Good afternoon, everyone, and welcome to the fourth session of our Recovery to Practice webinar series. Today's webinar is titled Peer Support Services – Creating an Environment for Success.

My name is Laurie Curtis, and I am the Project Director for SAMHSA's Recovery to Practice Project, and I will be moderating today's webinar.

I will review first some housekeeping tips and then provide a very, very brief overview on Recovery to Practice.

I would first like to acknowledge our webinar participants. We have, oh, over, at this point, getting close to 200 people on the inner audience today, and on behalf of the Substance Abuse and Mental Health Services Administration, we would like to welcome you, each and every one of you, and to thank you for all of your participation.

I would also like to thank our co-presenters today, Rita Cronise and Renee Kopache for sharing their rich experience and the unique contributions of peer support workers across the country, as well as some of the organizational factors that contribute to having a successful Peer Service Program (inaudible) services.

Housekeeping. Let's review our page layout very quickly to help you get the most out of the features of this webinar platform.

You have three options for communicating with us. First, if you experience any technical difficulties whatsoever during the webinar, please enter your question into the Technical Chat box on the far left of your screen, and a technical support technician will quickly be there to help you.

There is also a question-and-answer box for questions that you would like to have addressed to the presenter when we move on to our question-and-answer period. We will raise as many of the questions that you ask as possible during the discussion.

And lastly, we also have a Chat box. And that Chat box is for general conversation and comments and discussion with other participants.

If you would like to zoom in on any of the slides that we are sharing today, we understand some people find the amount of stuff going on on the screen is pretty busy. If you want to minimize that, all you need to do is to push the full screen button on the upper right corner of the display pod. To exit the full screen, just push the Escape key on your keyboard, and this allows you to view the presentation without all those pods or switch back and forth to the pod view so that you can ask a question or make a comment.

You can load a pdf version of today's presentation and additional resource materials and the certificate of attendance from the Download Materials box which is below.

The webinar is being broadcast via your computer, so please make sure your computer speakers are unmuted and that you adjust your volume for your comfort. If you do not have any computer speakers or your sound is not working, please email us because we have an option for you.

We have posted the webinar evaluation link as well, and that will appear in a box below after we close the opening polls. Please take a moment to complete the evaluation at the end of the webinar, and your feedback will help us learn about how to improve on today's presentation for the next webinars.

The webinar series is, as I mentioned hosted by SAMHSA's Recovery to Practice initiative, but what is Recovery to Practice? Recovery to Practice is a workforce development initiative that focuses on integrating recovery and recovery-oriented principles and practices in the behavioral healthcare in multiple disciplines and service settings.

The overarching goal is to improve the knowledge and skill of the behavioral health workforce but as importantly to transform concepts of recovery-oriented practice into real, everyday guidelines and clinical practice support interventions.

So what do we mean by recovery or recovery oriented? Well, Rob Manderscheid described recovery as one of the most powerful words in our behavioral health lexicon because it creates lives, it promotes hope, and it can open doors through enlightened and dramatic care and service reforms.

The concept of recovery is transforming the mental health and substance use landscape in ways that were unimaginable just a decade ago. People with lived experience of recovery have fostered this vision, and SAMHSA has made this vision an everyday reality for many.

Recovery is not a journey alone. Through other people, peers, family members, friends, practitioners, and supportive communities are fellow travelers on a person's road to recovery from behavioral health challenges.

In 2011, SAMHSA released a working definition of recovery with What Does It Mean, and a set of guiding principles that incorporate aspects of recovery from both substance use and mental health. The four major dimensions, Home, Health, Purpose, and Community, and these ten components that you see on the wheel on your screen, form a structure and a foundation for developing recovery-oriented lives, building recovery-oriented services and systems. AMHSA initiated the Recovery to Practice project to incorporate these principles into the behavioral health workforce.

The initial phase of Recovery to Practice was launched in 2011, and it focused on working with six professional disciplines to create discipline-based curricula that would promote an understanding in the uptake of recovery principles and practices within that discipline.

The six disciplines were the American Psychiatric Association, the American Psychiatric Nurses Association, the American Psychological Association, the International Association of Peer Support Specialists, the Council on Social Work Education, and NAADAC, the Association for Addiction Professionals. Each of these disciplines used the language and the framework that was relevant to their membership and developed ways to integrate curricula into the professional development activities and certification procedures of that particular discipline.

Each association does have a web page dedicated to Recovery to Practice, and you will find those links in the Resource pod on the lower part of your screen.

The second phase of Recovery to Practice initiative focuses on more multidisciplinary and integrated services and settings to push out these concepts and resources to more diverse audiences and settings. This Recovery to Practice webinar series is designed and built around these discipline-based curricula and opens them up to a much broader, broader audience.

So I would like today to introduce our speakers. We have with us Rita Cronise, who is the Education and Training Director for the International Association of Peer Supporters, also known as iNAPS. And she is also an adjunct faculty at Rutgers University. She has been involved with the self-healthcare movement since the late 1990s.

Renee Kopache is the Coordinator of the Wellness Management for Hamilton County Mental Health and Recovery Services Board in Cincinnati, Ohio. She also serves as the Chair for the Psychiatric Rehabilitation Association, or PRA, People in Recovery Task Force.

As an avid photography enthusiast, Renee is actively involved in consumer arts, community, and promotes art as a tool for personal wellness, adding stigma, social enterprise, and community integration.

So please with me welcome Rita and Renee, and Rita, I am going to turn it over to you. Thank you.

Rita?

Rita, I think you are on mute. Would you please unmute your telephone?

How is that? Is that better?

That's a lot better.

Thank you.

Thank you so much.

Sorry about that.

Okay, so welcome everyone. I am Rita. And the agenda for today's webinar is just a very brief overview of peer support, peer support services, and the settings where peer support happens.

A little bit on the definitions of recovery and recovery services that you build on that foundation that SAMHSA has already established.

We will talk a lot about the environment support peer services, and a little bit more about the available curricula that (inaudible) the Recovery to Practice (inaudible).

And I think I just went backwards. Sorry.

Before we get started, I would like to just do a real quick poll so I have a sense of the experience level within the room. I like to have a sense of whether you are here as a peer support practitioner yourself, whether you are a supervisor of peer support practitioners, whether you currently work with peer support practitioners, or if you have never worked with peer support practitioners. It will give me a sense of how deeply I want to go into detail about some of the material (inaudible). So thank you.

And it looks good.

And as we get started I would like to give a quote that Pat Deegan gave at the 2012 – where did I go?

Hello? Can you hear me?

Okay, yep, you're back.

Okay. I would like to give a quote that Pat Deegan gave at the 2012 Alternative Conference which I think really describes peer support very well. We are the evidence that recovery is real and our very presence scrambles decades of academic theories about the course of mental disorders. We are the evidence that it is possible to live our lives, not just our diagnoses. Just by showing up at work we raise the bar on service outcomes. Mere maintenance in the community or life of hand captivity is not a good outcome and represents systemic failure, not success. Recovery is the goal.

I just really think that speaks volumes to what peer support is about. And I wanted to also give a quick definition from Steve Harrington, and wanted to mention, for anyone who is not aware, Steve has recently had some very serious health concerns, so if you can just send some really good, positive energy to him, that would be really terrific.

Steve was the – is the Executive Director of iNAPS. He did the original situational analysis that was the basis for our iNAPS version of the Recovery to Practice initiative. And here is a quote from that situational analysis, which we have a link to in the download pod. There is a reference section, and we have links to all of the resource material that we are providing.

Because the peer specialist profession is a relatively new phenomenon in mental health services, it is often unknown and misunderstood by other mental health professionals, medical health professionals, and the general public. Confusion and misunderstanding also exist in regard to the roles peer specialists can or should play in mental health services.

Uh oh.

And as I said, the situational analysis was done as part of the initial Recovery to Practice project, and I will highlight a few of the findings from that analysis as we go forward.

First of all, peer support emerged from three different traditions: the 12-step, the self-help tradition, and the consumer/survivor movement. And it was based on longitudinal studies of recovery from serious and persistent mental health issues that showed that a majority of people who were hospitalized for a lengthy period recovered significantly or even completely from schizophrenia.

And in those studies, recovery was defined to mean people completely recovered without any symptoms, they were off any kind of psychotropic medications, they were living independently in the community, and they were relating well to others with no behaviors considered odd or unusual. And the researchers continue to say that they consider people significantly improved when they have fulfilled all but one of those domains.

The majority of people got better, and that was not something that was even believed in back in the days that those studies were done.

Another factor that led to the emergence of peer support was that psychiatric institutions (inaudible) across the U.S. during (inaudible) moving towards community mental health care. And that was based on treatment (inaudible) psychiatric patients who lived and obtained support in the communities in which they lived.

And then more and more, as more people got well, they regained the skills that were lost and they developed new skills including leadership, engagement, communication, and when combined with a desire to give back, mental health systems were finding that peer involvement in the delivery of mental health services offered from former service users was very, very attractive.

And peer specialists themselves reported that their interest in peer support as a profession often came as the result of participating in peer support groups on a voluntary basis.

Hey, Rita. This is Lori. People are having a little bit of difficulty with the sound. I don't know if you are too close or too far or too loud. But I also want to let folks know who are listening that this is being closed captioned, and if you are having some difficulty with the sound, you can follow along through the closed captioning pod. Thank you.

Okay. Thank you, Lori. Sorry about that.

I have another poll for you. Does having a lived experience of mental illness or substance use qualify a person to be a peer support practitioner? True or false?

And as we are doing this poll, I will mention that the qualifications for becoming a peer support provider still vary from state to state and from setting to setting. Depending on whether the services will be Medicaid billable, a certification process may be required before a peer can bill for services. In settings that don't require Medicaid billing, requirements can be different.

But in any case, the answer to the poll is that lived experience is essential – an essential component, but it is only the starting point. Lived experience alone does not qualify a person to deliver peer support services especially in a managed care behavioral health setting. Training, supervision, and continuing education is necessary to fit into the landscape.

And I have one more poll. Wait a minute.

So what are peer support services? Well, I love this quote from Peter Pocklington that goes, There is already a dizzying array of services that call themselves peer support and that employ peer support specialists to provide services that bear little or no resemblance to peer support nor share its values.

And we will come back to the values of peer support in a moment.

And we talk about what are peer support services as opposed to peer support.

In 2001, Georgia became the first state to obtain reimbursement for peer support services. In 2007, CMS issued guidelines to the states for Medicaid-billable peer support services. They named peer support as an evidence-based practice at that point, and we will come back to evidence based in a minute as well.

But at this moment in time, 42 states plus the District of Columbia have peer certification processes that certify peers to be able to bill Medicaid for services.

And what are those services? Well they come in a variety of different flavors. There are services that relate to one-on-one support. There are services for group facilitation. There are services for recovery education. There are community resource connections. And many peers are also change agents within the system and influence policies and practices.

So there are a lot of different ways that the peer support is provided.

And it is a diverse workforce. We have done a lot of surveys, and peers range in all kinds of education levels. They have many, many different skills that they bring to the table, and many of those skills are integrated into the work that they do.

They are in many different settings. And we also have done surveys that have looked at the range of different settings where peer support providers provide services, and I want to share that.

And they perform a lot of different tasks.

The basic premise of peer support is that it is a person with a lived experience who is working directly with another person who is having one of those experiences to provide hope. And if that direct connection and interpersonal relationship is not happening, there are things that are happening out there like people are employing peer supporters to do parking lot security, or janitorial help, or office support, or medication monitoring. Those are not necessarily utilizing peer support in the way in which (inaudible).

And I mentioned also that there is evidence related to the effectiveness of peer support. That evidence that they have studied relates to reductions in inpatient service use, improved relationships with practitioners, better engagement with care, better levels of empowerment, higher levels of patient activation, and higher levels of hopefulness for recovery.

Recently Psychiatric Services published an article called Assessing the Evidence Base, and they went back to look at the evidence that was gathered at the point in time that CMS named peer support as an evidence-based practice. And what they found is that there is a substantial amount of evidence that talks about the effectiveness and they have recommendations for future research. But they have studied three different types of services. One where peers were added to traditional services with the kind of peer support most of us are familiar with.

When peers down south have clinical roles, and they happen to be peers but they also have a licensed role, does being a peer help them in that role? They studied that. And they also studied peers (inaudible). And, again, a lot more information is available (inaudible).

So environments that support peer services. Peer support thrives in recovery-oriented environments, and not all environments that offer peer support are recovery oriented. Let’s explore this.

When we think about mental and behavioral health care, that world view is based on treating illnesses. That is what drives the funding for providing (inaudible). And so there is a transition happening, but in some cases it is a slow transition.

And there is something – like how psychiatrists are (inaudible) clinicians’ illusion, and that is when people (inaudible) people who are sick all the time, they think that they – the people who are sick, they think they are sick all the time, well there is a belief that people with mental illness are always ill. Peer supporters

have a very different world view because they have gotten well. In fact, getting well is a (inaudible) for being a peer supporter.

So peer supporters have the ability to bring hope, not only the hope that the people that they support, but also to the other providers on the team who so rarely see people doing well and especially settings that are very intensive.

So managed care treatment providers focus on diagnosis and treatment that they are paid to provide services for. Peer providers who are in these environments are often at risk of becoming what they call medicalized or offering more sterilized kind of care than we find in the community. There is a lot of concern that this is not really peer support. If we are doing it in the medical environment, is it really peer support if we are being provided by and doing services that really depend on Medicaid billing.

So the wellness world view of peer support is different than the illness world view that – quote – traditional providers – have operated under traditionally. And yet what this entire project is about that we are under right now with Recovery to Practice is putting more of a recovery focus on the entire system. And peer supporters with a world view of recovery have that experience of working with quality, working with choice, working with dignity, and with natural relationships. And bringing that reciprocal relationship into the work environment.

In 2013, iNAPS was involved in doing what we call the Practice Guidelines for Peer Supporters. And as part of that we did several surveys in focus groups about 12 core values (inaudible). Now this was a direct outgrowth of the Recovery to Practice initiative that we were involved in. And over 1,000 peer supporters gave 98% agreement that these 12 core values were core values of peer support and should be a part of recovery-related practices. And in fact, these are built directly on the SAMHSA definition of recovery.

And because recovery is so fundamental to peer support and the values of peer support providers, let's take a closer look at what we mean when we talk about recovery.

I have another poll for you.

So the first poll is: People who recover from mental illness were not really mentally ill in the first place. And I would imagine that most people who would be tuned into this webinar would say either disagree or strongly disagree.

And this really goes back to that clinician's illusion I talked about earlier. People who only see people when they are very ill, they tend to believe that these people will always be ill. And to recognize that they do get better is an important part of recovery. So the old belief of the chronic and hopeless nature mental illness and substance use has been challenged. The fact that people with use disorders can enter a life of recovery that involves emotional stability, with physical health, meaningful social and work-related activities, and close supportive relationships is a reality for most people.

And, in fact, in my own life I have gone through many, many hospitalizations, but it has been many years since I have had any kind of hospitalization, and I attribute that to the work that I have gotten (inaudible) peer support groups, wellness recovery action plan and many other elements of recovery that I (inaudible).

So one more quote – or one more poll. And that is: All people with serious mental illnesses strive for recovery.

And it looks like we have got a lot of agreement on that.

And I think it really comes down to recovery is one of those terms that means different things for different audiences. I know in the traditional medical (inaudible), recovery was originally viewed as cure. And (inaudible) meant a remission but recovery meant a complete cure. So that is one definition of recovery.

For some activists, recovery is about human rights. (Inaudible) but it is about people aren't really ill, it's just that their rights have been violated.

And in addiction recovery it is about abstinence and long-term sobriety.

And in the rehabilitation view, recovery is a self-decided process of transformation which is very close to the SAMHSA perspective of recovery.

What happens often when people talk about recovery, is that they are talking about a different recovery entirely and there is disagreement. I think when everybody comes to a point of recognizing if the use the recovery definition that SAMHSA provides that it is a process of change through which individuals can improve their health and wellness with a self-directed life and strive to reach their full potential, then I think just about everybody agrees that recovery is possible for everybody to choose their own definition of recovery.

Beyond that, there are many different dimensions, and we will talk about wellness and recovery. Wellness and recovery are not the same necessarily, but recovery really touches upon all the different dimensions of wellness. Recovery, there is emotional recovery, financial recovery, environmental recovery, intellectual recovery. Each and every one of these dimensions of wellness contribute to a person's sense of wellbeing. So recovery is not just about eliminating mental illness or physical illness or symptoms. It is really about improving people's lives in all areas.

I am not going to go through this slide in great detail, but we did – in 2014, iNAPS did a survey that looked at many dimensions of what it is to be a peer support specialist or a peer supporter. And in the settings – we are looking right now we're doing an analysis for Boston University that is going to be published very shortly – about where peers are providing services, the most restrictive to the least restrictive setting.

And as you see this listed, it is listed pretty much from the most restricted, which would be psychiatric inpatient (inaudible) institutions all the way to recovery centers and wellness centers and drop-in centers which are the least restricted. Peers are providing services in every one of these settings. (Inaudible) providers (inaudible) volunteers. Many, many peers are providing volunteer services as well as being paid by the (inaudible).

Hey, Rita? Rita?

Yes?

Would you mind picking up your phone? We are having a lot of problems with audio still. If you are on a speakerphone, if you would switch to a handset or headset, that would be better.

How is this? Is that better?

I think so, yes.

Okay. All right.

So at this stage in the evolution of peer support and the practice discipline, every state has been developing different certification programs, and within each state different programs have been using peer support providers in very different ways so that there is a real lack of standardization. And in fact, one of our recent surveys, out of 800 responses, we had 200 unique job titles, which is there is just not any standardization out there in many places about how peers are defined or the job description of what they do.

And so recently SAMHSA embarked on a project to continue to work toward establishing core competencies, which is a very big first step toward standardizing the job descriptions and the job titles and categories of what people do.

So defining the core skills and competencies is essential to promote understanding of the peer support field.

And with this standardization we can help prevent what we call peer drift or drifting away from the values of peer support and cooptation, which is when people get kind of pulled into value systems that are different than their own. So both of those will be helped once we get through the process of developing core competencies, and that is in process.

As you can see on the right side of the screen, the key principles and values, recovery-oriented, person centered, noncoercive, trauma informed, and relationship focused. Those are all very much in alignment with the core values that we had talked about earlier in our iNAPS survey.

So I am coming down to the last slide. I'm just going to skip over these. And just talk a little bit about why the practitioner's world view is so important in the delivery of peer support services.

The success of your peer support program is in direct proportion to the entire organization's belief in recovery. That is, everyone who is achieving services can achieve a self-determined level of recovery.

And it is influenced by the clinician's illusion that I talked about earlier. You'll see that little New York State in the middle of the eye. And that is because – and I can say this because I am from New York – those of us in New York, and especially New York City, tend to see that as the world view, there is nothing outside of New York. But the truth is that there is a whole wide world outside of New York. And there is a whole wide world outside of the Medicaid billing model of providing services.

Now how this gets implemented throughout an organization really depends on is there going to be – are peer services valued? Does everyone in the organization believe that recovery is possible for everyone receiving services? And another issue is, are the people throughout all levels of the organization people who have experienced recovery? Because the more people who have experienced recovery who are at all levels within an organization, the more recovery oriented an organization is.

And do the peer providers themselves believe that recovery is possible for everyone? Sometimes what happens when peer providers are embedded in an organization where they are alone and the only peer in the organization, it is easy to lose touch with the peer values. So it is really important for peers to be hired in multiples and then to work together as much as possible.

If the entire organization does not value peer support or operate under the world view, then it is very much like thinking that the Medicaid billable version of peer support is the only version of peer support and that recovery is – sorry – is not possible outside of the only view that is funded through one particular funding stream.

Anyway, I am going to hand the microphone over to Renee at this point and let Renee continue on to talk more about the environment support peer services.

Thank you.

Hi. This is Renee Kapache. I unfortunately seem like I have lost my connection for Webcam, but hopefully people can hear me.

We can. Renee, can you speak directly into the phone instead of a speakerphone?

I can try that. Is that better?

That is much better. We learned that earlier that that makes a big difference for people's experience in being able to hear what you are sharing with us. Thank you.

Okay. I am not sure why all of a sudden I don't have the button for the webcam, but I do have the PowerPoint so I will just proceed.

Okay.

Rita had kind of talked a little bit about kind of how the peer support has evolved. I want to spend a little bit of time, and she wrapped up a little bit about the importance of having a recovery-oriented workforce. And so I want to pick up with that and talk about recovery or creating an environment of success, or for success, from a couple of perspectives. First and foremost, from the perspective of the person who is using the mental health services. Because, obviously, that is what all services are about is the end user.

And I saw during the Chat while I was listening to Rita there was some conversation around whether or not there was the recommendation that we need to use the word “recovered” more often within the mental health and behavioral health arena, and I agree. So I will say that I am a person who is recovered from mental health diagnoses because I no longer receive mental health services.

So when I talk about recovery or what a successful environment would look like for an individual receiving services, there are a couple of things that, you know, I say I am recovered, but if there was a time I needed to return for services, there are certain things I would look for in an environment. And I would look specifically in that environment for things that support recovery.

One of those things, and the most important thing I would look for, is whether or not the environment is one that is supporting or fostering a sense of hope. Because for me personally I believe that hope is the foundation of recovery. And I would go so far to say that I think it would be very difficult, if not impossible, for an individual to make progress in recovery without having some sense of hope. Whether that is hope that they have internalized or hope that they are being able to draw from someone else through the support process.

So how would I know that that agency renews and fosters hope or that the peer provider does that? Well, I would listen. I would listen to the individuals receiving services. And I would listen to the staff. I would look for things like is there a focus on the limitations of the illness, or is there a belief that things are going to get better?

What is kind of the framework from which people are starting? Are they starting on a focus on overcoming and being well, or is the focus still on that of the limitations and the illness itself?

Another thing that I would look for in an environment that is creating opportunities for success is I would observe to see whether or not people have an opportunity to learn. What are they being taught? Oftentimes when I was in the service environment in the early 1990s, pretty much through the 1990s, there was a heavy focus on activities for daily living, and that is what everyone kind of taught or made a priority everywhere I was receiving services.

If I were looking for a service environment that is going to allow for success, I would be wanting to see that if, you know, a focus on basic activities of daily living skills if those are needed, but I would also expect to see a focus on things like learning about self. I would expect to see people gaining knowledge and skills that enhance their quality of life or give them an opportunity to improve their quality of life.

I would expect to see diversity within the programming that is being offered so that I know that a variety of needs and desires and goals can be met in that environment.

Another thing I would hope to see in my little site visit would be that people were starting to see things and experience things differently or through a different lens. See that there is more evidence of optimism in the environment as a result of the service and support that people are being provided.

Are people taking risk? Are they given opportunities to take risks and try new things? This is something I would expect to see in an environment for success. Part of the recovery process is stepping outside of the comfort zone, and that involves taking risks, trying new things, maybe meeting new friends or new people. And all of that, of course, means that the staff and peer support workers would be nudging and challenging and cheerleading to allow people to have that sense of comfort that goes along, you know, that confidence that they would need to be able to take those risks.

You know, oftentimes many of us who have been part of recovery process have had to overcome something. And we have had trauma as a part of our lives. Part of what I would want to see in a recovery-oriented environment would be that even though our pasts are not something that we necessarily should forget or want to forget, it is important that we see that people are being able to live their lives despite those things. That they are overcoming the traumas and those setbacks. So I would like to hear comments like I am learning to let go of my past. Or, while I will never forget what happened, I am learning to not let it control me. Or I no longer let it impact me. Those would be some of the things that I would look for.

And then ultimately I would expect to see that people are making progress in gaining independence. By that I mean that they have got a growth in their self-esteem, their confidence. They are people that are at varying places along the recovery continuum and the environment. Perhaps someone I am witnessing is sharing their excitement as they talk about their new apartment, you know, or their first job. Maybe I am having an opportunity to witness a party for someone who is graduating from treatment. All of these things are signs of progress, and these are things I would expect to see in this environment that fosters recovery from the perspective of the person receiving services.

Now shifting gears a little bit, let's talk about what creating an environment for success and what it would look like from the peer practitioner perspective.

You know, last year, very briefly, we did a national survey through the Ohio Psych Rehab Association chapter, and we were looking specifically, wanted to know what the experiences of peer providers were like and how those experiences varied across service settings and tied to also what the workplace environment was like and what their feelings were around their level of supervision.

So we focused on two things in particular for this presentation that I wanted to highlight in the findings from that. When we compared individuals who reported that the environment that they work in is recovery oriented with those who reported that the environment they work in is not so recovery oriented, we found that there is a couple things that happen.

Individuals that reported that their place of employment is recovery oriented were significantly more likely to report that they work, first of all, at a consumer-operated agency than if they were in a traditional mental health setting. More likely to report that they are satisfied with the work environment. And they are more likely to report that their job description matches the work that they perform. The significance of the job description is that those individuals who report that their job description matches their work were also more likely to indicate overall satisfaction with the work environment and their supervision.

So, you know, one of the things we were trying to kind of establish in the survey we did was whether or not satisfaction with the supervision was tied more to the workplace environment and kind of how it was operated and (inaudible) or tied to status, for example, that of being a peer provider clinician. And clearly, the results showed that when, again, when we compared those who reported as being a part of a recovery-oriented workplace environment with those who were in a non-recovery or a less-recovery oriented, we found that those in a recovery-oriented environment were significantly more likely to report that their supervisor values peer support and recovery if their supervisor is a peer, and that they had a higher level of overall satisfaction with their supervisor.

So even though it was a small study and it had some limitations because of the small study, and it was a national survey, or it was open nationally but 75% or so of the respondents were from Ohio and Michigan and Pennsylvania, it gives us a glimpse of what peers themselves feel about their work environment and how that changes depending on where they are working and what the culture is that they are working within.

So another thing I want to talk about a little bit is, you know, when we – we always talk about or hear the phrase "recovery-oriented environment." So one thing I want to talk about is from my perspective, as not only as a person in recovery but also as someone who has worked in the mental health community for the past 20 years, you know, what does that look like? And there are a couple of things that you can break down and take a closer look at.

One is what is the interaction like? When you walk into a setting that is recovery oriented, or you are looking for how recovery oriented your environment is, think about where you, yourself, work. Are people approachable? Is there a mutual exchange between the staff and the people being served, the individuals being served?

What is the body language like? Is there a distance? Is there more of a closed stance? Or is there more of an embracing body language?

Another thing to look at is what is the tone of people's voices? What are people – their interaction? Does it look like it is a hopeful, respectful interaction or is it more of a closed interaction?

And from the perspective of the person recovering and observing staff at that organization, are staff giving individuals full attention when they are interacting with them or is their attention going all over the place?

More than anything it is just does the interaction feel like it is an environment that is welcoming.

Another thing to think about what success looks like is how the planning or the goal setting takes place and how that plays out or what it looks like. And one of the things that, you know, I like to revisit and share my visit around is my own experiences with treatment planning. And oftentimes I would have treatment providers point out to me that I am failing to achieve my goals. And later on in my recovery I was able to point out back to them that I don't even know what the goals are and those were not my goals.

So, you know, one of the things – and I think our system has gotten much better at this – and it is really important is that the individual in recovery is the individual who is driving the goal-setting and the treatment-planning process. I can't have success with my goals or failure with my goals if they are not truly my goals.

So from the standpoint of being a peer provider, or, frankly, any provider, in order to help an individual in their recovery, part of that is are they able to establish and pursue their own goals? Are they able to do things based on their own perceived interests and needs? Is it strength based? Is it something that is challenging them, that is growth oriented?

All of those things are critical to the planning and recovery process in an environment of success and an environment that is supporting recovery.

And then also finally around kind of the interactive part of it is, what does the programming look like? Is it safe? Is it effective? Are the activities, whether it is one-on-one or a group environment, is it diverse in terms of what is being offered and addressed?

Is it something that is of interest to the people being served? You know, are you exploring opportunities for people to be creative? Is it growth oriented?

Is it available to all the people using services? Oftentimes people want to access a particular type of service and aren't able to. That is something that can hinder the recovery process. And it is something that could make it difficult to keep someone engaged in recovery.

Renee, I just want to cue you, we've got a few more minutes left so we can move on to conversation.

The last piece here real quickly, is, you know, looking at the structure and the bricks and mortar, most importantly, you know, around the structure, is are people in recovery, are the service recipients involved in the decision making? Are they part of the planning and are they visible throughout the organization?

And then the building itself, the structure. Is it open? Is it colorful? Is it welcoming? And is it safe but at the same time not locked down?

And I am being told that I am running out of time, so one of the things I want to end with is what does an environment of success feel like? And you see this description here that it is basically all of the emotions

that we have. And the significance of this is that these are the things that if peer support or any type of support is being provided in a recovery-oriented environment, these things will be evident. Because these are the things that challenge us. You know, if someone isn't experiencing emotion, chances are they aren't experiencing recovery. Someone who is making progress will be challenged. Challenge isn't easy. They will make change, and change isn't easy. So if the individual isn't experiencing these emotions, they are likely not being challenged to change. That is what recovery is about. That is what recovery-oriented care is about. It is that there is opportunity for growth.

Peer support is – real quickly here, a couple key last points.

Peer support is not equal to recovery. It is far too common that I hear individuals or providers say we have recovery culture because we have peer providers. They are not the same. Peer services take on a different look depending on what environment they are in, and just because you have peer employees does not mean that it is a recovery-oriented environment.

And then finally, one size does not fit all. Job descriptions, it is critical that they be in alignment with the work that individuals do. That individuals are paid according to their responsibilities. And understanding that having a single, sole job description that is titled Peer Specialist doesn't work, especially if you have, for example, one individual who is working on a homeless outreach team as a peer provider and another one who is working on a peer (inaudible) line. It is important to distinguish those in the descriptions and also potentially in the pay – what individuals are being paid.

And then finally, from a recovery framework, that framework benefits not just the peer provider, but everyone. The service team, the supervisors, the administrators, but most importantly the individuals who are in recovery and receiving services. A recovery framework increases the likelihood the supervisors will value peer support and recovery, that peer specialists will receive adequate supervision. And then tied to that, detailed and accurate job descriptions that are typical in a recovery environment allow for optimal performance and supervision. They allow for appropriate training. And they tend to result in higher levels of satisfaction.

At that point I think we will turn it over to Lori.

Lori, I'm afraid you are on mute.

Okay, is that better?

Yes, thank you.

Oh, thank you. Sorry everybody.

I want to thank Rita and Renee for a wonderful presentation. I always enjoy listening to both of you speak.

We are going to begin with questions in just a moment. Please, if you have any questions for Rita or Renee, would you please type them in the question-and-answer box so that we can begin to bring those up.

And while you are doing that, I want to let you know that Recovery to Practice has a newsletter. And if you are not on that newsletter mailing list, we would love to have you sign up for that. You can sign up for it at Recovery to Practice, RTP@ahpnet.com.

So with that, let's see. We have got a few questions here. So let's start from kind of the top here.

One of the things that people were talking about in the Chat box, and I think I will toss this to you, Rita, that – about the difference between recovered and recovering and recoveree. Do people – there are a lot of differences in our views in mental health as well as in addiction about that concept, but do people in mental health and addictions recovery ever fully recover?

Can you hear me okay?

Yes.

Okay. Well, let me tell you a little story. Way back in the day when I used to be a facilitator for a support group, I had just come off of a presentation that Dan Fisher had given about people do recover. Up to that point in time, none of us ever believed that recovery was possible to the point where people actually could get better and stay better. And then add to that the self-(inaudible) definition of recovery.

Well Dan Fisher had said to me, whoever told you you couldn't recover? And tell me about your life. And I was actually at that point back to work, and I had been back to work for 12, 15 years. I had a family. I was doing well, you know. And, yes, I was taking medication, but that was about the only thing at that point that was really hindering me from being considered completely recovered. And he said, well, being recovered doesn't mean you don't take medication. You know, you take aspirin, right?

So I went to my support group and I said, you know what? I have recovered. And every one of them really jumped all over me and said, you can't recover, it's not possible. I said, well how hopeful is that?

So I really do believe that full recovery is possible. That was really what Courtney Harding's study had been about, people who had fully recovered from the back wards of the worst of the worst psychiatric institutions. They found that 68% of people went back and had fully, completely recovered. So I do believe that full recovery is possible.

Great. Renee, do you want to add anything to that?

Renee, you might be on mute.

All right. There's another – oh, go ahead.

Thank you.

I was going to say I think the other thing for me I would say about that is that I was in the hospital 40 times from 1989 to '99. I was probated, or hospitalized against my will, three of those times. So when people say that I was never really mentally ill, my response back to them oftentimes is, well then, please explain to me why the courts and the police and the clinicians kept putting me in the hospital. Because I think people see us when we are well, so they can't picture us if they didn't know us when we were ill. But when we are well, they just assume that we were never really ill.

Okay. thank you. Here is another question I am going to put to you, Rita, to start. It could be fairly involved, so given our time, I am going to ask you to kind of be pretty focused with it. And that has to do with the issue of supervisors also being people with less experience. This one participant says, I am often told that we should not insist on supervisors with lived experience supervising the peer recovery supporters because in our state there are just not enough peers with experience to be supervisors or at the supervisory level. And also that ties into some pending legislation on the federal level that may mandate licensed clinical supervisors for peer recovery supporters. How does that align with what you have found in your research and what your thoughts are around best practice and future direction?

There are obviously many sides to the issue. One of the things that came to me very recently is that we wouldn't ask a lawyer to supervise a psychiatrist. It is a different scope of practice. And it is a very different kind of practice.

What they are doing with the certification in New York State, is that supervisors of peers who are not peers themselves consult with experienced peer providers. And I don't know that that is the answer, but it is certainly a better answer than having people who are clinicians take on the role of something that is completely out of their scope of practice.

Renee, do you want – you have a lot more with supervision than I do.

Yeah, I mean I will add that in support of that study we actually found that – because we asked that questions – one of the questions was, do you think it should be a requirement that supervisors of peers

be peers? And we found absolutely no significant difference across a variety of different types of comparisons. It didn't matter whether we looked at recovery versus non-recovery environment. It didn't matter when we looked in level of supervision. There was just nothing that showed any significant difference in group responses around that item. Instead what we found was that people said the issue is that there needs to be an understanding of what peer support is. There needs to be some value in what it is we have to offer. And really what that comes down to is there needs to be an environment that allows for quality peer services, peer support, that is supported across the environment.

Thank you, Renee.

All right. Looking at our time we are going to need to close this off for today. So on behalf of SAMHSA I would like to thank our participants for taking time out of your afternoon to participate with us. We know you have demanding jobs, and we appreciate your interest in learning about the value of peer services.

Special thanks to both Rita and Renee for sharing their time, their wisdom, and their expertise.

If you have not filled out the participant evaluation form in the box below, we will post the link at the close of this session. We value your input and we truly do find it helpful for planning future sessions. So please help us out there.

We are not able to offer preapproved CEUs, regrettably, for this webinar, but you can download a certificate from the Materials pod below and print that out and take that to your CEU provider and apply for those CEUs on your own.

So with that, thank you all very, very, very much. This concludes our call for today. Please note that we will be having another call Wednesday afternoon on Evidence-based Practice and Recovery-oriented Care. Same time, same place. And we look forward to seeing you then.

Take care and have a lovely evening. Bye-bye.