Peer Specialist to HR when appropriate.
- Provide regular, scheduled, and formal supervision.
- Focus supervision on job performance and support.
- Explain the big picture.
- Promote professional development.
- Break the glass ceiling!
- Ask for and be open to feedback.
- Be trauma sensitive!

A good Supervisor:

- Informs and prepares non-peer staff
- Explains the peer role and job functions
- Advises peers on program values and philosophy
- Promotes supervisee's development
- Offers tools, skills, and knowledge

LEARNING 5

Supporting Fidelity to Peer Support Values in Supervision

One of the challenges in peer support supervision is supporting the values that distinguish peer support services from those of other professions and assisting the Peer Support Specialist to maintain those values. Although there is significant overlap with the values espoused by other behavioral health professions, there are foundational values that are different.

As a review, here is the list of values central to the practice of peer support:

Peer support is voluntary	Peer supporters are honest and direct
Peer supporters are hopeful	Peer support is mutual and reciprocal
Peer supporters are open minded	Peer support is equally shared power
Peer supporters are empathetic	Peer support is strengths focused
Peer supporters are respectful	Peer support is transparent
Peer supporters facilitate change	Peer support is person-driven

Source: National Practice Guidelines for Peer Supporters, Washington, DC, National Association of Peer Supporters, 2013.
https://www.peersupportworks.org/wp-content/uploads/2021/02/nationalguidelines_updated.pdf

Exercise:

Which three values might differ from those of your profession?

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The National Association of Peer Supporters published guidelines that assist both Peer Support Specialists and their supervisors reflect upon these peer values in their work. Access to the guidelines can be found at: https://www.peersupportworks.org/wp-content/uploads/2021/07/National-Practice-Guidelines-for-Peer-Specialists-and-Supervisors-1.pdf.

Here are some examples of what you will find there:

Example 1-

Core Value: Peer Support Is Mutual and Reciprocal

In a peer support relationship, each person gives and receives in a fluid, constantly changing manner. This is very different from what most people experience in treatment programs, where people are seen as needing help and staff is seen as providing that help. In peer support relationships, each person has things to teach and learn. This is true whether you are a paid or volunteer peer supporter. It is the responsibility of the supervisor to be fully educated on PSS boundaries and their differences in comparison to clinical boundaries.

Clinical supervision versus Peer Supervision

IN PRACTICE: ENCOURAGE PEERS TO GIVE & RECEIVE	SUPERVISOR GUIDELINES
Peer supporters learn from those they support and those supported learn from peer supporters	The supervisor role is to: Ask peer support specialists how they best receive feedback and direction.
Peer supporters encourage peers to fulfill a fundamental human need — to be able to give as well as receive	Encourage co-learning (collaborative learning) and welcome Peer Support Specialists' input in decision-making wherever possible
Peer supporters respect and honor a relationship with peers that evokes power-sharing and mutuality, wherever possible	Welcome feedback from Peer Support Specialists during supervision sessions to develop supervisory relationships based on mutuality.

Example 2:

Core Value: Peer Support Is Equally Shared Power

By definition, peers are equal. Sharing power in a peer support relationship means equal opportunity for each person to express ideas and opinions, offer choices and contribute. Each person speaks and listens to what is said. Abuse of power is avoided when peer support is a true collaboration. A full and respected seat at the team table supports this area of practice. Be mindful that this practice is important but may increase the possibility of peer drift which is defined as when peers move away from their core values. It is important to understand that peer supporters may be alone on a team. As a member in the minority, there is a natural impulse to want to join the majority culture by imitating perspectives, language, and values (Jackson, Thoits, & Taylor, 1995). This is what leads to peer drift.

IN PRACTICE: EMBODY EMPATHY	THE SUPERVISOR'S ROLE IS TO:
Peer supporters use language that reflects a mutual relationship with those they support	Educate Peer Support Specialists on the concept of power and the potential for inadvertently reinforcing power differentials in the peer support relationship
Peer supporters behave in ways that reflect respect and mutuality with those they support.	Reinforce the non-clinical nature of the peer support role with Peer Support Specialists and other organizational colleagues to avoid 'peer drift' or co-optation, and role ambiguity.
Peer supporters do not express or exercise power over those they support.	Consider how power in relationships, including the relationship between the supervisor and Peer Support Specialist, affects those with histories of trauma, to create a safe work environment.
Peer supporters do not diagnose or offer medical services but do offer a complimentary service.	Support Peer Support Specialist values and scope of non-clinical practice, especially in situations in which the Peer Support Specialist is called upon to endorse or enforce a form of treatment or clinical practice

Exercise:

Choose one of the supervisor guidelines listed above and script a short role play describing how you would respond using both the peer and supervisor roles. Name any barriers you anticipate either personally or organizationally that would make you hesitate to use the guideline?

Mutual learning or co-learning

One way to approach supervision with someone whose job functions and scope are different is to think of it as mutual learning or co-learning.

From this perspective both individuals can learn from one another. The skills needed to accomplish this are simple: an open mind, an open heart and humility. It means setting aside the power hierarchy in favor of building a mutually beneficial relationship. Frequently, organizations create a culture of meritocracy which makes it difficult to admit ignorance or express curiosity. It can take a special kind of courage to set that aside and admit to oneself and others what we do not know.

Exercise:

Describe a time you've been curious and open with a colleague. If you are a non-peer supervising a peer, name something you want to learn about what they do? What question might you ask?

Co-supervision as an alternative model of supervision

The guidance from CMS in 2007 that suggested peer support workers be supervised by mental health professionals as determined by each state was probably well intentioned but misguided advice. The result has been that peer support workers have been most often supervised by licensed mental health professionals or clinicians.

As noted elsewhere, clinicians may have the same recovery goal in mind as a peer supporter, but they are trained in different approaches and perspectives. These differences can often result in conflict and communication difficulties. Supervising someone in a job you have never done yourself is very challenging.

An alternative to this situation can be crafted by using a co-supervision (sometimes called dual supervision) model. Co-supervision is understood as guidance by more than one person, especially the addition of one who has expertise in peer support to the supervisory team. It means that the functions of supervision can be shared, with one more experienced peer supervisor focusing on supportive, educative, evaluative, and advocacy functions of supervision. The non-peer supervisor can then focus on oversight and the other on administrative functions. There are many advantages to this model: peer supporters receive supervision from someone experienced in doing peer support work; role clarity is upheld; and peer drift is less likely. In situations where peer support is being newly introduced into an organization, there may not be a more experienced peer support worker. However, this co-supervision model allows the organization to recruit a more experienced peer worker either through a partner organization, or from another part of the same organization.

There are many benefits to this arrangement, but there are also some challenges. Some agencies lack the resources to offer co-supervision but may create a partnership with a local peer run organization to address the need. There may be challenges in communication or disagreements between the co-supervisors. Co-supervisors may not share the same expectations of supportive relationships for example or may interpret boundaries differently. Whatever the challenges, having an alternative for providing effective peer supervision is always worth considering.

Adapted from (Bureau of Justice https://www.cossup.org/Content/Documents/Publications/Altarum_Supporting_and_Managing_Peer_Specialists.pdf).

Appendix 1: The Recovery Context

Peer support is most successful when it is provided in an organization or environment that is recovery-oriented. It is widely accepted that peer support is a critical element of a recovery-oriented system of care. (Anthony, 1993; Deegan, 1988; Drake & Whitley, 2014; Lunt, 2002; President's New Freedom Commission, 2003; Ralph, 2000, Slade, 2009; Watts & Higgins, 2016)

According to William Anthony (1993)" Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness".

Exercise:

Do you agree or disagree with these statements? Spend a few moments considering why they may be true or false and if you like, jot down your thoughts here

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_____

_____

Exercise:

How do you define recovery?

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The Clinician's Illusion is a form of bias error in which a person who works with a troubled or unhealthy population develops a distorted perception of a phenomenon based on the cases they deal with (Cohen & Cohen, 1984; Jackson, 2006). Frequently it is the bias that makes it difficult to believe that recovery from mental illness is possible. An example of this might be a psychiatrist making a judgment about a peer based on the doctor's limited experience on a locked inpatient psychiatric unit. It could be said that this illusion is the foundation of many of the myths that clinicians consider facts about persons with mental health challenges. Look back at **page 11** to review the myths.

Sometimes a supervisor can treat peer supporters disrespectfully or in stigmatizing ways based on their bias and that affects peer support performance.

Exercise:

Can you think of a time when you may have made a judgment about a peer using diagnostic approaches instead of mutual experience?

Understanding Recovery

"What is recovery?" SAMHSA developed the following working definition of recovery by engaging key stakeholders in the mental health consumer and substance use disorder recovery communities:

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Throughout the competencies, the term "recovery" refers to this definition. This definition does not describe recovery as an end state, but rather as a process. Complete symptom remission is neither a prerequisite of recovery nor a necessary outcome of the process. According to the SAMHSA Working Definition of Recovery, recovery can have many pathways that may include "professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches."

SAMHSA has identified four major dimensions that support a life in recovery:
(SAMHSA, 2010 https://store.samhsa.gov/sites/default/files/pep12-recdef.pdf)

1. **Health:** Learning to overcome, manage or more successfully live with symptoms and make healthy choices that support one's physical and emotional wellbeing;
2. **Home:** A stable and safe place to live;
3. **Purpose:** Meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; increased ability to lead a self-directed life; and meaningful engagement in society;
4. **Community:** Relationships and social networks that provide support, friendship, love, and hope.

Peer Support Specialists help people in all of these domains.

Take time to review the 10 Guiding Principles of Recovery to better understand the work of peer specialists. The National Practice Guidelines for Peer Supporters begin with and build upon these 10 Guiding Principles. Review them in the SAMHSA brochure at this link: https://store.samhsa.gov/sites/default/files/pep12-recdef.pdf.

Exercise:

Please see SAMHSA's Recovery Support Initiative (http://www.samhsa.gov/recovery) for more information on recovery. List three resources you might take advantage of here

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_____

Medical Models and Recovery-Oriented Approaches

Peer Support Specialists are integrating into a mental health service system that is in transition from a medical model to a recovery-oriented model of care. PSSs are the embodiment of recovery. The mental health recovery paradigm has become a significant philosophical influence on the delivery of mental health services; however, the use of the term recovery has varied widely. As the possibility of recovery was introduced into mental health systems through the writings of proponents and through documents such as the President's New Freedom Commission Report (2003), mental health service providers slowly began to incorporate the language and tools of recovery into mental health settings.

The term recovery is used differently in different settings. For some mental health practitioners, the term may refer to expected clinical outcomes, or for other practitioners, it may refer to a philosophy or attitude that casts doubt about viewing all serious mental illness as a chronic condition (Anthony, 1993; Deegan, 1988; Harding, Brooks, Ashikaga, Strauss, & Brieier, 1987; Forbes, Pratt, & Cronise, 2022). What is important for both supervisors and supervisees is to have a clear idea of how far along the organization for which they work is on the journey to a recovery orientation. There are scales and questionnaires available to help determine this (Armstrong & Steffen, 2009).

Exercise:

Go to https://medicine.yale.edu/psychiatry/prch/tools/rsa_provider_204210_284_23933_v1.pdf

Take the assessment scale.

In 1987, Courtenay Harding and other researchers presented over 30 years of accumulated evidence supporting the recovery of most people with even the most severe mental illnesses. This research was foundational to changing the paradigm from custodial care to recovery-oriented practice. RECOVERY IS POSSIBLE was a new but important paradigm shift for the mental health community (Harding, et al., 1987a, 1987b).

It is important to reflect on these distinctions as the different perspectives may cause miscommunication between those who model and believe in recovery and those who have a different perspective.

Exercise:

Briefly write an answer to this question:
How do you define recovery?

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Is that definition true for all of the people you supervise or support? (If not, how might it be different for them?)

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A lot of friction and confusion can occur because people are using the same word to mean different things. In the Medical Model, recovery=cure; in the substance use field, recovery=abstinence (or at least it did before harm reduction became popular); for the consumer/survivors' recovery=missing the point - the point was restoring human rights and dignity. In mental health, recovery (SAMHSA, 2014) is defined as: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" .

Medical Model: What does this mean?

The Medical Model focuses on:

- Symptoms
- Diagnosis
- What's "wrong"

As described by Dr. Duckworth in the NAMI newsletter (2015), "The medical model relies on science—such as a correct biological diagnosis and research. Diagnosis is rooted in pathology—i.e., what is wrong—in order to develop ways to help either cure or reduce symptoms... the medical model has been criticized for being too deficit-oriented and physician-defined. The medical model can also ignore a person's strengths and thereby turn people off by being too pathology-based." https://www.nami.org/treatment/science-meets-the-human-experience-integrating-the-medical-and-recovery-models/.

Exercise:

What are three benefits of the medical model orientation? Jot them down here.

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What is the alternative?

For a very long time, there was a belief in mental health systems of care that people with a serious diagnosis of mental illness could not recover and would need care in institutions forever. However, research by Harding, et al., (1987) found that people with a diagnosis of mental illness can and do recover. In fact, Harding's research showed a high rate of recovery without medication or additional treatment. (Harding, et al., (1987). Dr. William Anthony (1993) brought the idea of recovery into the mainstream of mental health services. Since that time, there has been the expectation that a recovery orientation is part of modern mental health services. Peer Support Specialists model recovery and provide hope for others in their journey.

Exercise:

Take a moment to think about the idea of recovery. Is this an idea you are familiar with? How does it affect your professional practice? If you already have a recovery-oriented approach, name one thing that you do differently from the traditional medical model.

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Recovery orientation

Examples of Recovery-oriented values in practice:

- Hope-inspiring the growth potential in all
- Person-centered-based on the individual's aspirations
- Strength-based-focused on the unique gifts of each worker
- Personal responsibility-holding people accountable for their commitments
- Interdependence-a balance between teamwork, autonomy, and mutual support

(SAMHSA, n.d.)

Exercise:

What are some barriers and challenges to adopting this view? Name one thing you believe to be a barrier to adopting a recovery-oriented practice?

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- Supervisors model these values in their work
- Agencies operationalize these values in their policies, procedures, and practices

Recovery beliefs versus non-recovery beliefs

When Peer Support Specialists become part of a multi-professional team, they are often in meetings with non-peer professionals, supervisors/directors, and it is easy to lose the peer values that support recovery. As a new or minority team member, it can be especially difficult to speak up when asked to perform tasks at odds with peer values. An example that is frequently heard is when Peer Support Specialists are asked to enforce medication compliance. This violates the core value of voluntary/choice: peer specialists do not force or coerce the people they support. When peers move away from their core values it is referred to as peer drift. The desire to fit in and be accepted by the dominant culture is a natural phenomenon for humans who are social beings. Supervisors can be aware of this and assist peers to stay true to their values.

NON-RECOVERY BELIEFS	RECOVERY BELIEFS
Stability/maintenance is the goal	Recovery is the goal
Low expectations	Lots of hope: high expectations
No clearly defined exit	Clear exits and graduates return/share
People are judged by level of motivation.	Restoring hope creates new energy
Provider creates the plan for the new person	Each person creates their own plan
Compliance is valued	Choice and independence are valued
Coercion used to achieve compliance	Empowerment: people are the experts
Provider directs the services	Each person chooses their services
People protected from trial/error learning	People encouraged to take risks
One-size fits all treatment approach	Wide range of options
Little or no access to information	Education; easy access to information
People live in “treatment centers”	People choose their own housing
Employment is too stressful	Everyone can have a meaningful career
Medication is the primary tool	Medication is one of several tools
Emphasis is on treatment	Peer support and self-help are essential

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Supervisors are well positioned to support a certified peer specialist's efforts to maintain peer values that support recovery. It is often helpful to keep a poster of peer values and recovery values on display. It is also important to remain aware of the pressure CPS may feel to join the dominant (non-peer) culture. Resistance to doing things differently is an expected aspect of system change. Peer Support Specialists bring a different perspective to the discussion. Allow time in supervision for the peer specialist to explore the pressures, both subtle and overt, they are experiencing. Remember that peer supporters model recovery for others. Each person's journey of recovery is unique, however peer supporters on the team show that it is possible.

Exercise:

Review non-recovery beliefs versus recovery beliefs: Identify two beliefs that may be part of your workplace culture. How would you support a peer support worker's action that is contrary to those beliefs?

Appendix 2: Understanding Organizational Challenges

Appendix 1 described how Peer Support Specialists (PSS) are are integrating into a mental health service system that is transitioning from a medical model to a recovery-oriented model of care. PSSs are the embodiment of recovery. Your organization is likely somewhere on the journey from medical model to a recovery orientation. The experiences of PSS reflect the challenges inherent in role innovation. Supervisors are the necessary guides who assist the PSS in navigating a system not yet aligned with peer values. If the mental health system is going to successfully become recovery oriented, then supervisors need a unique skill set to support those with lived experience whose recovery can help point the way. Rosa Parks, Thomas Edison, Wilber and Orville Wright, Steve Jobs, and Elon Musk for example are innovators in their own arena.

Exercise:

Think broadly about role innovators. Who comes to mind? If you know someone who challenged the status quo, name them here.

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Role Innovation

"Multiple issues arise from the perceived differences between peer values and values espoused by mental health professionals reflected in provider responsibility. Providers are responsible ethically and legally to provide care within the standards and expectations of their specific profession (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). It is the expertise granted through formal education in a particular profession that provides the foundation for this responsibility. Peers, on the other hand, use their lived experience as a person diagnosed with mental illness within a mental health system of care. Providers are held to certain standards or expectations of care. Although the active ingredients of peer support have received attention in the literature, the question of how peer-led interventions successfully interact with provider-led interventions remains underexplored (Davidson & White, 2007; Hodges & Hardiman, 2006; Lammers & Happwell, 2003; Mahlke, Kramer, Becker, & Bock, 2014; Stewart, Watson, Montague, & Stevenson, 2008)

Here's what one Peer Support Specialist said about the burden of role innovation:

"But their understanding of the peer support role should never fall solely on the shoulders of us… because that's going to be what is happening 90% of time and it's almost devastating, it's really disheartening to us that... we're put in a position where then we have to explain or prove our worth to individuals who are supposed to be supporting us. And it almost feels like they're questioning us in ways that (they) shouldn't like we shouldn't have to do that (prove our worth) at all. It feels divisive … (C044 White female, PSS 1-5 yrs., dissatisfied, Associates' degree) (Forbes, et al. 2022).

While not always possible, the literature suggests that certain ingredients such as full support by administration, a recovery orientation and job clarity are necessary for such integration (Ashcraft & Anthony, 2006; Ashcraft & Anthony, 2009; Chinman, Young, Hassell, & Davidson, 2006; Davis, 2013; Deckert & Statz-Hill, 2017; Hamilton, Chinman, Cohen, Oberman, & Young, 2015). There are tools available to assess organization readiness as well as the level of recovery orientation. The Organization Assessment Tool can be found here: https://www.thenationalcouncil.org/wp-content/uploads/2022/03/110620_CCBHC_Self-Assessment_Guide.pdf. The Provider Recovery Assessment tool can be found here: https://medicine.yale.edu/psychiatry/prch/tools/rsa_provider_204210_284_23933_v1.pdf.

Exercise:

What does it mean to have support by administration? Why is that important?

Does support for peer support services get expressed where you work?
What would you find helpful from your administration in this regard?

Supervisors of Peer Support Specialists (PSS) should be aware of the potential issues that may arise in supervision that reflect policies, procedures, and cultural norms of the organization. Agency administration can provide solutions to some of the challenges, but these would likely require identification and advocacy by the supervisor. Many of the challenges are a result of the practice guidelines which direct the work of PSS and are different from guidelines belonging to most professional disciplines. These barriers and challenges have received a lot of attention in the literature on peer support. A brief review of the barriers most often cited as able to be addressed by supervision are:

Job/role clarity and role integration

Since role clarity presents a substantial challenge to successful integration of peers into mental health settings, it is possible that miscommunication between a peer worker and a non-peer supervisor could have unintended consequences.

For example, PSS supervised by non-peer supervisors might produce peers functioning like non-peer support workers, essentially abdicating their intended role. If we accept a general tenet of supervision, that supervision has the purpose of enhancing professional functioning of the more junior person within their particular practice domain, then perhaps a peer worker supervised by a peer supervisor might best produce peers as PSS (Forbes, et al., 2022).

Here is how one PSS expressed frustration about being accepted as part of the team:

"It's (lack of acceptance) a consequence of us trying to fit into medical models that are... antithetical to how peer support actually operates because a lot of it (peer support) is based on self-help and the actual patients' rights movements of olden times, and even the anti-psychiatry movement ...we push the envelope- we push people's buttons... this makes it difficult for us to be able to integrate ourselves into models that are trying to support us but ultimately can't move beyond how they view the world (L061 White other, PSS 1-3 yrs., very satisfied, bachelor's degree)" (Forbes, et al., 2022).

Exercise:

If your supervisee said this to you in supervision, what might you say?

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Possible solution:
It has been found helpful when supervisors are advocates and translators of this new role to other members of the mental health team. If role clarity is an issue, how does one go about constructing role clarity? Many PSS report either a lack of a formal job description, or a job description different from how they perceived their roles; or different from what they learned in peer certification training.

Exercise:

Have you seen the job description which either advertised for the PSS or was given to the PSS during on-boarding by Human Resources? Set up a time to review what you have found with the PSS. What was that like?

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Here is what one PSS said:

"We need to have clearly defined roles …the supervisor should be someone who is very familiar with what the role entails and then someone who can speak to other therapists who are concerned that because we have mental health challenges ourselves that we might damage people. My supervisor really is championing us and is somebody who can help us with our…difficulties that we have with each other, with other staff, help us navigate (S041 white female, PSS 1-3 yrs., moderately satisfied, Associates degree") (Forbes, et al., 2022)

However, if a supervisor is unaware of the PSS job description, or unable to navigate the role confusion along with the PSS, the experience might be summarized this way:

"And it can really make your life miserable as a peer counselor if… you're very new and the person can't tell you anything about your job, because they know nothing about it, or that you actually know your job really well and they won't get out of the way to let you do the job… It's maddening (J049 Asian female, PSS 1-3 yrs., dissatisfied, Master's degree)" (Forbes, et al., 2022).

Possible solution:
The supervisor's assistance with a lack of role clarity is important. It is clearly preferable when the supervisor is already familiar with, and supportive of the PSS role. There are many ways to accomplish this: learn all you can about peer support practice: review and refine the existing job description with the PSS; set up opportunities for the PSS to explain their role to other team members. Advocate for the supervisor to be the one that writes the job description (or works with HR) or, if they are a non-peer, works with an experienced peer to write and verify the accuracy of the peer roles and responsibilities. There are resources to help with clarification. For example, review the NYS Peer Specialist Certification Board Scope of Activities. It is what every CPS agrees to when they apply to be a CPS. It can be found on page 2 of the application to be a CPS: https://nypscb.org/ Or/and take a look at the Academy of Peer Services website https://www.academyofpeerservices.org/ to learn more about the roles of PSS.

PSS empowered by the supervisor to discuss areas of conflict or confusion reported positive experiences:

"And that's what I'm finding what our supervision is—that when I come back with an issue that might conflict with what we do as peer and things get blurred sometimes with a peer doing one thing and you all want us to do something else. And that's not our role. I'm happy… that even though my supervisor is not a peer… she's open and she's willing to listen to what we bring to the table and that's been awesome experience so far (G023 Black female, PSS 1-5 yrs., very satisfied, Bachelor's degree)".
(Forbes, et al., 2022)

For example, attendance at team meetings allows PSS to understand the full context in which their work occurs. PSS stated such an understanding gave them a chance to adapt how they prioritized information, for example, which in turn presented their role in ways that built understanding between PSS and licensed professionals. It also gave PSS an opportunity to explain their roles in a manner helpful to their respective team.

Here's what one PSS said about interacting with other team members at team meetings:

"It's interesting. The difference in thinking, … I think that's really one of our opportunities to shine with difficult patients because we're able to flex that creativity that helps make us solution oriented and yeah, sometimes it's just perspective, having somebody else's sight on stuff but being there (team meetings) and getting to hear the way that those professionals are interacting was an incredible take-away for me…The other side of that and knowing having a glimpse of their world, I think has helped … me (be) more effective in encounters with them. So…if I present a case… I could do it in a way that leads with the stuff they're interested in hearing… what they need out of it and it makes them a lot more receptive to the things that I want them to know about the person (J039 White male, PSS 5-10 yrs., moderately satisfied, Bachelor's degree)".
(Forbes, et al., 2022)

One area of practice differences can create a lack of role clarity and confusion. The challenge of maintaining practice boundaries comes about from the confusion about addressing relationship boundaries cited in agency policies. Very often such policies reflect a different stance to interaction with service users than those with which PSS are familiar. Recall that important peer values are those of transparency and mutuality.

Exercise:

What guidelines does your organization have about boundaries with other staff? Write a role-play of a discussion with the Peer Support Specialist about the intersection of peer values and organizational policies?

"But our supervisor is a non- peer, but they're open to suggestions. They listen to anything that … the peers have to say, and will work on it, whatever… we need and are very open… they ask me for my advice. They …truly accept things that I can say (M028 White female, PSS over 10 years, very satisfied, bachelor's degree)" (Forbes, et al., 2022).

The supervisor was an important partner for the PSS as the difference in practice boundaries were negotiated

"Just kind of being more aware of the struggles and, you know, making sure that the supervisor understands what a peer support does in the field. Um, how difficult, it can be holding boundaries. Being understanding of that where we want to reach out and help you know these clients that we're working with in in a variety of different ways, but understanding, you know, that is where we come from (R037 White female, PSS 6-9 yrs., very satisfied, High school degree)" (Forbes, et al., 2022).

"Everybody needs supervision doing this type of work to make sure…, because sometimes I might want to go do something that's kind of on the edge. Maybe I shouldn't give out my phone number to people, which I do occasionally, but I don't do, generally as a rule (D017, Pacific Islander male, PSS 1-5 yrs., very satisfied, Bachelor's degree)" (Forbes, et al., 2022).

Staff Attitudes

Professional staff attitudes towards Peer Support Specialists are often cited as a barrier and challenge and therefore the supervisor's attitude is an important factor in supervision.
(Gates, Mandiberg & Akabas, 2010; Happell, 2008; Vandewalle et al., 2016)

A supervisor's attitude can be experienced in either a positive or negative way. Generally, if the supervisor is welcoming, open-minded and able to listen, the supervisor attitude is perceived as positive. If the supervisor is unable to listen, stigmatizing and patronizing, then the supervisor's attitude is often perceived as negative. PSS who experiences a supervisor's attitude as positive, reported feeling supported and could thrive. Negative staff attitudes are often expressed through discrimination or stigmatizing behaviors often called microaggressions. E. Washington (2022) suggests these" may occur in situations at work when someone says or does something that feels hostile or offensive to some aspect of our identity — and the person doesn't even realize it. These kinds of actions — insensitive statements, questions, or assumptions — are called "microaggressions," and they can target many aspects of who we are. For example, they could be related to someone's race, gender, sexuality, parental status, socioeconomic background, mental health, or any other aspect of our identity". Inviting feedback from all members of the team is an essential part of modeling mutual practice and co-reflection.

Exercise:

Give an example of a microaggression you have encountered (either done by or experienced by you). Have you ever thought about your own bias? It takes courage to ask someone to give you feedback.

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Possible solutions:
There are several ways to demonstrate a positive attitude toward Peer Support Specialist team members. The first suggestion is to find ways to demonstrate respect for the peer role. Sometimes it helps to be curious about their perspective and value their input and seek their opinions.

"But our supervisor is a non-peer, but they're open to suggestions. They listen to anything that… the peers have to say, and will work on it, whatever… we need and are very open... they ask me for my advice. They… truly accept things that I can say (M028 White female, PSS over 10 years, very satisfied, bachelor's degree)" (Forbes, et al., 2022).

A respectful attitude can be reflected in a supervisory approach that enables the PSS to function autonomously. Allowing autonomous role functioning can demonstrate an attitude of respect and value for the peer contribution. Another approach can be to support the PSS as they create their role and functions within the team.

Exercise:

Name three changes that would allow the PSS to suggest ways to use their skills and talents to support participants the team is working with.

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"She's (supervisor) a clinician… she says to me,' you know I rely on you to know what you do and I'm gonna let you make those decisions, you know … educate me!' (G023 Black female, PSS 1-5 yrs., very satisfied, Bachelor's degree)"(Forbes, et al., 2022).

"She's giving me that freedom and I feel very heard by her, I wrote it (guidelines) and then gave it to her for approval, but she really studied all the different materials that I gave her about peer support and I found some guidelines online for supervising peer support and she read those. And she's given me a lot of freedom to develop a real peer support program (S041 White female, PSS 1 -3 years PSS, moderately satisfied, Associates degree)"(Forbes, et al., 2022).

"Since I'm pretty good at what I do, I was really given it (the freedom) to kind of make my own program, which I did and I really flourished under that kind of supervision… which was pretty much hands off. I'm given a lot of freedom here, a lot of trust. I guess you could say, and some in (the) beginning (was) so scary... it's an incredible amount of trust in me, being the expert (R021 White male, PSS 6-9 years, satisfied, High school degree)" (Forbes, et al., 2022).

Another possible solution involves the supervisor learning the PSS role by working alongside the PSS described this way:

"In my supervision, he (the supervisor said) …I'm kind of covering this (PSS) and …he was good at doing the supervision but he didn't know what we (PSS) did yet, and had to cover shifts, so during supervision, he kind of asked me … I'm going to kind of follow your lead and if you have any concerns, let me know. So that's …another reason why I say he was a good supervisor because he did ask my opinion right off the bat. And …tell me that he needed the help and so I felt really supported in that way. And I feel really supported on the team for that reason too (D017 Male Pacific Islander, PSS 1-5 yrs., very satisfied, Bachelor's degree"(Forbes, et al., 2022).

Under staff attitudes, there is another aspect to consider when you assess how your attitude is expressed. Communication skills that are non-judgmental, emphasizing trust, empathy. and availability are experienced as positive. Anyone who has been supervised understands that having supervision by an individual who sincerely listened was key to a successful relationship. The need to feel safe in supervision and have trust in the supervisor was frequently expressed:

"Somebody we can feel safe, talking to, if we are experiencing more symptoms or feel like the stress is getting to us…that's something that traditionally the folks I work with have been afraid to talk to their supervisor about because they feel like they're held to a higher standard and scrutiny, as far as like, you know, managing stress and all that kind of stuff. And relapses happen…so having a supervisor that understands that and is willing to work with you when you are experiencing more symptoms or just your stress levels getting too high (S041 White female, PSS 1 -3 years PSS, moderately satisfied, Associates degree)" (Forbes, et al., 2022).

Exercise:

List and reflect on possible unpleasant experiences PSS may have had in the mental health system.

Perceived Stigma

A final issue which is often more apparent to peers and not apparent sometimes to non-peers is perceived stigma. Most peers report feeling stigmatized on a continuum from subtle microaggressions within the team to supervisor attitudes that created fear and distrust:

"Some of those supervisors that I have had were threatened by my "peerness" and was shocked by my abilities… underestimating my capacity to learn and grow and evolve in the workplace. And some of them were just not very nice to me and I think there were times where I felt that I was still expecting to be treated with equality. And once people realized that I had a mental health diagnosis, I was treated with some derivative of stigma (M036 Black female, PSS over 10 yrs., very satisfied, high school degree)" (Forbes, et al., 2022).

Exercise:

Take a look at the webinar- Did They Say That? Yes They Did! Dealing with Microaggressions in Supervision by Jonathan Edwards, NYC Department of Health and Mental Hygiene, NYC, New York; Jessica Wolf, Yale Group on Workforce Development

Review Webinar Presentation Slides: https://shareselfhelp.org/wp-content/uploads/2023/07/Jonathan-Edwards-Did-They-Say-That_EdwardsWolf_Final_R_041323_Swap-13.pdf
Or Watch the Webinar Video: https://youtu.be/LFmuhYbxHX0?si=XDNCYUBKSQy5Yy60

Write your thoughts and reactions to the webinar.

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Possible solutions:
There are many opportunities for supervisors to pave the way in overcoming the barriers and challenges PSS may experience in an organization. There are ways to promote the professional development of PSS. Many PSS have a basic education and given the education-based remuneration in most organizations are therefore often not paid very well. Someone in a position of authority such as a supervisor could advocate on issues of low pay and lack of a career ladder.

A facilitative/supportive environment is important for everyone but may take on a different meaning when applied to peers. Many PSS have credited supervision for allowing them to grow personally and professionally. Through advocacy and ongoing support, the supervisor can create an environment that allows the PSS to gain confidence in themselves and their skills.

For some PSS, the PSS job is their first employment opportunity. The supervisor is essential in successful adaptation to agency policies and procedures. Lived experience or PSS training does not necessarily prepare a PSS for procedures such as, time and attendance policies, record keeping, or team goal-setting.

Exercise:

Are you aware of the salary range for Peer Support Specialists in your agency? What opportunities for advancement are available?

An opportunity to understand the clinical view of the work can give PSS exposure to multiple administrative policies and procedures or clinical perspectives that would not have been either a part of their lived experience or their peer certification training.

For example, challenges in creating billable hours, record keeping, and managing HIPAA may need extra attention by the supervisor. The supervisor can be important as a guide to the work setting's norms and culture and perhaps, more importantly, to the informal rules and regulations.

A facilitative supportive environment can also develop opportunities for PSS interaction. Many organizations hire either a single peer specialist or if multiple peer specialists are hired, they are assigned to different areas. It is strongly recommended by the peer community that in the absence of a peer supervisor, opportunities for networking with other PSS is important. PSS benefit when the supervisor creates opportunities or support self-initiated opportunities for PSS to meet with other PSS. Ensuring a community of practice within an agency, whether by providing space and access for an agency's peers to meet, or a more formal group supervision, should be considered a best practice. Providing access to conferences and trainings can be the role of the supervisor. Conferences and trainings gave PSS essential opportunities to meet the criteria of their code of ethical conduct (stay current in knowledge and practice) and to learn from other PSS.

And finally, many non-peer supervisors engage a more experienced PSS to informally supervise the other PSS.

Despite the possible barriers that might arise in an organization, supervisors play a pivotal role in addressing them with creativity and advocacy. This practice can be viewed as the beginning of peer career ladder development and is strongly encouraged.

Exercise:

Think about your first day at work. How did you learn what to do and which policies were most important?

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