

A Decade of  
**Peer Culture,  
Support & Leadership**

Igniting Behavioral Health Transformation in Philadelphia



**Analysis of Status and Impact**

City of Philadelphia, Department of Behavioral Health and Intellectual disAbility Services  
Strategic Planning Division  
1101 Market Street, 7th Floor, Philadelphia, PA 19107  
Arthur Evans, Ph.D., Commissioner

2016



**A Decade of Peer Culture, Support and Leadership:  
Igniting Behavioral Health Transformation  
in Philadelphia**

**AN ANALYSIS OF STATUS AND IMPACT**

**A Report of the  
City of Philadelphia, Department of Behavioral Health  
and Intellectual disAbility Services (DBHIDS)  
Strategic Planning Division**

**1101 Market Street  
7<sup>th</sup> Floor  
Philadelphia, PA 19107**

**Arthur Evans, Ph.D.  
Commissioner, DBHIDS**

**March 2016**

# Table of Contents

<b>Letter from Dr. Arthur Evans .....</b>	<b>3</b>
<b>Acknowledgments.....</b>	<b>4</b>
<b>Executive Summary .....</b>	<b>5</b>
<b>Section I: Introduction.....</b>	<b>6</b>
A. Context.....	6
B. Purpose of the 2015 Asset-Mapping Process.....	8
<b>Section II: Asset-Mapping Methods.....</b>	<b>9</b>
A. Focus Group Methodology .....	9
B. Survey Methodology.....	10
C. Data Analysis.....	11
D. Report Preparation and Review.....	11
<b>Section III: Focus Groups and Survey Results.....</b>	<b>12</b>
A. Focus Group Results .....	12
a. Results from CPS Focus Groups.....	12
b. Results from Supervisor/Manager Focus Groups.....	15
c. Summary of All Focus Group Findings .....	18
B. Survey Results .....	19
a. CPS Survey Results .....	19
b. Supervisor/Manager Survey Results .....	20
c. CEO and Upper Management Survey Results .....	22
d. Summary of All Survey Findings .....	24
<b>Section IV: Discussion.....</b>	<b>27</b>
<b>Section V: Recommendations and Next Steps .....</b>	<b>30</b>
A. Tier 1: System Level Initiatives .....	30
B. Tier 2: DBHIDS and Provider Level Initiatives.....	32
C. Tier 3: CPS Level Initiatives .....	34
<b>Section VI: The Next Decade.....</b>	<b>36</b>
<b>Appendices.....</b>	<b>38</b>
A. Peer Focus Group Questions .....	39
B. CPS Supervisor Focus Group Questions .....	41
C. CPS Survey Instrument.....	43
D. Administrator Survey Instrument.....	47
E. CPS Supervisor Survey Instrument.....	52
F. PA MH Bulletin, Attachment 4, 11/1/2006, <i>Peer Support Services Activities Guidelines</i> .....	55
G. Peer Support Web Resources.....	56
H. CPS/Supervisor Training Needs Identified During Asset Mapping Process .....	57

## A Letter From Arthur Evans, PhD

Dear Stakeholders:

I am truly excited to present this report entitled *A Decade of Peer Culture, Support and Leadership: Igniting Behavioral Health Transformation in Philadelphia—An Analysis of Status and Impact*. As the Department of Behavioral Health and Intellectual disAbility Services enters its second decade of system transformation, it is important for us to celebrate the powerful contribution made by peer support staff and people in recovery each and every day, and to:

- provide a summary and analysis of the results of and recommendations from the 2015 peer support asset-mapping process; and
- identify next steps in our commitment to long-term recovery and the central role of peer culture, support and leadership.

Peer culture, support and leadership is one of the ten core values of the Department's transformation process. The centrality of this element of transformation is one of the hallmarks of Philadelphia's unique approach to this fundamental change in what we do and how we do it. This emphasis was and continues to be a principal driver, a "transformation engine" that energizes, redefines and reinforces this new day in behavioral healthcare.

Our transformation process continues to evolve. As a Department, we continue to move toward greater integration of services, a focus on population health and stronger efforts to address toxic stress, trauma and the many other challenges that can have such profound effects on health. Through this process, we also continue to grow in our certainty that peer culture, support and leadership are critical to the success of all our efforts.

We invite you to read and discuss this report, to hold it up to your experience and to think about how you might join these ongoing efforts to co-create organizational, system and community cultures that honor the lived experience of people in recovery and the passionate commitment of these men and women who are passing transformation on to their peers.

Sincerely,



Arthur C. Evans, Jr., Ph.D.

Commissioner

Department of Behavioral Health and Intellectual disAbility Services



# Acknowledgments

## DBHIDS Strategic Planning Division

### Peer Culture & Community Inclusion Unit:

Mika Dabney-Walton  
Crystal Edwards  
Roleta Jenkins  
Jazmin Banks

### Transformation Research Unit:

John Antonovich  
Gerald Foeman

### Special Acknowledgements:

Tierra Pritchett  
Kenya Smith-Johnson  
Lori Bell  
Joann Mills  
David A. Thomas  
Rachel Thompson  
Sherita Mouzon

All of the Philadelphia Service Providers and Certified Peer Specialists who participated in the DBHIDS-sponsored focus groups and online surveys

### Consultants:

Paul Poplawski, Ph.D., Author  
Ijeoma Achara-Abrahams, Psy.D., Advisor  
Pamela Woll, MA, Editor

## Executive Summary

In 2005, when the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) began a comprehensive transformation of its service system to a recovery-oriented system of care (ROSC), one of the essential core values underlying this process was “Peer culture, support and leadership.”

From the beginning, this value served as a central force in igniting and driving transformation, and it continues to inspire and motivate the people and processes involved in this fundamental realignment of systems and services. Many partners in this movement report that much of its success is due to passionate, committed and meaningful effort by people with lived experience of mental health and/or SUD challenges and recovery.

In 2015, DBHIDS decided that the future course of this core element of transformation would depend very much on its past and its present, so a review of the status and impact of peer services would be necessary. This report reflects the findings of that review. Much of what informed the early stages of the transformation process in 2005 was gathered through a system-wide “asset-mapping process,” designed to assess the progress and performance of the system and to establish the future course for systems change. The 2015 process has used similar methods to fulfill similar purposes. This process is designed to:

1. gather lessons learned from the work accomplished in the area of peer culture, support and leadership in Philadelphia;
2. look at those lessons in light of current realities and opportunities; and
3. determine the direction DBHIDS and stakeholders should take to keep their efforts true to the spirit and principles of peer culture while they move toward a reimagined future.

Further discussion of the context in which transformation has taken place and the purpose of the 2015 asset mapping process is presented in Section I, the Introduction.

Focus groups and surveys were used to assess the strengths and challenges of this ten-year implementation and gather input for future directions. The methods used to conduct these processes are presented in Section II, their results are presented in Section III and discussion follows in Section IV. Recommendations and next steps are presented in Section V, organized in three separate but connected areas (called “Tiers”) of systems change and refinement:

Tier 1: System-level initiatives

Tier 2: DBHIDS and provider-level initiatives

Tier 3: CPS (Certified Peer Specialist)-level initiatives

This report is designed to inspire and inform a level of discussion and collaborative effort that will move this work forward in ways that honor both the tradition of ROSC transformation in Philadelphia and the fundamental importance of peer culture, support and leadership.

# Section 1: Introduction

## A. Context

### *Timeline:*

- *In August of 2005, 16 Philadelphians with lived experience in mental health and/or substance use disorder (SUD) recovery successfully completed the first of many DBHIDS-sponsored Certified Peer Specialist (CPS) trainings.*
- *Beginning in March of 2006, DBHIDS hosted several kick-off events that introduced providers to the benefits often associated with peer support services, focusing on ways in which these services promote a system of hope, where recovery is possible for everyone.*
- *In November of 2006, managers and supervisors from the Philadelphia behavioral health provider system were trained to prepare the organizational environment to adopt a recovery orientation at the provider and staff level. As the Department was giving birth to the Certified Peer Specialist initiative in Philadelphia, supervisors of peer specialists at the program level were being introduced to the principles of recovery, coached in their roles as sources of support to Certified Peer Specialists and given examples of the potential value of this new workforce to the people receiving services from them.*
- *In the months that followed, DBHIDS also established several technical assistance strategies (such as the CPS Professional Development and Networking meeting, the CPS Supervisors meeting and training opportunities in recovery-oriented topics). These were designed to strengthen the implementation of this groundbreaking component of treatment and recovery support (From an interview with a DBHIDS administrator and recovery champion).*

In 2005, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) embarked on a comprehensive transformation of its service system. This effort engaged the entire community of providers, advocates, people participating in services, people in recovery, City government, strategic partners, institutions of higher learning and family members in a mission to establish the Philadelphia system as a national example of a successful recovery-oriented system of care. Under the leadership of Arthur C. Evans, Ph.D., this transformation has sought to alter the concepts, practices, settings and the very architecture of the system. At its heart are ten core values:

1. Strength-based approaches that promote hope
2. Community inclusion, partnership and collaboration
3. Person- and family-directed approaches
4. Family inclusion and leadership
5. Peer culture, support and leadership
6. Person-first, culturally competent approaches
7. Trauma-informed approaches
8. Holistic approaches toward care

9. Care for the needs and safety of children and adolescents
10. Partnership and transparency

From the beginning, the fifth of these core values—peer culture, support and leadership—served as a central force in igniting and driving transformation. Meaningful involvement and leadership by people in recovery has been one of the strongest elements in the success of this movement. Their passion and commitment have helped them transform, not only their own lives and those of their peers, but the life of an entire system.

The first concrete steps in making Philadelphia’s recovery-oriented system of care (ROSC) a reality included (but were not limited to) the following:

- A critical element in creating ownership of the developing Philadelphia ROSC was the formation of the Recovery Advisory Committee (RAC). This workgroup included DBHIDS staff and consultants, people with lived experience in recovery, family members, advocacy organizations and providers. Its early responsibilities included: 1) the identification of key actions that would help DBHIDS move toward a recovery-oriented system of care, 2) establishment of Philadelphia’s action plan for implementing a CPS workforce and 3) development of a mission for and definition of recovery.
- DBHIDS developed a selection process for provider agencies contracted with Community Behavioral Health (CBH), to choose organizations that would participate in the Certified Peer Specialist Initiative.
- After the participating agencies were selected, key representatives of those agencies were invited to attend an informational kick-off mini-conference. This mini-conference featured information about Peer Support Services and guidance from national experts in the field.
- Providers received technical assistance in the development of CPS job descriptions.
- Partnerships and collaborative processes were established with a locally based CPS training vendor, to work together on:
  - Development and enhancement of the CPS training curriculum
  - Promotion and scheduling of CPS trainings
  - Creation of the CPS training applications
  - CPS interviews and selection process
- DBHIDS established a partnership with Philadelphia’s Office of Vocational Rehabilitation, in accordance with the existing statewide Memorandum of Understanding.

As this report is being written, DBHIDS is celebrating its first decade of system transformation, a decade rooted in the critical importance of recovery. As transformation has evolved, the Department’s efforts have broadened, to include a stronger focus on trauma-informed care and a public health approach to behavioral health. Given the importance of long-term recovery support for people who have experienced toxic stress and trauma, and the central role that peer-led, grassroots efforts play in community activation and health promotion, it becomes clear that peer

culture, support and leadership are as essential to the future of transformation as they have been to its past.

## **B. Purpose of the 2015 Asset-Mapping Process**

In late 2014 and early 2015, the Department decided that the future course of peer culture, support and leadership should be built on the momentum and success of its past experience, and that an examination of the program’s status and impact would be necessary to establish an effective foundation for forward movement. Much of what had informed the initial stages of this work in 2005 had been accomplished through a system-wide “asset-mapping” process, designed to assess the status and performance of the system and set a course for future systems-change efforts.

The 2015 process used similar methods to accomplish similar purposes. These purposes were to:

1. identify the lessons learned from the work that had been accomplished in the area of peer culture, support and leadership and—given current realities and opportunities—determine the direction that DBHIDS and stakeholders should take to honor the spirit and principles of peer culture while moving toward a reimagined future;
2. assess the strengths and challenges found in implementing and sustaining this core component of the DBHIDS transformation over the past 10 years;
3. ensure that the methods used reflected the voices of a cross-section of the 600 CPSs trained in Philadelphia, as well as clinical staff, program supervisors and leaders; and
4. develop an approach that included a qualitative component (focus groups) and a quantitative component (surveys).

Focus group and survey methods were used to assess the strengths and challenges of this ten-year implementation, and to gather ideas for shaping the future of these efforts. Recommendations are organized into three separate but connected areas (called “Tiers”) of systems change and refinement:

Tier 1: System-level initiatives

Tier 2: DBHIDS and provider-level initiatives

Tier 3: CPS (Certified Peer Specialist)-level initiatives

## Section II: Asset-Mapping Methods

This section of the report will outline how the asset-mapping process was conducted. The overall effort was meant to gather information that would allow the city to evaluate:

- the growth of peer culture in Philadelphia;
- the experiences of certified peer specialists, supervisors, administrators and other key stakeholders in the development of peer culture, support and leadership; and
- key statistics regarding the employment, roles, supervision and training of CPSs.

The approach called for the use of both qualitative (focus groups) and quantitative (surveys) information-gathering processes. This peer support “asset mapping” process in many ways mirrored the methods used at the beginning of the Philadelphia transformation process, when DBHIDS was assessing citywide behavioral health system strengths and challenges.

### A. Focus Group Methodology

**Purpose:** The DBHIDS Strategic Planning Division’s (SPD) Peer Culture and Community Inclusion Unit (PCCIU) conducted focus groups, with participation by Certified Peer Specialists and Managers/Supervisors of provider agencies that deliver peer support services. This aspect of the asset-mapping process was designed to identify successes and challenges in the implementation of peer support services over the past ten years, and to provide input that would help DBHIDS map out a strategic direction for fostering and supporting Peer Culture throughout the city.

**Participants:** A total of 27 CPSs and 22 Managers/Supervisors participated in the focus group process. A DBHIDS consultant and a DBHIDS CPS staff member facilitated eight focus groups, including three groups of managers/supervisors and five groups of Certified Peer Specialists. Given the role DBHIDS had played over the past ten years, in the initial process of training and preparing people to become CPSs, DBHIDS was interested in gathering information from CPSs who had been in different training classes (ranging from 2005 to 2013) and employment status groups (20 full time, 6 part time, 1 unemployed). The employed CPSs, managers and supervisors worked at a variety of Philadelphia-based agencies (17 in all) and programs. The employed CPSs and Managers/Supervisors volunteered to participate in the focus group during regular work hours.

**Methods:** Upon arrival at each focus group, participants completed a specialized survey designed to gather historical information regarding their involvement as CPSs. Next steps included the following:

- Individuals signed a consent form to participate in the group, with assurances of confidentiality regarding their individual contributions.

- Four different staff roles were involved in the execution of each of the focus groups, with each role described in this section. The focus group began with the moderator greeting participants and stating the overall purpose of the asset-mapping process. The moderator then established the norms for group interaction, assuring everyone that all would have an opportunity to contribute. During the planning of the overall asset-mapping process, focus group questions were specifically designed for the CPS focus groups, with a different though complimentary set of questions designed for the manager/supervisor focus groups. There were ten questions for each group category. The moderator described the additional roles involved in the process (see below): Co-facilitators, Scribe and Note-taker.
- A DBHIDS consultant and a DBHIDS CPS staff member co-facilitated each of the focus groups.
- A DBHIDS staff person also fulfilled the role of scribe, by identifying key themes, recommendations, strengths/challenges, etc. during the discussion and entering those elements on newsprint in the front of the room. This was designed to enlist all participants in ensuring that the discussion was recorded accurately.
- There was also a note-taker, who took handwritten notes throughout each of the focus groups.
- In addition, the group agreed to allow the discussion to be tape-recorded, so that a record of the actual discussion would be on file. Participants were assured that participant confidentiality would be maintained throughout the asset-mapping process and in the final report.
- Participants were also encouraged to jot down and submit additional responses to questions on 3 x 5 index cards, in order to share additional responses to and thoughts concerning the questions posed. This approach was used as a tool to give each person more opportunities to share his or her perspective, both within in the group discussion and through additional written comments.

At the completion of the focus group, the moderator summed up the discussion and its link to the DBHIDS priority of reigniting peer culture in the years ahead.

## **B. Survey Methodology**

The Peer Culture & Community Inclusion Unit also collaborated with the DBHIDS Transformation Research Unit (TRU) in developing the survey. In engaging the voices of key informants in this process, their intent was to assist DBHIDS in identifying the successes and challenges in the implementation of Peer Support Services over the past ten years.

The TRU developed three sets of survey questions, each to be completed by one of three key informant groups: Certified Peer Specialists, Managers/Supervisors and CEO/Upper-Level Managers of provider agencies that deliver peer support services in Philadelphia.

**Participants:** PCCI recruited Certified Peer Specialists, CPS Supervisors and CEOs to take surveys specifically designed for their respective groups. A total of 108 Certified Peer Specialists, 33 Supervisors/Managers and 38 CEO/Upper-Level Managers completed the online surveys.

**Methods:** The three survey types were created and loaded into the Survey Monkey program. Through a mass email with a specific Survey Monkey link, the CPS, Managers/Supervisors as well as the CEO/Upper-Level Managers were asked to access the survey and complete it. Each online survey was active for two weeks. Afterwards, the Transformation Research Unit analyzed the data.

### **C. Data Analysis**

After the focus group and survey data were collected, all of these qualitative and quantitative questions/answers were analyzed by TRU and PCCIU.

**Focus Groups:** At the conclusion of each focus group, the moderator and scribe reviewed their notes and the taped participant discussions. The individuals rating these comments identified themes that had emerged from the CPS and Manager/Supervisor responses to each question and counted how many times each of these themes had been raised in the discussions. Once they determined the frequency of these response themes, the themes were re-worded in ways that would make them easier to analyze and use in the report. The individuals engaged in this rating process also recommended a second analysis using a second rater, something that may be performed in the future.

**Surveys:** Responses to survey questions were previewed in frequency tables in Survey Monkey, to give the analysts a chance to determine which reactions seemed to be shared by large numbers of people. Often these tables were transferred into Excel worksheets, to produce frequency charts that would help them analyze and explain the data they had collected. After the initial findings were produced, a four-person committee from PCCIU and TRU reviewed all findings and produced initial summaries as a result of their analysis.

### **D. Report Preparation and Review**

A DBHIDS consultant prepared an initial draft report based on all the findings. This consultant had also facilitated the focus groups and was familiar with the planning and conduct of the asset-mapping process. The PCCIU performed their initial review of the draft report and, based on that review, the consultant prepared a second draft. An editor completed the preparation of a third draft, DBHIDS leadership reviewed the third draft, and a final draft was prepared for distribution.

## Section III: Focus Group and Survey Results

This Section of the report presents a summary of the results from the focus groups and surveys. Since each method (focus groups and survey) was administered to more than one target group or system role (with CPSs, managers/supervisors participating in separate focus groups and CPSs, managers/supervisors and CEOs/upper management taking separate surveys), and because DBHIDS wanted to understand the differences and similarities between and among target groups, the results are reported within these separate categories. Part A of this Results Section presents the summary of focus group discussions, and part B summarizes the findings from the surveys.

*Note: A comprehensive presentation of statistics, graphs and tables summarizing data from each focus group and survey question is contained in the 2015 Philadelphia DBHIDS Peer Culture, Leadership and Support Asset Mapping Data Compendium. It is anticipated that this document will be posted on the DBHIDS website following the posting of this report.*

### A: Focus Group Results

People in two targeted system staff roles participated in separate focus groups: Certified Peer Specialists (CPS) and CPS Supervisors/Managers of DBHIDS provider agencies who deliver CPS services. Below is a summary of the results for each focus group question across both groups, followed by a combined summary.

#### Results from Certified Peer Specialists Focus Groups

##### *What does a typical CPS day look like?*

- A typical day includes engagement of and outreach to people in recovery and to providers, through face-to-face and telephone contact, at a program or in the community. CPSs also provide citywide public transportation training and actively connect program participants with information about housing resources and ways of obtaining legal documents (such as IDs and birth certificates). CPSs also account for their time and responsibilities by completing documentation that records their work.
- CPSs discussed their participation in team meetings, linkage meetings, case authorization meetings, recovery planning meetings and treatment planning meetings, some of them planned and some unplanned. It became clear that CPSs were key participants in both program operations and service planning/delivery.
- Many CPSs stated that they worked beyond their scheduled hours by choice.

***How are you using your strengths, abilities, and gifts as a peer/recovery specialist in your program?***

- The predominant response from CPSs was that their lived experience and self-disclosure continue to be their most powerful tools in engaging and developing supportive relationships with those they serve. CPSs also expressed that their firsthand knowledge and experience in successfully accessing appropriate resources—both for themselves and for others—is a significant gift they bring to people they support.
- In addition, their own experiences in receiving services have sensitized them to the importance of “meeting people where they are in their own recovery” and to the positive impact that approach has on initial engagement and ongoing relationship building. CPSs expressed their own passion for their work, especially in sharing their lived experiences to inspire hope in program participants.

***What has been the greatest challenge regarding your role as a peer specialist in your organization?***

- The most prevalent challenge named was the perceived lack of respect that CPS staff sometimes experience in the workplace. They reported that they perceived this challenge as a result of staff confusion regarding the CPS role, a lack of staff awareness of CPS skills and a general program environment that does not reflect alignment with the values and principles of recovery transformation.
- CPSs reported that the amount and quality of documentation continues to be somewhat challenging for them. They also expressed a desire for additional training and coaching in understanding and maintaining professional boundaries in the workplace.

***How are you supported in your role as a peer specialist at your program? What does supervision look like for you in your role at the program?***

- CPSs reported that they received individual supervision, at a frequency that ranges from weekly to monthly. Three of the 15 CPSs stated that access to supervision is limited to an “open door” approach.
- The content of supervision reported includes CPS employment-related issues and a focus on any current challenges the CPSs encounter in working with program participants, their colleagues and other providers. The CPSs also reported that they viewed supervision as an ongoing professional development opportunity. Employment-related issues discussed between supervisors and CPSs included such things as childcare arrangements, caring for an elderly parent, balancing school with work and overall wellness.
- CPSs also stated that they felt comfortable expressing opinions and ideas at staff meetings.

***What was the most valuable thing that you took away from the original Peer Support Training that you attended?***

- The most prevalent response to this question concerned the Wellness Recovery Action Plan (WRAP). The importance of this self-directed practice tool cannot be understated.
- Other themes that emerged included learning how to engage people, self-advocacy and advocacy on behalf of others. CPSs described the positive impact the training had on their confidence and self-esteem.

***To what extent did the Peer Support Training equip you in your current role as a certified recovery specialist and/or a certified peer specialist?***

- CPSs reported that the training was critical in establishing their skills in initiating contact and maintaining engagement with program participants.
- Other themes included self-disclosure, using one's recovery journey to inspire and encourage hope in program participants and colleagues, and the process of developing a plan to maintain their mental health wellness in the workplace.

***From your perspective, what additional things might have been included in the original training that would have been helpful in preparing you for your current role?***

- CPSs shared that receiving more in depth training and ongoing coaching in Motivational Interviewing would have been helpful to them in their work.
- Many of the CPS focus group participants did not cite the following; however, when these topics were raised, they resonated with the focus group members: understanding more clearly the role of the CPS, greater skill development in documentation, ability to facilitate groups and an orientation to general workplace practices.

***From your perspective, what has been the overall impact of the work of peer and recovery specialists in benefiting those in recovery who are receiving or seeking support?***

- The most prevalent theme was how much more acceptable it is to admit that one is in recovery. Using self-disclosure as an engagement technique paves the way for people considering services (and those receiving services) to feel more comfortable sharing their lived experience.
- It is difficult to measure the impact that CPSs have had upon others regarding the possibility of employment in the behavioral health/addiction system, and of pursuing advanced education and obtaining an advanced degree beyond a high school diploma. However, evidence of this influence further strengthens the image of CPSs as role models in the behavioral health system.

***In what ways can Philadelphia’s Behavioral Health system continue to move toward a recovery-oriented system of care, one where peer voice, leadership and support are at the cornerstone?***

- The most prevalent response was that DBHIDS could make available additional training and educational opportunities for Supervisors and Managers regarding the value of the CPS role in service provision.
- DBHIDS and provider organizations could also facilitate the deepening of the CPS presence and role in the system by supporting the pursuit of CPRP certification by CPSs, increasing the CPS wage and identifying innovative ways to utilize the CPS in the overall behavioral health and addictions workforce.

***DBHIDS is in the early phases of significant enhancements to the framework and organization of peer services. That is one of our purposes for conducting these focus groups. We can’t create it without the voices of our peers.***

- Create incentives for employers to hire CPSs.
- Establish a career ladder for CPSs to move beyond the CPS position.
- Provide financial support for the pursuit of the CPRP and CAC credentialing.
- Establish standards and expectations regarding the CPS supervisor training, attendance at special CPS supervisor meetings and the creation of a system-wide CPS supervisor model.

## **Results from the Supervisor/Manager Focus Groups**

***Please describe your approach to CPS supervision ... frequency ... goals ... etc.?***

- CPSs receive support from weekly individual supervision meetings and/or access support based on the open door policy of the manager and/or supervisor.
- The topics discussed during supervision focus on workplace issues, including documentation and the achievements and challenges of program participants.
- CPSs receive peer support (from other CPSs) and ongoing practice improvement through their attendance at the monthly CPS Professional Development and Networking (PDN) meetings. However, attendance at these meetings varies significantly from month to month.

***What are the Peer Support Specialists’ day-to-day responsibilities in your program?***

- Engagement and outreach with people in recovery and program providers in person, on the phone and in the community

- Facilitating recovery education groups (WRAP, Men's and Women's groups)
- Connecting program participants with resources for housing, obtaining legal documents (state IDs and birth certificates) and training participants in use of transportation systems
- Participating in team, linkage, case authorization, recovery planning and treatment planning meetings, planned and unplanned

***Please share with us your experiences and observations regarding the benefits of peer staff in serving people on their recovery journey in your program?***

- The ability of CPS staff to connect with program participants, especially participants who are particularly difficult to engage
- The ability of CPS staff to use their lived experience in engaging with program participants, and the inspiration their stories have for their colleagues
- Their knowledge of and relationships with the resources, access processes and key people within the community

***What has been the greatest challenge in their role as a peer specialist in your organization?***

- Difficulty understanding and using an ethical and personally informed approach to boundary management in CPS work
- Difficulty maintaining personal wellness at the workplace, for example, limited use of vacation time, not taking enough breaks during the workday and working too many extended days
- Limited communication with supervision about personal or professional challenges they might be experiencing
- The fact that achieving role clarity is not a one-time task but requires continuous attention in the context of CPS employment

***What improvements to the original training would be helpful in preparing peer staff for their current role?***

- Instruction regarding the completion of basic documentation, including notes taken after sessions with people participating in services
- An introduction to computer skills, including sending email and using Word and Excel
- Additional training on ethics and boundaries in Peer Support services
- Availability of and access to internship opportunities after training
- Ability to use Electronic Health Records
- Leadership skills training

***What has been the overall impact of the work of peer and recovery specialists in benefiting those in recovery who are receiving or seeking support?***

- The fact that CPS staff are living evidence that recovery is possible for everyone, communicating hope
- Their ability to engage with challenging program participants
- Their candidness and willingness to give honest feedback on systemic issues

***What has been the greatest success (then challenges) in your role as a Manager/Supervisor in a program that includes peer support?***

*Successes*

- CPS staff facilitating the work of program participants in achieving their recovery plan goals
- CPS staff advancing their education by enrolling in college and obtaining advanced degrees
- Positive feedback from program participants and family members about CPS work performance.

*Challenges*

- High levels of burnout and relapses amongst CPS staff
- Supervisor difficulties in managing their boundaries with CPS and ensuring that supervision focuses on the work and CPSs receive any necessary therapy support in other contexts
- Lack of basic computer skills among CPSs

***DBHIDS is in the early phases of significant enhancements to the framework and organization of peer services. How can DBHIDS improve Peer Services?***

- Provide funding incentives for agencies to hire CPSs; additional CPS positions are not created because the funding often does not exist
- Resume support; CPSs looking for work often do not have a resume, or their existing resumes need improvement
- Establish post-training internships
- Persuade additional colleges (besides CCP) to accept CPS training as college credit for behavioral health, human services or social work degrees
- Create a long-term CPS training curriculum, adding continuing education and professional growth opportunities to the initial training
- Train other provider staff about the role of a CPS

- Involve supervisors and managers in CPS training; engage supervisors and provide technical assistance; create follow-up supervisor training and consultation beyond the start-up phase

## Summary of All Focus Group Findings

### Strengths

- *The CPS passion for service and the power of storytelling:* There is clear evidence of a passion for service, and the power of the CPS story is key to success in their work and in the contribution they make to the DBHIDS transformation in general.
- *Lived experience as the foundation of support:* CPSs' own lived experience is a foundation for the support they provide to people in meeting their recovery challenges, no matter what those challenges might be.
- *Assertive outreach and engagement as a foundational practice:* CPSs describe their role as largely driven by assertive outreach and engagement in both friendly and difficult environments.
- *The CPS role as a gateway:* The CPS role has served as a gateway to additional professional pursuits, including enrollment at colleges and universities seeking advanced degrees and/or designation as Certified Psychiatric Rehabilitation Professionals or Certified Addiction Counselors, etc.
- *Navigating the system in partnership with those whom they support:* This is a significant role played by peer support staff, and they take pride in working and navigating the system on behalf of people participating in services.
- *Impact of the peer support role upon peers, staff and agencies:* Though this impact is not universal, it is acknowledged by staff at all levels of the system.
- *Improved understanding of the peer support role:* This understanding has grown among peer support staff, their colleagues and their supervisors.
- *Intense desire for self-improvement and attaining excellence in a variety of relevant skills.* (This strength is discussed in the final sections of this report.)

### Challenges

- *Confusion about the CPS role:* Though it is improving, CPS role confusion persists and continues to create inconsistent on-site implementation of peer support. This confusion diminishes the original intentions for the position.
- *Lack of consistency in supervisory guidance, coaching and support:* This lack of consistency in the provision of CPS supervisory supports exists across the system, despite the presence of regulations.
- *CPS overextension:* Employed CPSs tend to work long hours, and in many cases consistently overextend to the point of exhaustion. According to focus group members, this challenge is often a result of a lack of clear boundary setting, lack of direction from supervisors or challenges in trying to address the needs of extremely deprived and distressed individuals.

- *Funding shortfalls and a lack of understanding of funding:* This serves as a barrier to wider peer support implementation. Results of the focus group process did not identify the degree to which adding CPS positions was a priority in the system.
- *Continued challenges for integration into the workplace:* CPSs often have challenges integrating and assimilating into the workplace environment, and implementation often lacks sufficient measures for preparing provider teams to assimilate new CPSs.
- *Inability to adequately fulfill CPS documentation expectations:* CPSs, supervisors and managers described this as a significant hurdle in taking full advantage of the CPS perspective within the clinical team, and in meeting the standards of the DBHIDS and regulatory bodies.
- *Reduced attendance at citywide CPS and Supervisor support groups:* This attendance has diminished over the past five years, resulting in some reduction in community building among peer support staff across the system.
- *Challenges in integration of clinical treatment and long-term recovery support:* This hallmark of the DBHIDS ROSC transformation requires continued innovation.

## **B: All Survey Results**

This section provides a summary of the survey findings from the three groups participating in the asset-mapping process: 108 Certified Peer Specialists (CPS), 33 CPS Supervisors and 38 CEO or Upper Level Leadership staff. All percentages reported below are based on the population in each participant group.

### **CPS Survey Results (N = 108)**

A total of 108 Certified Peer Specialists were surveyed on various aspects of CPS employment, including CPS training, employment preparation, work environment and the CPS role.

- From the CPS perspective, CPS training was effective in preparing them to interview for a CPS position and to start work as a CPS in an agency. Nearly 7 out of 10 CPSs reported that they felt as if CPS training had prepared them for their job interviews, while nearly 9 out 10 CPS reported that they felt as if CPS training had prepared them to obtain a position as a CPS.
- Job placement is a strength of the DBHIDS CPS recruitment effort. At the time of survey completion, most CPSs had full time positions and had secured their positions quickly after graduating from CPS training. Of those employed, 63% of CPSs currently had full-time positions, while 37% had part-time positions.
- CPS training was relevant to their careers, with 77% of CPSs working within designated CPS roles. The positions cited were those of Certified Peer Specialists, Peer Specialists, Community Recovery Specialists, Peer Support Specialists, Intervention Peer Specialists, Recovery Specialists, Recovery Coaches, Veteran Recovery Coaches and Peer Recovery Coaches. The vast majority of CPSs (82%) reported that peer support training prepared them for their current positions.

- The benefits (compensation plus healthcare) that CPS receive are comparable to those of similar workforces. On average, full-time CPSs received \$15.56 per hour, while part-time CPSs received \$12.30 per hour. Receipt of health benefits depended on whether a CPS was employed full time or part time. Of the CPSs who were employed full time, 94% received health care benefits. Overall, only 68% of CPSs received health benefits, which reflects the fact that part-time staff does not receive these benefits.
- Most CPSs expressed hope for further advancement in their newly acquired careers, with 72% of CPSs reporting that they believed there would be opportunities for advancement, promotion or a salary increase in the years ahead.
- Only 15 of the 108 respondents who had completed CPS training were unemployed. Of the unemployed CPSs, 50% were seeking employment, while the other half were not seeking employment. The reasons reported for not seeking employment were mental health challenges, administrative hiring delays and self-perceived lack of experience.
- Of the CPSs who were unemployed, most were contributing to their community by volunteering in DBHIDS-sponsored events as Recovery Advocates, participating in *Taking It to the Streets* and/or volunteering at CPS job fairs.
- CPSs reported engaging people both within the agency and in the community. CPS practice includes the following:
  - 74% of CPSs facilitate group discussions and provide recovery education.
  - 92% of CPSs reported that they engage people in recovery within their office/provider community.
  - 89% of CPSs reported that they engage people in recovery in the community.
  - CPSs reported a lack of participation in Peer Advisory Councils, with only 45% either supporting or participating in these councils.
- CPSs play a significant role on clinical teams. Of the respondents who work in clinical settings, 96% of them reported collaborating with clinicians. CPSs reported participating with clinicians in providing input into assessment, service planning and continuing support.
- Supporting program participants' recovery journey is fundamental to the CPS role. A primary method they employ is the use of recovery check-ins. CPSs reported that recovery check-ins are used both before and after a treatment episode. Of those CPSs engaged in check-ins, only 62% reported that they had received training in providing that service. The survey indicated that 90% of CPSs had self-disclosed their recovery story as a part of their work as a CPS.

### Supervisor/Manager Survey Results (n = 33)

A total of 33 CPS supervisors were surveyed on various aspects of CPS employment and CPS workplace integration. The survey of supervisors focused on five subject areas: supervisor training, CPS hiring, the employment process, the supervision of CPSs, and the peer culture at agencies.

- According to supervisor responses, supervisor training can clearly improve participation and effectiveness. Regarding participation, only 67% of supervisors reported that they had attended the CPS Supervisor Orientation training. Asked why they did not attend the training, they reported that training was not offered to them, they lacked opportunity to take the training and/or they believed that the background of a certified peer specialist and/or certified recovery specialist made supervisor training unnecessary. Of those who attended training, 67% agreed with the statement that the training had prepared them to supervise CPS, but only 5% indicated that they strongly agreed with that statement.
- Supervisors largely reported that CPSs were prepared for their job interviews, with 75% of respondents reporting that CPSs were adequately prepared for their interviews and 25% reporting that they were not. Leading resources used to recruit CPSs were vocation websites like CareerBuilder and CareerLink, word of mouth, CPS Job Fairs and hiring people within their agencies who had graduated from CPS.
- Most supervisors reported that CPSs were only somewhat prepared for the work place when they began. 70% of supervisors reported CPSs were “somewhat prepared,” and only 11% reported that they were “very prepared.” This is in stark contrast to CPS survey results, in which 59% reported that they were very prepared for the workplace. Overall, supervisors were 81% less likely than CPSs to believe CPSs were very prepared for the workplace. According to supervisors’ responses, there were several areas in which CPSs needed work to improve their adaptability to the workplace. The two main areas in which they reported a need for improvement were CPSs understanding of workplace practices and boundaries and their writing and documentation skills.
- Supervisors reported that CPSs were often promoted to higher positions. 78% of supervisors reported that CPSs on their staff had at one time been promoted to higher positions. CPSs who were promoted were often promoted to positions as Case/Care managers, CPS Supervisors, Assistant Case Managers/Case Technicians or CPS Coordinators.
- Supervisors largely indicated that they believed it was acceptable to employ CPSs who have been involved in the criminal justice system, with 85% of supervisors reporting that their agencies hired CPSs with criminal backgrounds.
- Most supervisors also reported that they believed it was acceptable to employ CPS interns, with 70% reporting that their agencies would be open to hiring interns.
- Supervisors conducting supervision sessions with CPSs is common. 72% of responding supervisors provided either weekly or bi-weekly individual supervision with peer support specialists (29% weekly, 43% provide bi-weekly). Another 21% of supervisors reported providing supervision once a month. A substantial percentage of supervisors also receive supervision, a critical element for them as well as for their CPSs. 79% of responding supervisors reported that they received ongoing supervision and/or training to support their supervision. Unfortunately, a large percentage is not receiving training or supervision through the DBHIDS-sponsored Bi-Monthly CPS Supervisors meeting. Only a slight majority (52%) reported they attend that meeting. However, all 14 supervisors who reported attending the bi-monthly CPS Supervisors meeting indicated that they found it helpful.

- 69% of responding supervisors reported that agency staff understand the importance of the CPS role in service to people enrolled in their program. They also indicated that their agencies encourage CPSs to develop in their profession. 88% of responding supervisors reported that CPSs are encouraged to attend outside trainings during working hours, to enhance their professional development.
- Community integration is a central component in the transformation of DBHIDS services. CPS Supervisors and CPSs themselves agree that those receiving services benefit from both site-based activities and working within the community of the individual being served. However, only 38% of supervisors reported that CPSs facilitate, support or participate in agency Peer Advisory councils.

### CEO and Upper Management Results (N = 38)

A total of 38 provider CEOs and upper management staff were surveyed in order to gain their perspective on CPS involvement in their agencies. Areas covered included the growth of agency peer culture, the employment of Certified Peer Specialists and sustaining the CPS role within agencies.

- The majority of upper management respondents reported having a positive opinion about the quality of peer culture at their agency, with 77% reporting that they viewed the peer culture at their agency as strong. Many respondents (63%) indicated that they have a positive view of the progress that has been made with the inclusion of peer supports at their agency. However, a disconcerting 37% indicated that they were neutral or had a negative perception of the direction of CPS inclusion.
- CEOs reported that the integration of CPSs agency-wide is limited to a select number of staff, rather than being infused throughout an agency. The majority of upper management respondents reported that 25% of staff or less participates actively in the integration of CPSs in their day-to-day programs. However, reports indicated that some agencies (less than half) are models of CPS integration.
- In establishing peer culture, the right resources are essential. According to upper management, the three main vehicles for establishing a formal peer culture were the involvement of internal staff (84%), DBHIDS training on peer culture (72%) and the active participation of people participating in services (68%). Reasons cited for not establishing an active peer culture were financial limitations, incompatibility between populations served (such as individuals with intellectual disabilities or autism) and peer supports, lack of opportunities for CPSs and an existing informal peer network that makes a formal peer network unnecessary. Findings indicated that upper management could benefit from specific consultation regarding their critical role in facilitating the growth and understanding of peer culture.
- Of the programs represented in the survey, most CPS positions (80%) are currently filled. According to upper management, the three main resources used to recruit people for CPS positions are word of mouth, CPS Job Fairs and CPS training organizations.
- One area in which respondents indicated concern was the hiring of CPSs with criminal justice histories. While 52% of upper managers reported that they hired CPSs with criminal histories, 39% reported that they occasionally hired people with these histories and 2%

reported that they did not hire people with criminal justice histories. Confusion seems to focus on what types of crimes should be taken into account in the hiring process. Factors they reported taking into account when hiring CPSs included whether the crime was recent, of sexual nature, of violent nature, involving children or involving welfare or Medicaid fraud. In the future, organizations will need more clarification regarding how and when forensic histories should be taken into account when hiring CPSs.

- Another area of concern was agency tracking of hired CPSs, with indications that tracking was not taking place in many agencies. 61% of upper management reported that they did not track CPS careers or attrition rates.
- According to upper managers responding to the survey, CPSs work in many programs and positions within their agencies. 53% of upper managers reported that CPSs work in Psychiatric Rehabilitation, 26% reported they work in Intensive Case Management and 21% reported that they work in Resource Coordination. Outpatient is also a common level of care for CPSs, with 37% of Upper Managers reporting CPSs working in outpatient programs. The most common position for CPS employment is a designated Certified Peer Specialist position, with 75% of Upper Managers indicating this finding. However, respondents reported that Certified Peer Specialists could also fill other peer-related positions. These positions include those of Recovery Coach, Recovery Advocate, Recovery Specialist, Recovery Worker, Community Integration Specialist, Employment Specialist, Recovery Educator and Residential Advisor.
- Consistent with responses from CPSs and Supervisors, upper managers indicated that CPSs are commonly promoted, with 74% of upper managers reporting that their agencies promote CPSs to higher positions. 35% of upper managers reported that they had promoted CPSs to CPS Supervisors, and 29% had promoted CPSs to Recovery Coaches.
- The idea of having CPS graduates work as interns at their agencies appeals to CEOs/Upper Managers, with 73% of respondents stating that they would hire CPS graduates as interns in order for them to acquire critical work experience. Of the Upper Managers interested in having CPS graduates work as interns with their agency, 74% reported that they would prefer unpaid interns exclusively, while one CEO (representing 5% of the sample) wants only paid interns. Another group of four CEOs (21%) reported that they prefer to have both paid and unpaid interns.
- Two challenges emerged regarding CPS employment development and sustainability. The first is that upper managers indicated that their agencies are not willing to invest in the development of new CPS positions, with 52% of CEOs reporting that they are neutral or not open to investing in the development of new CPS positions at their agency. The second challenge is the lack of a thorough understanding of CPS funding among upper level managers. Only 41% of responding upper-level managers indicated that they are knowledgeable about the funding and reimbursement process for securing CPSs. While most indicated that they are at least somewhat knowledgeable on funding and reimbursement, few lack strong knowledge.
- CEOs and upper management are only somewhat clear about the roles and responsibilities of CPSs, with only 45% of upper managers reporting that they strongly agree they have a clear vision of the roles and responsibilities of CPSs. Fortunately, upper-level managers report that frontline staff possess a better understanding of peer support than they do, with

91% of upper level managers indicating that the staff in their organizations understood peer support.

- For upper managers, the two main resources for staying informed on the themes of peer culture, support and leadership are “DBHIDS and BHTEN trainings” (83%) and “Executive Management Meetings” (65%). Another major resource was OMHSAS, with 43% of upper managers reporting that they gathered information from that source.
- A positive aspect of peer culture is that CPSs are encouraged to pursue professional development, even during office hours, with 76% of upper level managers indicating that their agencies encourage CPSs to attend outside training for professional development during regular working hours.

## Summary of All Survey Findings

### Strengths

- A majority of agencies are open to hiring CPS candidates with forensic histories.
- A majority of agencies are open to having unpaid CPS interns.
- Though attendance has varied over the last several years, CPSs are interested in attending the monthly CPS Professional Development and Networking meetings, if programs allow it.
- Recruitment of CPS positions occurred through vocational websites, work of mouth, CPS job fairs and hiring from within the agency.
- Post-training job placement occurs swiftly.
- Supervisors indicated that CPSs were often promoted to higher positions.
- CPSs fill a variety of positions within the system, and several job descriptions with inter-related knowledge, skills and abilities exist in the system.
- Benefits and compensation for full-time CPSs are within an acceptable range. As is true in many labor categories, part-time employees often suffer from lack of benefits, and this is true for part-time CPSs.
- Most agencies offer part-time and full-time CPS positions.
- CPSs for the most part reported that the initial training prepared them for employment within an agency. Supervisors did not agree with this assessment and reported that the training did not adequately prepare CPSs for employment.
- Of the CPSs completing the survey, 93 of the 108 were employed as CPSs or similar job description. Most of those not employed were volunteering within their roles.
- Most CPSs employed within treatment programs report that they participate in and collaborate with the treatment team.

- CPSs often use the widely accepted practice of recovery check-ins in their work with people in recovery.
- CPSs and CPS Supervisors agree that the CPS role involves both site-based and in-community engagement.
- In general, CEOs and upper-level management hold positive views of the work of certified peer specialists and of the inclusion of peer supports with their enrolled population.
- CEOs identified three main vehicles in support of establishing a peer culture within their organizations: staff work to help activate the peer culture, DBHIDS training on peer culture and the active participation of people receiving services in these efforts.
- Among the programs represented in the survey, 80% of CPS positions are filled.

## Challenges

- Tracking of peer support employment variables must be improved to facilitate understanding of the conditions that sustain job satisfaction.
- Greater system-wide understanding of peer culture is needed, along with the steps that providers can take to encourage its growth.
- CPS pre-employment preparation and the orientation of CPSs at employment startup must be enhanced, with 81% of responding supervisors reporting that CPSs were not very well prepared for the workplace.
- Challenges specific to CPS supervision include the following:
  - Inconsistent supervision practice remains a significant issue.
  - Supervisors do not regularly attend the bi-monthly CPS Supervisors meeting.
  - Only 67% of supervisors completing the survey participated in the prescribed initial CPS supervisor training.
  - There are strengths in CPS supervisory practices, demonstrated (in terms of frequency) by the finding that 72% of supervisors meet individually with CPSs on a weekly or bi-weekly basis. However, 21% of supervisors reported their frequency of individual supervision at one time per month.
- The CPS training should emphasize the importance of documentation as well as ethics and boundaries (professional and personal).
- Supervisors and CPSs reported that only 45% and 38% (respectively) of CPSs participate in or support the work of a Peer Advisory Council. What was not asked and is not known is whether this number is more an expression of their participation per se or of the availability of Peer Advisory Councils in the system.

- Only 62% of responding CPSs reported that they have received training in providing recovery check-ins, a skill that is often used in their work.
- CEOs reported that the infusion of peer support into their organizations is limited to an estimated 25% penetration into all levels of care.
- Though CEOs and upper-level management were supportive of hiring individuals with criminal justice histories, they also expressed confusion as to the types of crime that should be taken into account when hiring.
- Regarding the increased deployment of CPSs in the system, half of the CEOs and upper-level managers surveyed reported that they were not open to developing new positions, and only 41% reported that they are knowledgeable about the funding and reimbursement process for securing CPSs.

## Section IV: Discussion

This Discussion section identifies some of the principal themes that surfaced during the asset-mapping process. In many ways, these themes represent the continuing story of recovery support, tracking from the beginning of the transformation until today. These themes will inform the strategic direction and next steps presented during the remainder of this report. The themes represent a synthesis of survey data and focus groups findings, as well as contributions from discussions and the drafting of preliminary reports by the DBHIDS Strategic Planning Division and Transformation Research Unit. In addition, a sampling of quotes gathered during the focus groups of CPSs and supervisors provide another voice in this story.

### **Theme 1: Peer Culture, Support and Leadership as an Activator of System, Program and Individual Transformation**

*“Being a survivor of substance abuse helps others to begin their recovery journey”*  
*“Modeling the way has made such an impact in the peer movement in what I have seen in the city”*

The significance of the implementation of peer support during the early stages of system transformation in Philadelphia was clear throughout the asset mapping process. CPSs refer to the transformation process in many ways as **their** transformation, and they have linked their journey in many ways with that of the system. Their knowledge and familiarity with the history of the effort was stunning, and their passion for service and interest in participating in this project further underscored their commitment to the ongoing success of this transformation.

Stories of the day-to-day work of CPSs were often discussed during focus groups. Given that CPSs participating in the focus groups represented 10 years of program implementation, their role in affecting the thinking and practices of programs was at the core of many focus group discussions. In the stories they told of their roles during program-level transformation and the teaching and inspiration they have provided their colleagues and program participants, the impact of those efforts may not be measurable, but in the opinion of CEOs, upper-level management and supervisors, these were and continue to be significant contributors to the deepening of the recovery orientation of services.

### **Theme 2: Initiating Structures, Policies and Expectations that Support(ed) the Growth of Peer Culture**

*“My CPS training was a self-esteem booster for me”*  
*“Organizations need to understand the need for CPS”*

Five key features that provided important guidance to the implementation of peer support were: funding support, clear provider-level job descriptions approved by DBHIDS, CPS and CPS supervisor training, preparing the provider environment for the inclusion of peer support and the

role that the DBHIDS assumes in ensuring alignment with these expectations. DBHIDS has played a significant role in supporting the funding of CPS positions. It has also operationalized an oversight role to ensure that job descriptions, all training and environmental preparation were completed, were of high quality and were aligned with DBHIDS goals .

These efforts were discussed during the focus groups and are considered critical to ongoing success. Focus group participants expressed concerns regarding a “drift” in the system’s attention to peer culture, support and leadership in the last several years, specifically in attention to the continuation of provider training and environmental preparation. The possibility of bringing an enhanced focus to further institutionalization of the DBHIDS role will be discussed in the following sections of this report.

### **Theme 3: The Impact of Witnessing the Work of Peer Support Staff**

*“I am able to use all aspects of myself ... the things I am good at ... the things that remain difficult for me”*

*“My ability to meet people ‘where they are’ is important to what I do”*

*“My knowledge of resources and talking about them with my colleagues makes me feel that I am making a contribution at my program”*

The disruption posed by the transformation process was significant. Program policies, staff practices, supervision and management, all at the program level had to be retooled and in many cases replaced. Everyone, including people participating in services, felt the anxieties, doubts and fears associated with such a significant shift. Part of this disruption had to do with answering questions and concerns such as:

- How do I as a provider of services conduct myself now?
- What does it mean to be recovery-oriented?
- What is my role in the helping relationship?
- I am worried that I will do something wrong
- How do I partner with the new certified peer specialists who are now on staff in my program?

Traditionally trained behavioral health staff received training, orientation and expert consultation in aligning their work with a recovery orientation. However, the relationships developed with peer support staff and the openness of staff in witnessing and understanding the work of CPSs made a huge contribution to changing the hearts and minds of people in the system. This story was told throughout the focus groups and is present in the survey data.

Several factors have emerged as essential to this discussion, including the importance of a sustained effort to deepen the transformation, the attrition rate of staff and a number of new challenges (such as health care reform and a blending of behavioral health and public health approaches). Given these and other factors, having peer support staff play a significant role in these new endeavors as well as continuing to “model the way” is no less important now than it was ten years ago.

#### **Theme 4: Sustaining the Power of Peer Support**

*“I do not see my CPS position as a job; I enjoy doing this work”*

*“I encourage people in their journey”*

*“If I am going to continue to be a good CPS, I need training, supervision and support”*

*“I model recovery, and that helps to remove stigma”*

*“Organizations don’t always understand the need for Certified Peer Specialists”*

*“People often devalue the importance of CPS”*

The data clearly reflected where systematic efforts to infuse peer culture, support and leadership were present, but it also contained several findings requiring reflection, renewed efforts and the establishment of a stronger leadership role by both DBHIDS and system leaders. A rebirth ensures the relevance, growing presence and deepening of peer culture, support and leadership in the decade to come. This final theme will inform the content for the next two sections of this report.

## Section V: Recommendations and Next Steps

The asset-mapping process produced a wide range of findings at the system, provider and staff levels. For that reason, a range of response strategies is required that will involve the knowledge, skill and actions of an array of stakeholders. The process also communicated to DBHIDS, providers, CPSs and other stakeholders a strong mandate to widen and deepen the implementation and institutionalization of certified peer specialists in all levels of care, in system/provider leadership positions and in community opportunities. This mandate calls upon, not just DBHIDS, but all providers to take increasingly greater leadership in fulfilling this mandate.

This section is organized to target the work at these multiple levels. Below is a three-tiered response framework that would involve efforts at the system, program and staff levels.

### A. Tier 1: System-Level Initiatives

#### 1. Creation of a Strategic Plan specific to this core value of Transformation

Complete a *Peer Culture, Support and Leadership Strategic Plan* that would expand upon the historical strengths of the peer-level achievements of the transformation process while addressing current and anticipated challenges, and develop a peer-based public health approach to treatment and community supports. The results of the current report may provide a significant portion of the basis for this important task. More than a document, this plan may serve to:

- articulate an assertive vision for the future of peer culture, support and leadership;
- identify concrete strategies, action steps and accountabilities necessary to broaden access to peer support services and long-term recovery support throughout the system; and
- suggest innovative policies, system-wide practices and compliance measures to ensure that the preferred practices for CPS expansion, oversight and CPS provider initiation are clearly articulated, communicated and understood.

#### 2. Empanel a new Peer Culture Transformation Advisory Board (PCTAB)

This Board would be composed of CPSs, provider leaders who are proven recovery champions, family members and community stakeholders, as well as DBHIDS leadership. It would serve as the continuous quality improvement arm of Peer Culture Transformation and associated initiatives. The Board would assist DBHIDS and the entire system by:

- serving as a guardian for the DBHIDS and Provider vision of peer culture, support and leadership in the years to come;

- increasing the leadership role of the Provider community in infusing peer culture, leadership and long-term recovery support within all behavioral health programs in Philadelphia;
- establishing peer support in all programs in the city;
- identifying priorities for funding and growth over the next 10 years; and
- assisting DBHIDS in the formation and execution of the *Peer Culture, Support and Leadership Strategic Plan*, by taking primary responsibility for oversight of its management and execution.

### **3. Create the CPS Employment and Technical Assistance Program (CETAP)**

In partnership with Providers, this program of the DBHIDS's Peer Culture and Community Inclusion Unit (PCCIU) would create supports for newly trained CPS graduates, as well as the existing CPS workforce, either employed or seeking employment. Such supports may include:

- Career exploration activities, including resume development and mock interviews
- Orientation to workplace cultures and typical workplace expectations, combining the refinement of the initial 2-week training with a comprehensive orientation and coaching established by each Provider
- Support in connecting employers and CPSs with available entry-level behavioral health positions
- Engagement of local colleges and universities in accepting CPS training and WRAP Facilitator training as credit toward an advanced degree in human services or other relevant degree program

This program would be further defined as a part of the *Peer Culture, Support and Leadership Strategic Plan*.

### **4. Create the CPS Internship Program**

PCCIU would develop partnerships with behavioral health/addictions providers and community businesses that would allow CPS graduates to participate in a 4-to-6-week supported, experiential internship opportunity. The internship would provide CPS graduates with critical workplace experience that would improve the marketability of the CPS position and increase the peer support and customer service skills of the internship's participants. This program would be further defined as a part of the *Peer Culture, Support and Leadership Strategic Plan*.

### **5. Link Peer Culture, Support and Leadership to DBHIDS and Provider Priorities**

Create initiatives and strategic partnerships, both within DBHIDS and with community partners, to ensure the primacy of peer culture, support and leadership as a foundation of system planning and action. Considerations might include the following:

- The *Peer Culture, Support and Leadership Strategic Plan* should inform and be influenced by the overall DBHIDS Strategic Plan.
- The Peer Culture Transformation Advisory Board (PCTAB) should appropriately engage in the creation of peer-related initiatives that would benefit programs and increase the success of the overall peer culture transformation process.
- As DBHIDS and the provider community contemplate and develop plans involving healthcare reform, the evolving public health approach and the wider activation of community inclusion, peer culture, support and leadership should be woven into these and similar efforts. Peer support represents a critical element of health activation, and CPSs have significant potential for assisting in the navigation of healthcare systems and promoting wellness in the broader community.
- This would call for a wider distribution of peer voices than currently exists in the system. With the Strategic Plan and the PCTAB recommended above, DBHIDS would be taking bold steps to infuse peer voices into future planning and function. At the provider level, the following steps should be considered:
  - Expand CPS employment opportunities within the provider community.
  - Establish high-quality supervision practices throughout the system, including supervision for CPS staff.
  - Infuse peer culture among all providers and on all levels of care.
  - Ensure environmental preparation for the initiation and/or expansion of peer support in provider organizations.

## **B. Tier 2: DBHIDS- and Provider-Level Initiatives**

This tier couples the importance of establishing and implementing system-wide policies regarding peer support with the importance of provider alignment with such policies and practices. For the purposes of this report, Tier 2 will identify program and professional development supports that may help guide the system toward adherence to developed policies and practices. With wide-ranging stakeholder involvement, the Peer Culture Transformation Advisory Board would be a logical body to craft the specifications of these policies and practices and, once they have been approved by DBHIDS, communicate them to the system. In partnership with the peer support technical assistance arm of the Strategic Planning Division (the CETAP), the Advisory Board would also continuously identify the kinds of provider supports that would be necessary, both to adhere to developed policies and to enhance peer support in the years ahead.

The following are strategic policy recommendations for the DBHIDS/Provider system:

1. Initiate steps to broaden access to CPS services throughout the system.

2. Establish a mechanism (consider the PCTAB) for ongoing clarification and institutionalization of the role of the CPS and other peer support roles in the system (such as peer support volunteers).
3. Establishment of a system-wide supervision framework for all peer support staff, to be implemented in all programs and monitored by DBHIDS.
4. Reestablish specifications for the following:
  - Required steps to be taken by providers when they are adding CPSs to a program, including CPS training requirements, CPS supervisor training and preparing the treatment environment for the inclusion of peer support staff
  - Preparation by providers of a relevant job description for any new CPS position
5. Establish provider-level personnel tracking systems, to allow for the exploration of CPS employment sustainability, separation and other key employment factors.

The following recommendations are designed to bolster the abilities and practices of peer support staff:

1. Develop and improve the CPS and supervisor support networks, in order to create an environment conducive to the growth of a city-wide peer culture community, including collaborative learning, networking and skill enhancement for the people providing and supervising peer support services.
2. Provide weekly one-to-one CPS supervision, designed to address the successes and challenges encountered by CPS staff in the provision of services to each individual.
3. Develop and introduce *Integrating Peer Staff Within Service Settings: Guidelines and a Toolkit for Treatment Providers*. This toolkit, currently in development, will be available in early 2016 and will serve as guidance to providers in the implementation, provision and supervision of peer support services.
4. Develop and introduce additional tools and toolkits for daily use by peer specialists in the execution of their roles. Where appropriate, develop structured guidance in the performance of their roles, such as scripted lesson plans and curricula for a variety of peer-run groups, guidance in the application of evidence-based practices and tools that assist with documentation.
5. Develop preferred practices for treatment and peer support collaboration, including strategies for teaching, modeling and institutionalizing such practices at the provider level.
6. Develop and support innovative strategies for the completion of peer support service documentation. Documentation is a key concern throughout focus groups and surveys at all levels. It often relies on traditional methods of capturing information on services provided by CPSs. Given the traditions of most clinical and other professional staff, new and

seasoned CPSs continue to find themselves at a disadvantage in this regard. It is hoped that greater efficiencies and strategies can be found to address this ongoing concern.

7. Create strategies to incentivize CPSs in their expressed desire for self-improvement, their desire for increased formal education and the supports necessary to acquire advanced certifications (such as CPRP or CAC).
8. DBHIDS would conduct the 2016 Future-Focused, Peer-Informed Public Health Symposium, designed: 1) as a system-wide renewal of the commitment to peer culture, support and leadership; 2) as an opportunity to identify best practices in peer support; and 3) to explore the role of peer support in the evolving DBHIDS public health transformation.

### **C. Tier 3: CPS-Level Strategic Initiatives**

1. These would include the establishment of a CPS professional development capacity, with leadership from DBHIDS and the provider community, designed to support the initial preparation of CPSs and the ongoing support necessary to further excellent service provision at intermediate and advanced levels of peer support. DBHIDS partnerships with the Mental Health Association of Southeastern PA's Institute for Recovery and other training and educational institutions might serve as resources for fulfilling this objective. Appendix H contains a listing of all training areas identified during this asset-mapping process. The PCTAB and CETAP would be accountable for guiding this effort.
2. During the information-gathering process for this study, several CPSs expressed their passion for the work they do for people and expressed how far they would extend themselves to fulfill the needs of the individuals they serve. In most cases, this expression of commitment was a statement of personal belief and personal drive. However, at times these efforts also resulted in staff working twice as many hours as they were expected to complete in any one-day or week. This concern is cited here as an issue for the field, for all CPSs and for all supervisors and managers, one that is worth exploring, debating and resolving with an eye toward CPS wellness, and toward the effects of their wellness on their ability to maintain clear boundaries and provide safe and effective services.
3. Additional steps recommended for increasing the understanding of peer culture and support include the following:
  - Increase efforts to deepen the understanding of peer culture and the agency role in activating peer culture and sustaining that growth over the long term.
  - Continuously fine-tune the initial CPS training curriculum and the orientation that programs provide for new CPSs. For some CPSs, it may be the first job they will have in a long time and/or their first job in the behavioral health field. Often the challenges for both employee and employer can be ameliorated by coaching these new employees

during the first 30-90 days in the culture of the organization and clarifying the often unstated expectations that exist in many workplaces.

- The issue of professional/personal boundaries was raised on countless occasions during the asset-mapping process. Given the complexity of this topic, one recommendation is that this become a standing agenda for check-in between supervisor and CPS during weekly supervisory sessions.
- One finding from asset mapping was the low level of involvement of CPSs in the Peer Advisory Councils at programs. What is not known from the data is whether this finding reflects low levels of inclusion, or limitations in the number of Peer Advisory Councils actually in place in the provider system. This finding would be further evaluated by the PCTAB.

## Section VI: The Next Decade

### **The Next Decade of Peer Culture, Support and Leadership: System Transformation as a Journey**

The past decade of system transformation within the behavioral health system in Philadelphia has brought about significant shifts in the concepts, practices and contexts that have helped build a recovery orientation to behavioral health services. The implementation of peer support and certified peer specialists and the integration of clinical and long-term recovery support constituted a foundational element of the DBHIDS system transformation, one that did not exist ten years ago. Lessons learned from this project reinforced:

- the fact that system transformation may at first be ignited by a visionary leader and supported by the actions of people aligned with that vision;
- the vulnerability of innovations to erosion once they have become part of the status quo; and
- if the transformation is to continue, the importance of re-igniting it, to inspire additional change as new practices require refinement.

The relevant lessons include the importance of:

1. appreciating the tenuousness of a newly evolving workforce (in this case Certified Peer Specialists) and idea (ROSC); and
2. ensuring that all stakeholders remain committed to continuous growth, including the institutionalization of the concepts, practices and contexts necessary to support the innovation (ROSC, long-term recovery support, Certified Peer Specialists) over time.

Like individuals, system transformation often requires long-term support. Within any organizational system transformation of this magnitude, this dynamic requires that leaders and stakeholders shepherd the innovations forward, ensuring alignment to the original vision and intent, as well as attending to the essential role of refinement by “adopting, adapting or abandoning” policies and practices meant to produce improved outcomes. A process such as NIATx can assist in those efforts.

With this framework in mind, the future course of peer culture, support and leadership will be intimately tied to the intentions, hopes and ingenuity of the Department of Behavioral Health and Intellectual disAbility Services, provider agencies, CPSs and the community, as the boundary

between the behavioral health system and community living is replaced with real community integration. A 'system without walls' is on the horizon, and certified peer specialists have an opportunity to play a significant role in this deeper application of their lived experience and skills. Peer support staff as activators, integrators, teachers and advocates can and will play many roles in defining and executing the important work to be accomplished in this new landscape.

- A. Peer Focus Group Questions
- B. CPS Supervisor Focus Group Questions
- C. CPS Survey Instrument
- D. Administrator Survey Instrument
- E. CPS Supervisor Survey Instrument
- F. PA MH Bulletin, Attachment 4, 11/1/2006, *Peer Support Services Activities Guidelines*
- G. Peer Support Web Resources
- H. CPS/Supervisor Training Needs Identified During Asset Mapping Process

## Appendix A

### Certified Peer Specialist Focus Group Questions March/April 2015

#### A. General Introductory & Role Questions: Typical day, strengths, and support

1. Please tell us your name, when you attended your training for certified peer and/or recovery specialist, and if you are currently employed, where you are currently employed and how long you have been employed in your role; FT or PT? (State that we know that some attendees may not currently be employed and/or may have previously been employed. State that their opinions, knowledge and ideas on what they know about these roles in the system as well as their ideas for improving the system are incredibly valuable).

2. We want to get a general picture of what a **typical day** looks like for you. Would someone offer to tell us what his or her typical day looks like (not that you are all the same, just in general) – after that we will then ask the rest of you about how your typical day is similar or different. (*Probe here about the other kinds of things they may do in their roles but not mentioned yet – e.g. facilitating peer run groups, involvement with Peer Advisory Councils, recovery check-ins or check-ups*)

3. We want to get an understanding about how you are using your **strengths**, abilities, and gifts as a peer/recovery specialist in your program. Please tell us how you are able to bring these to your work.

3b. What has been the greatest **challenge** regarding your role as a peer specialist in your organization? (Possible areas to probe – time mgt., documentation, personal wellness, setting boundaries, integration with the rest of the team)

4. How are you **supported** in your role as a peer specialist in your program? What does **supervision** look like for you in your role in the program? Have you been provided continuing education and training opportunities in the last year – topics? In your role as a peer or recovery specialist, how are you involved in **discussions/decisions regarding program policies and procedures**?

---

#### B. Questions about Training

5. What was the most **valuable thing** that you took away from the **original** Peer Support Training that you attended?

6. To what extent did the Peer Support Training **equip you in your current role** as a certified recovery specialist and/or a certified peer specialist?

7. From your perspective, what **additional things** might have been included in the original training that would have been helpful in preparing you for your current role?

*(Probe here for specific content or skill sets that given their experience in their roles now, could have better prepared them originally)*

### **C. Questions regarding Impact & Next Steps**

8. From your perspective, what has been **the overall impact of the work of peer and recovery specialists** in benefiting those in recovery who are receiving or seeking support? *(Possible additional probes regarding: accessing services; intake & assessment; assertive outreach and/or re-engagement).*

9. In what ways can Philadelphia's Behavioral Health system **continue** to move toward a **recovery-oriented system of care**, one where peer voice, leadership and support are at the cornerstone?

- How can your agency/program play a role in this?
- How can DBHIDS support your agency/program in doing this?
- In what other capacities can you envision the involvement/contribution that could be made by peer support including peer and recovery specialists?
- For those of you who have or are working in programs where **Common Ground** was implemented, what is your assessment of the value of CG?
- Have you heard of **self-directed care**? What are your thoughts/opinions about it?

10. DBHIDS is in the early phases of **significant enhancements** to the framework and organization of peer services. That is one of the purposes in our conducting these focus groups. We can't create it without the voices of our peers.

- What should the focus be?
- What should the goal of Peer Services be?
- How would you like organizations to be involved?
- How can DBHIDS improve Peer Services?

**Lastly – Is there anything we should have talked about, but did not?**

---

#### **Extra Questions if there is time**

What currently gets in the way of your being as effective as you'd like to be? Do you feel that you work as a team with the clinicians (for those in a clinical setting)?

What has been improved at your organization as a result of your role/position? What still needs to be improved?

## Appendix B

### Peer Services Focus Group Project CPS Supervisor Questions March/April 2015

#### A. General Introductory & Role Questions

1. Please tell us your **name**, where you are currently employed, when you received training for peer/recovery specialist's supervision, how long you have supervised these staff?
2. Please describe **how you provide supervision** to peer/recovery specialists – how often, method (1-1, group, other?). What are the goals of your supervision process? How often do you provide unscheduled supervision – for what purposes may that arise? In what other ways do you ensure the quality of the work of your peer/recovery specialist staff?
3. **What are the Peer Support Specialists day-to-day responsibilities** in your program? Brainstorm these ... Probe the extent to which the following occur >
  - Facilitating recovery based groups/workshops – what kinds?
  - Community Connection/Integration Activities – describe?
  - One-to-One Peer Support – provide examples of how, when, for whom this happens?
  - Peer Advisory Council support? – how?

---

#### B. Benefits and Challenges

4. We want to get your perspective about how (or to what extent) peer staff is using their **strengths**, abilities, and gifts in your program. Where do peer staff **excel**? Please share with us your experiences and observations regarding the **benefits** of peer staff in serving people on their recovery journey in your program? What **benefits does peer staff bring to their colleagues**, to you and to the overall success of your program?
- 4b. What has been the greatest **challenge** in their role as a peer specialist in your organization? (Possible areas to probe – time mgt., documentation, personal wellness, setting boundaries, integration with the rest of the team). In your observation, **are there themes that emerge** more often than others in your work with peer staff where additional support is necessary? What other challenges have emerged that may be barriers to their excelling in their roles?
5. From your perspective, what **additional things** might have been included in the **original training** that would have been helpful in preparing peer staff for their current role? (*Probe here for specific content or skill sets that could have better prepared them originally*)

6. If you were to prioritize your **peer staff training needs** right now, what areas are at the top of your list that would assist them in being more successful in your organization?

---

### C. Questions regarding Impact & Next Steps

7. From your perspective, what has been **the overall impact of the work of peer and recovery specialists** in benefiting those in recovery who are receiving or seeking support? *(Possible additional probes regarding: accessing services; intake & assessment; assertive outreach and/or re-engagement).*

8. What has been the **greatest success (then cover challenges) in your role as a Manager/Supervisor** in a Peer Support program? You might probe around successes related to the following areas:

- Promotion of Peer Support Specialist staff
- Program Members meeting IRP goals
- Increased Community Integration

9. In what ways can Philadelphia's Behavioral Health system **continue** to move toward a **recovery-oriented system of care**, one where peer voice, leadership and support are at the cornerstone?

- How can your agency/program play a role in this?
- How can DBHIDS support your agency/program in doing this?
- In what other capacities can you envision the involvement/contribution that could be made by peer support including peer and recovery specialists?
- For those of you who have or are working in programs where **Common Ground** was implemented, what is your assessment of the value of CG?
- Have you heard of **self-directed care**? What are your thoughts/opinions about it?

10. DBHIDS is in the early phases of **significant enhancements** to the framework and organization of peer services. That is one of the purposes in our conducting these focus groups. We can't create it without the voices of staff and peers.

- What should the focus be?
- What should the goal of Peer Services be?
- How would you like organizations to be involved?
- How can DBHIDS improve Peer Services?

**Lastly – Is there anything we should have talked about, but did not?**

## Appendix C

### Peer Services Focus Group Project Certified Peer Specialist Survey

*This is a survey for Behavioral Health and Addictions Services Stakeholders. This survey is intended to give DBHIDS feedback about the Peer Support Services Initiative in Philadelphia. This survey is to be answered anonymously. Thanks for your feedback!*

#### EMPLOYMENT READINESS

1. **Did you feel prepared to obtain a job as a CPS as a result of completing Peer Support training?**
  - Very prepared
  - Somewhat prepared
  - Not very prepared
  - Not at all prepared
  
2. **Did you feel adequately prepared for an interview?**
  - Very prepared
  - Somewhat prepared
  - Not very prepared
  - Not at all prepared
  
3. **Did you feel that you received enough assistance on creating a resume?**
  - Yes
  - No
  
4. **Are you currently employed?**
  - Yes (Please tell us which agency and your position)  
**Agency** \_\_\_\_\_ **Position** \_\_\_\_\_
  - No (Go to Question 12,13,14)

#### EMPLOYMENT

5. **Overall, the Peer Support Training prepared me in my current role in the workplace**
  - Strongly Agree
  - Agree
  - Neutral
  - Disagree
  - Strongly Disagree
  
6. **This the first CPS position I have held after the CPS training?**
  - Yes
  - No (please tell us where else you have been employed as a CPS)

Organization Name	Full-time or Part-time


**7. Are you currently a full-time or part-time employee?**

- Full-time
- Part-time

**8. How long did it take for you to find a job?**

- 1-3 months
- 3-6 months
- 6-9 months
- 9-12 months
- over one year

**9. What is your salary range in your current position?**

---

**10. Does your current position offer health benefits?**

- Yes
- No

**11. Is there an opportunity for advancement, promotion or salary increase for your role?**

- Yes
- No

**12. If you are currently UNEMPLOYED, have you been actively seeking employment?**

- Yes (Please list the positions for which you have applied) \_\_\_\_\_
- No

**13. If you are currently UNEMPLOYED, what do you see as some of the barriers that have prevented you from gaining employment?**

---



---

**14. If you are currently UNEMPLOYED, have you volunteered any of the following DBHIDS sponsored activities?**

Employment Opportunities	Yes	No
CPS Job Fair		
Taking It To The Streets		
Recovery Advocate/Training Support Person (TSP)		
Other		

If Other,  
please provide  
examples:

---



---

**ROLE AND**

## RESPONSIBILITY

15. If you are currently *EMPLOYED*, please describe your job duties:

---

---

16. Do you facilitate peer-led group discussions/workshops (i.e. anger management, wellness)?

- Yes (Please answer question 17)
- No (Skip to question 18)

17. Have you received training related to peer-led discussions/workshops?

- Yes
- No

18. If you are not currently facilitating peer-run group discussions, do you think having them in your organization would be helpful?

- Yes
- No

19. Are you facilitating, supporting or participating in Peer Advisory Councils?

- Yes
- No

20. Do you engage with people in the community outside of the office?

- Yes
- No

21. Do you engage with people in the community inside of the office?

- Yes
- No

22. For those of you in clinical settings, do you collaborate with clinicians?

- Yes
- No

23. Are you involved with the assessment, service planning or continuing support processes?

- Yes
- No

24. Do you feel that you work as a team with the clinicians?

- Yes
- No

## WELLNESS

**25. Are you conducting recovery check-ins while working with someone either before during or after they are in treatment?**

- Yes
- No

**26. If you are, did you receive training related to this?**

- Yes
- No

**27. If you did not receive training, would this have been helpful?**

- Yes
- No

**28. Have you disclosed your recovery status in your workplace?**

- Yes
- No

**29. If you answered YES on Question 28, Do you believe your disclosure has impacted you in the workplace? How so?**

---

---

---

**Is there anything you would like to share with us? Is there anything we forgot to ask? Please let us know in the space below!**

---

---

---

---

---

---

---

Thank you for taking the time to complete this survey

## Appendix D

### Peer Services Focus Group Project CEO/Administrator Survey

*This is a survey for Behavioral Health and Addictions Services Stakeholders. This survey is intended to give DBHIDS feedback about the Peer Services Initiative in Philadelphia. This survey is to be answered anonymously. Thanks for your feedback!*

#### SYSTEM TRANSFORMATION

*As we reflect on 10 years of system transformation of Behavioral Health services in Philadelphia, these questions are intended to capture the strengths and challenges faced with the implementation of Peer Culture, Support and Leadership at your agency.*

#### 30. What is your job title?

- CEO
- COO
- Executive Director
- Director
- President
- Vice President
- Senior Executive
- Other: \_\_\_\_\_

#### 31. When DBHIDS initially implemented system transformation, my agency was prepared with establishing a formal Peer Culture?

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree
- Not Applicable - Peer Culture in Place upon my employment

#### 32. How did you establish a formal peer culture at your agency? (Check all that Apply)

- DBHIDS trainings
- Board of Directors
- Agency Staff
- Individuals receiving services at *your* agency
- Individuals receiving services at *another* agency
- Other: \_\_\_\_\_
- I do not have a formal peer culture currently at my agency (**Please explain why**)  
Comment: \_\_\_\_\_

#### 33. What percentage of your agency transformed their programs to include Certified Peer Specialists?

- 0-10%
- 10-25%
- 25-50%

- 50-75%
- 75-100%

**34. My view on Peer Culture at my agency today is**

- Extremely Strong and Developed
- Somewhat Strong and Developed
- Not so Strong, more Development needed
- Nonexistent

**35. I am satisfied with our strategic direction regarding the implementation of Peer Support Services and Peer Culture in the agency**

- Strongly Disagree
- Somewhat Disagree
- Neutral
- Somewhat Agree
- Strongly Agree

**EMPLOYMENT PROCESS**

*There are a variety of ways to obtain Certified Peer Specialists in our system. These questions inquire about the processes you used and the composition of those you have employed.*

**36. Please identify the resources utilized by your agency to hire CPS for employment at your agency. (check all that apply)**

- Job Fair
- Volunteer
- Word of Mouth
- Job Advertisement
- Other: \_\_\_\_\_

**37. How many CPS are employed at your agency at this time? (Specify the Number)**

**Comment:** \_\_\_\_\_

**38. How many vacant CPS positions does your agency have at this time? (Specify the Number)**

**Comment:** \_\_\_\_\_

**39. If you answered NONE for Question 8, please describe the barriers that have prevented you from hiring a CPS and then skip to Question 13**

Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**40. In what capacity are CPS's hired at your agency? (Check all that apply)**

- Full Time Employees
- Part-Time Employees

- Volunteer
- Full-Time and Part Time Employees

**41. Does your agency hire Certified Peer Specialists with criminal backgrounds?**

- Yes
- Sometimes  
Comment (identify the circumstances): \_\_\_\_\_
- No  
Comment (identify the reasons): \_\_\_\_\_

**42. Do you track the number of CPS working in your organization and the attrition rate?**

- Yes (Please describe method) \_\_\_\_\_
- No

**EMPLOYMENT SUSTANABILITY OF CPS**

*The intention of these questions is to ascertain the representation of Certified Peer Specialists in your agency, the roles in which they are employed and the sustainability of these roles.*

**43. My agency has the following programs that offer Peer Support (Check all that Apply):**

- Psychiatric Outpatient Clinics
- Community Integration Recovery Centers (CIRC)
- Crisis Intervention Program
- Intensive Outpatient Program
- Intensive Case Management Program
- Psychiatric Rehabilitation Program
- Other: \_\_\_\_\_

**44. How informed are you with Pennsylvania’s Medicaid billable peer support services?**

- Very Informed
- Somewhat Informed
- Not very Informed
- Not at all Informed

**45. If you DO NOT have CPS staff at your agency, do you contract with outside agencies to obtain Certified Peer Specialist supports?**

- Yes (please list the agencies and occasions that you contract) \_\_\_\_\_
- No
- N/A

**46. Do you have resources (i.e. community partners or provider associations) to assist you with the funding and reimbursement process for securing CPS staff at your agency?**

- Yes  
(Please list the provider agencies/community partners) \_\_\_\_\_
- No

**47. CPSs are hired to fill the following positions at your agency? (Check all that apply)**

- Certified Peer Specialist
- Recovery Coach
- Consultant
- Other: \_\_\_\_\_

**48. Does your agency promote CPS to other positions?**

- Yes  
Please list the positions: \_\_\_\_\_
- No  
Tell us why: \_\_\_\_\_

**49. Would your agency be open to providing internships (paid or unpaid) for Certified Peer Specialist training graduates?**

- Yes (please specify paid or unpaid) \_\_\_\_\_
- No

**50. I am willing to invest in the development of new CPS positions in my agency**

- Strongly Disagree
- Somewhat Disagree
- Neutral
- Somewhat Agree
- Strongly Agree

**PEER CULTURE**

*The implementation and maintenance of a Peer Culture is an evolutionary process that requires continuous attention and intentional development. These next questions inquire about the process your agency has in place to ensure that a formal Peer Culture is sustained.*

**51. How do you stay informed regarding the themes of peer culture, support and leadership in the City of Philadelphia?**

- Executive Management Meetings
- DBHIDS and/or BHTEN trainings
- Lunch and Learn Series
- OMHSAS
- Other: \_\_\_\_\_

**52. What types of professional development training do you require for staff to deepen the peer culture within your organization?**

\_\_\_\_\_

**53. How does your agency fulfill the role and responsibility of an organization with a formal peer culture?**

**(e.g. peer advisory council, peer-run groups, peer coaching and supervision, community connection)?**

---

---

**54. You have a clear picture of the roles and responsibilities of CPS staff at your agency.**

- Strongly Disagree**
- Somewhat Disagree**
- Neutral**
- Somewhat Agree**
- Strongly Agree**

**55. Staff members in my organization understand the peer support roles.**

- Agree
  - Disagree
- (Please describe some of your challenges) \_\_\_\_\_

**56. Please identify how your agency distinguishes the roles and responsibilities of a Certified Peer Specialist from other staff members?**

\_\_\_\_\_

**57. Are Certified Peer Specialists at your agency encouraged to attend outside training for Professional Development during regular working hours?**

- Yes
- No

**58. Does your agency track the correlation between the implementation of Peer Culture at your organization and increase success in individual's recovery journey? (i.e. Individuals receiving Peer support vs. Clinician support only- longevity in program)**

- Yes (How?) \_\_\_\_\_
- No

**59. Suggest at least one change your organization could make to improve the support CPS**

\_\_\_\_\_  
\_\_\_\_\_

**60. Additional Comments**

\_\_\_\_\_  
\_\_\_\_\_

Thank you for taking the time to complete this survey

# Appendix E

## Peer Services Focus Group Project Supervisory/Manager Survey

*This is a survey for Behavioral Health and Addictions Services Stakeholders. This survey is intended to give DBHIDS feedback about the Peer Support Services Initiative in Philadelphia. This survey is to be answered anonymously. Thanks for your feedback!*

### TRAINING

**61. Did you complete the CPS Supervisors Training**

- Yes
- No (Please tell us why \_\_\_\_\_)  
(Go to question 3)

**62. The CPS Supervisors Training prepared me to supervise CPS in the workplace**

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

### HIRING CPS

**63. Do you currently have a CPS on staff?**

- Yes (Please tell us how many \_\_\_\_\_)  
(go to question 5)
- No (Go to Question 4)

**64. If you answered NO for Question 3, can you tell us why?**

Comments:

---

---

---

**65. In what capacity are CPS' hired at your agency?**

- Full Time Employees
- Part-Time Employees
- We offer both options

**66. Please list the resource utilized by your agency to obtain a CPS for hire (i.e. Job fair, word of mouth).**

**67. Did you feel that CPSs were adequately prepared for the job interview?**

- Yes
- No

## EMPLOYMENT PROCESS

**68. Do you feel that CPSs are prepared for the workplace as a result of the CPS training?**

- Very prepared
- Somewhat prepared
- Not very prepared
- Not at all prepared

**69. Please share what additional areas are needed to prepare CPS for the workplace**

Comments:

---

---

**70. Are the CPSs on staff promoted to other positions?**

- Yes
- No (Go to Question 12)

**71. What other positions are CPS on staff promoted to in your agency?**

---

**72. What is the salary range for CPS positions?** \_\_\_\_\_

**73. Does your agency hire CPS with criminal backgrounds?**

- Yes
- No

**74. Would your agency be open to providing internships (paid or unpaid) for CPS grads?**

- Yes
- No

Comments:

---

---

## CPS SUPERVISORS

**75. Do you attend the bi-monthly CPS Supervisors meeting?**

- Yes
- No (Skip to Comment Section)

**76. Do you find the meetings helpful?**

- Yes
- No

**77. Do you receive on-going supervision or training to support you in your role as a Supervisor/ Manager of a Peer Support program?**

- Yes
- No

**78. How often do you have formal individual supervision with Peer Support Specialists staff?**

- Weekly
- Bi-Weekly
- Monthly
- I have group supervision, not individual supervision
- Not At All

**PEER CULTURE**

**79. Do the CPSs in your agency engage with people in the community OUTSIDE of the office?**

- Yes
- No

**80. Do the CPSs in your agency engage with people in the community INSIDE of the office?**

- Yes
- No

**81. Do you feel that other staff members in your organization understand the peer support roles?**

- Yes
- No

**82. What training and/or supervision do you provide to foster a strong peer culture?**

Comments:

**83. Are Certified Peer Specialists at your agency encouraged to attend outside training to enhance Professional development during regular working hours?**

- Yes
- No

**84. Do the CPSs in your agency facilitate, support, or participate in Peer Advisory Councils?**

- Yes (where does interaction with the Peer Advisory Council occur?) \_\_\_\_\_
- No

**Is there anything you would like to share with us? Is there anything we forgot to ask? Please let us know in the space below!**

---

---

---

Thank you for taking the time to complete this survey!

## Appendix F

### Peer Support Services Activities Guidelines (PA MA Handbook, 11/1/06)

Peer support service content includes various structured therapeutic activities. The following descriptions of appropriate therapeutic activities are provided as examples only and not intended to be prescriptive.

#### *Crisis support:*

- Assisting the individual to develop a Wellness Recovery Action Plan (WRAP) or a Psychiatric Advance Directive (PAD).
- Assisting the individual to recognize the early signs of relapse and how to implement the identified coping strategies or request help in order to avoid a crisis.
- Assisting the individual to use less restrictive alternatives that prevent hospitalization, incarceration and the use of emergency services when appropriate.

#### *Development of community roles and natural supports:*

- Assisting the individual to gain information about returning to school, job training, or full- or part-time paid work.
- Facilitating the process of obtaining reasonable accommodations for a psychiatric disability (for example, mental health day, flex time)
- Assisting the individual on how to be an active community member in the neighborhood and community where he or she lives, learns, and works.
- Assisting the individual to access and maintain stable housing or learning how to improve or change an inadequate housing situation.

#### *Individual advocacy:*

- Discussing concerns about medication or diagnosis with the physician or nurse at the individual's request.
- Assisting the individual to arrange necessary treatment at the individual's request and guiding the individual toward a proactive role in his or her own treatment.

#### *Self help:*

- Cultivating the individual's ability to make informed, independent choices.
- Helping the individual develop a network of contacts for information and support who have been through similar experiences.

*Self-improvement:* Planning and facilitating practical activities leading to increased self worth and improved self-concepts.

*Social network:* Assisting the individual to develop and maintain positive personal and social support networks (friends, family, associates), how to improve or eliminate unhealthy personal relationships, how to start a new relationship (such as going to a movie with a new friend, meeting someone new at a social gathering), and how to improve communications with family members and others.

## Appendix G

### Peer Support Web Resources

- [http://www.parecovery.org/services\\_peer.shtml](http://www.parecovery.org/services_peer.shtml)
- [http://www.parecovery.org/documents/PSS\\_FAQ\\_093015.pdf](http://www.parecovery.org/documents/PSS_FAQ_093015.pdf)
- [http://www.magellanofpa.com/media/1260929/documentation\\_training\\_including\\_cd-june\\_2015\\_compliance\\_july.pdf](http://www.magellanofpa.com/media/1260929/documentation_training_including_cd-june_2015_compliance_july.pdf)
- <http://www.uspra.org/content/practice-issues-cprp-certification-psychiatric-rehabilitation-practitioners-us-and-singapore>
- PA mental health bulletin number OMH-94-04:  
<http://www.dhs.pa.gov/publications/bulletinsearch/bulletinselected/index.htm?bn=OMH-94-04&o=N&po=OMHSAS&id=03/04/1994#.VIHxDoR2zHQ>
- [http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/d\\_004594.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_004594.pdf)
- <https://copelandcenter.com>
- Institute for Recovery and Community Integration > <http://mhrecovery.org/index.php>
- Recovery Innovations > <http://riinternational.com>
- [www.parecovery.org](http://www.parecovery.org)
- <http://www.drexel.edu/medicine/Academics/Continuing-Education/Behavioral-Healthcare-Education/>
- PA Peer Support Coalition > [www.papeersupportcoalition.org](http://www.papeersupportcoalition.org)

## Appendix H

### CPS/Supervisor Training Needs Identified During Asset Mapping Process

- Role of Peer Support
- Motivational Interviewing
- Basic Documentation
- Group facilitation
- Orientation to basic workplace behavior
- Ethics and boundaries
- Electronic Health Records
- CPRP and CAC preparation
- Introduction to computer use including Word and Excel
- Public transportation training
- Assertive outreach and engagement
- Recovery wellness planning
- Initial engagement
- New supervisor training in peer support
- Supervising peer support staff
- Employment, education and housing resources
- Acquiring legal documents for peers
- Peer support note taking
- Leadership and Advocacy
- Peer Support Internships
- Training all staff regarding the CPS role
- Practice Guidelines
- Writing skills
- Recovery Check-ups
- Training in Advocacy