Supervision of Peer Practice: The Challenges and Opportunities for Organizations with Peer Recovery Support Services Programs

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Executive Summary

Peer recovery support services (PRSS) have emerged as important resources for engaging and supporting individuals and families in their recovery. Contemporary PRSS are non-clinical, strength-based, and recovery-focused. They target recovery outcomes such as improved health and wellness, an increased sense of self-efficacy or empowerment, and increased success and satisfaction in a range of community settings such as work, home, and school, instead of merely focusing on symptom reduction. There are several key characteristics of PRSS. They:

- Are person-centered and strength-based. They help individuals to identify existing recovery capital and build future capital.
- Are relationship-oriented, garnering a sense of trust, confidence, authenticity and efficacy, based on shared experience.
- Support an individual in defining and directing his or her own recovery plan, backed with guidance, structure, support, and navigation assistance from a peer.
- Engage individuals in a timely and expeditious manner, at critical points of recovery vulnerability and throughout various stages of the recovery process.
- Support re-engaging individuals back into appropriate supports and services in a timely manner, in the event of relapse.

There are a variety of roles that peers play within PRSS programs. Two that have become most prominent are peer recovery coach and peer recovery support specialists. Over the past decade, the definitions of these two roles have become more defined as training and certification across the country has become institutionalized (although training requirements vary by state). In addition to the variety of roles that peers have, peers also work or are placed in a variety of community settings.

Much has been written about PRSS; little has been written about the supervision of peer supports. When it is considered, the conversation has too often centered around, “What do you do when the peer relapses?” This is a very limited and deficit-based view.

As the behavioral health, somatic health, criminal justice, and child welfare systems are embracing and welcoming peer workers, the need to develop solid and systemic supervision of peer practice has become paramount. In 2016, the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (CSAT) convened a group of experts in PRSS to describe the key elements of an effective model for supervision in a variety of settings. Online sessions with peer practitioners were also convened to discuss both strengths and challenges in the current peer supervision processes.

For peer practice to be most effective, supervision of peer supports needs to be patterned on the best practices of PRSS. Recovery values, principles, and core concepts must be embedded in the supervision practice. Eight principles of supervision emerged from the CSAT convenings:

1. Supervision is an act(ion) not a role.
2. Supervision is a strength-based process in which there is mutual accountability.
3. Supervision enhances and develops the unique knowledge and skills necessary for successful peer practice.
4. Supervision provides a safe space to address ethical dilemmas and boundary issues.
5. Supervision engages peer practitioners in strengthening the PRSS program.
6. Supervision fosters an organizational environment / culture that is conducive to recovery.
7. Supervision clarifies organizational systems, structures, and processes.
8. Supervision supports self-care.

Each of these principles has corresponding supervision practices and preceding premises based on peer support principles.

Currently, many peer practitioners face obstacles due to inadequacies of supervision, organizational policies that impact the nature of support, and/or the setting where support is offered. There is a general sense of lack that adds to obstacles and a sense of feeling devalued as a peer support worker: lack of policy regarding transportation, lack of policy regarding workload, lack of clear expectations, lack of clear job description, lack of funding for professional development, lack of communication, and unreasonable expectations on outcomes for peer practitioners.

Just as the peer practitioner needs training and support, so do those tasked with supervision. There is clear evidence that those tasked with supervision of PRSS are not receiving the training and ongoing professional development needed for this multi-faceted role. Supervision is a skilled process, requiring high levels of professional development. Those tasked with supervision must be well-trained and well-equipped. Key knowledge and skills needed for quality supervision are summarized in the table below.

Knowledge	Skills/ Proficiencies	Attitudes/ Approaches
Value and nature of peer support Culture of Recovery • Recovery Principles • Language • Multiple pathways Best practices and evidence-base of peer services Peer ethical guidelines (and how differ from clinical ones) Core competencies of peer practice • Recovery coaching process • How personal stories/ lived experience ties into professional work Peer role and how it fits into the organizational context	Motivational interviewing Cultural competence Active listening Articulate communication Provide concrete feedback Recognizing and responding to effects of trauma Shared decision making and problem solving Facilitation • collaborative processes • learning / learning community Goal setting and prioritization Task identification, prioritization and delegation Models self-care	Models the core philosophies and principles of recovery Is authentic in interpersonal relations- self-aware and reflective Respects peer's life experience and role Recognizes mutuality in relationship Embodies recovery principles • Focuses on strengths and assets • Is person centered • Shares power • Encourages self-direction Is flexible Uses person- first, wellness-focused language Has predictable and consistent

Science of addiction The components and value of a recovery oriented systems of care Recovery movement Trauma-informed practices and approaches Medicaid reimbursement for peer support	Advocacy Detailed record keeping and documentation practices Advocacy *Preferred* Lived experience of addiction and recovery Experience as peer	actions and responses Creates a safe and supportive context Commitment to building and fostering a culture of recovery

Supervision structures take many forms depending on the organizational resources and the context where peer support is delivered. Often the persons who do supervision have multiple responsibilities and are challenged to hold the needs of the peer practitioner and the needs of the organization simultaneously. Developing creative structures for supervision—such as co-supervision, group supervision, and peer-to-peer supervision—can assure that support for peer practitioners is available when needed and provide opportunities for other meaningful elements of supervision to happen consistently.

Increasingly, peer support is being offered at locations outside of the recovery community organizations (RCOs) in which they originated, by organizations that may have only a vague notion of the workings of peer support. In these settings, peer practitioners often are placed in a team and in a culture that has limited understanding of the role and value of peer support. In non-RCO settings, supervision tasks are not different than those within an RCO; however, there are nuances which may increase the challenges of supervision. Persons who do supervision in non-RCO settings must engage in thoughtful, intentional support of peer practitioners to: (a) maintain the peerness of the PRSS offered, (b) ensure the wellbeing of those served, and at the same time, (c) facilitate the just and respectful treatment of peer recovery support staff.

It is important to note that organizational context, setting, and culture can have a profound effect on nature and quality of peer support, which in turn affects supervision. Therefore, there are also three important considerations at the organizational level. Organizations must (1) properly prepare to integrate peer support, (2) review and revise policies and procedures to ensure that they are consistent with and supportive of peer practice, and (3) plan and implement peer supports that are appropriate for the context, with fidelity to the selected peer support model(s).

Introduction

Peer recovery support services (PRSS) have emerged as important resources for engaging and supporting individuals and families in their recovery. Much has been written about PRSS; little has been written about the supervision of peer supports in a variety of settings, including recovery community organizations (RCOs), community-based settings, and clinical settings. When it is considered, the conversation has too often centered around, “What do you do when the peer relapses?” This is a very limited and deficit-based view.

As the behavioral health, somatic health, criminal justice, and child welfare systems are embracing and welcoming peer workers, the need to develop solid and systemic supervision of peer practice has become paramount. In 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment convened a group of experts in PRSS to:

- Describe the key elements of an effective model for supervising peer recovery support services.
- Examine how the different institutional cultures and settings in which peer practitioners are placed affect peers and peer services.
- Develop guidelines for effective supervision that help to maintain the authenticity of PRSS.
- Outline components of effective training and professional development for peer supervisors.
- Recommend best approaches for supporting peer practice and the peer workforce.

Online sessions with peer practitioners were also convened to discuss both strengths and challenges in the current peer supervision process to:

- Discern the types and structure of current supervision practices.
- Discuss how supervision may be beneficial to both the peer work and services offered.
- Identify obstacles peer practitioners face due to the context where support is offered, organizational policies that impact the inherent unique nature of support, and/ or inadequate supervision.
- Describe initial training required, additional training provided, and training desired.
- Identify changes peer practitioners would like to have in the supervision process.

This document is the result of those two convenings. It builds on prior SAMHSA peer workforce efforts, including three key publications: (1) *Core Competencies for Peer Workers in Behavioral Health Services;* (2) *Equipping Behavior Health Services and Authorities to Promote Peer Specialist/Peer Recovery Coaching Services (Gagne, Olivet, & Davis, 2012)*; and (3) Supervising Peers in the Behavioral Health Workforce (not-yet published).

This report is divided into three sections:

1. *Considering the Current Context of PRSS* provides a snapshot of the field of peer recovery support at the time of the report, for those who may be unfamiliar. It also summarized observations from peer practitioners about contemporary experiences with supervision.
2. *Framing Supervision* considers some of the key question related to supervision of addiction peer supports, and presents a working framework for supervision.
3. *Practicing the Principles* looks at how the principles may be applied in a variety of PRSS settings.

Defining Peer, Peer Support, and Peer Practice

The term peer identifies a single person with a particular lived experience that positions the person as distinct others. As a label, it has been used to distinguish one group of people from another, often based on differing levels of power, compensation, perceived knowledge, or even social value.

When combining their experiential expertise with technical knowledge and specialty training and certifications, peers--that is, people in recovery--are the movers and shakers at the forefront of establishing quality addiction treatment and recovery supports.

The term peer recovery support services (PRSS) refers to recovery support services provided by persons in personal/family recovery and who may possess additional qualities (e.g., age, gender, ethnicity, sexual orientation, military service, past incarceration) that enhance the process of mutual identification with the recovery support relationship.

Peer support includes guidance through inquiry to allow for person centered goal planning, and sharing resources. It promotes self-directed healing from the past, creating, or re-creating, a meaningful life, and being of service to family, friends, and community. The help is often freely given. People in recovery are drawn to work in the field, often out of a sincere desire to “pass it on,” to use their experience to benefit others.

Peer Practice is the application and implementation of set and defined principles, structure and methods when providing a peer service or program.

Considering the Current Context of PRSS

Peer support in recovery is not new. Individuals who have recovered from alcoholism and other addictions have been supporting others to break the addictive cycle and find a new way of life in recovery for centuries. Native Americans formed social support groups to deal with problem alcohol use long before the United States became a country. In the mid-1800s, temperance societies arose focusing on personal reformation rather than political agendas. The influence of Alcoholics Anonymous (AA), with its beginnings in 1935, led the way for peer based supports in hospitals, rest homes, and drying out farms in the decades to follow. Recovery meant more than just abstinence. Along with AA and other 12-Step groups, the Native American mutual aid movement and emerging faith-based recovery ministries in the African American communities understood recovery as a journey of healing and balance— physically, emotionally, and spiritually.

Figure 1. Addiction Recovery timeline compiled by Altarum Institute. View full screen >>

According to William White (2009), by the 1960s, peers—that is, persons with lived experience of addiction and recovery—were 70 percent of the addiction services workforce. Recovery advocates believed that specialized addiction treatment could provide a way of entry into recovery for people who might not otherwise initiate or sustain recovery on their own.

By the mid-1990s, with the medicalization of addiction services and the influence of insurance companies and managed care, a treatment industry exploded, with major components often disconnected from recovery principles. The addiction treatment-focused system was a “one size fits all” model of pathology-focused, crisis-oriented services. Addiction was treated as an acute disorder, rather than understood as a complex social, physical, mental, and spiritual condition. According to White (2009):

> This system is inconsistent with the concept of addiction as a chronic condition, largely neglects the dire need for post-treatment community-based recovery support services,

and fails to involve and to capitalize on the resources and support of people's families and the larger community. Further, treatment services are delivered using a "top down" model where professional "experts" make clinical decisions without involving patients who are regarded as passive recipients of services. Redefining an illness from acute to chronic in nature not only fundamentally changes treatment delivery but also requires a reassessment of policy, funding, research and other key elements related to addiction and recovery.

Short term fixes and treatment plans drawn up by experts with degrees pushed aside the relational healing inherent in peer support, and the ongoing supports needed to face the challenges of sustaining recovery in community were lost. With the professionalization of addiction treatment, peers made up only 30 percent of the workforce. In a keynote address, White (William White, 1990) suggested that the "treatment field may need *treatment."*

Recovery-oriented System of Care

At SAMHSA–sponsored national summits on recovery in 2005 and 2010, attendees agreed that recovery-oriented systems of care (ROSCs) were needed at the local, state, and national levels to promote health and resilience and help people achieve and maintain a life in recovery. ROSCs are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders.

Although the understanding of what a ROSC entails has evolved over the last decade, the fundamentals outlined at these gatherings still hold true:

- ROSCs support person-centered and self-directed approaches to care that build on the personal responsibility, strengths, and resilience of individuals, families, and communities to achieve sustained health, wellness, and recovery from alcohol and drug challenges.
- ROSCs offer a comprehensive menu of services and support that can be combined and readily adjusted to meet an individual's needs and chosen pathway to recovery.
- ROSCs encompass and coordinate the operations of multiple systems, providing responsive, outcomes-driven approaches to care.
- ROSCs require an ongoing process of systems change that incorporates the experiences of individuals in recovery and their family members.

(Center for Substance Abuse Treatment, 2007)

In this new paradigm, addiction is understood in terms of a continuum of care model embracing what works to sustain recovery. The cornerstone of a ROSC is the involvement and commitment of people with lived recovery experience.

Recovery-supportive Communities

As RCOs continue to evolve, there is increasing understanding that recovery happens in community and, as with other health promotion, there are aspects that need to be addressed that are beyond the individual/personal. This has prompted many conversations about the concept of recovery-supportive communities, and the stages a geographic community (could

be as small as a neighborhood, or as large as metro area) go through to becoming an environment that is maximally supportive of recovery. This moves thinking beyond individual recovery (that is, personal transformation) and beyond "systems of care" (that is, institution-focused work) to communities that are rich with recovery (that is, community transformation).

Reclaiming the Landscape: Re-emergence of Recovery Voices

A combination of factors has led to a reclamation of the centrality of lived experience and recovery in assisting persons with substance use disorders. The emergence of RCOs and PRSS are recapturing dimensions of support lost with the professionalization of addiction counseling.

Since the 1990s, grassroots RCOs have developed organically in many areas as people in recovery gathered to explore the nature of recovery: What were fundamental values and principles? What sustained recovery? RCOs advocate a broad, holistic, long-term perspective on recovery. They work to ensure that organizations, institutions, and statewide systems incorporate the experiences of people in recovery and their family members, and they proactively support person-centered, self-directed, strengths-based approaches that individuals and families need to achieve sustained health, wellness, and recovery from substance use challenges.

According to White (W. L. White, 2009), "The recent growth of RCOs marks a new development in the long history of recovery support…. RCOs support a wide variety of recovery support institutions: recovery community centers, recovery homes, recovery colonies, recovery schools, recovery industries, recovery ministries/churches, recovery cafés.... These recovery community-building activities constitute one of the forces pushing addiction treatment programs to become 'recovery-oriented systems of care' and to wrap traditional clinical services within a larger and more time-extended umbrella of P-BRSS [peer-based recovery support services]."

The maturation of the movement has been marked by several recent successes that are the result of advocacy efforts. On October 4, 2015, tens of thousands attended the UNITE to Face Addiction rally in Washington, DC. In early 2016, two key pieces of federal legislation--the 21st Century CURES Act and the Comprehensive Addiction and Recovery Act--were passed. And in March 2016, the first ever US Surgeon General's report on addiction and health was published, with a complete chapter devoted to recovery. It noted:

> People in recovery, their family members, and other supporters are banding together to decrease the discrimination associated with substance use disorders and spread the message that people do recover. Because of this movement, policymakers and health care system leaders in the United States and abroad are embracing recovery as an organizing framework for approaching addiction as a chronic disorder from which individuals can recover, so long as they have access to evidence-based treatments and responsive long-term supports (United States Public Health Service, Office of the Surgeon General, 2016).

SAMHSA Support for Recovery
https://www.samhsa.gov/recovery
SAMHSA encouraged the burgeoning movement with the initiation of the Recovery Community Support Program (RCSP) in 1998. The RCSP grant provided funding for RCOs to organize and mobilize to address stigma, educate communities, and advocate for persons in recovery. The RCSP program evolved into a peer services program in 2001. Building on the rich and successful history of peer support in mutual aid groups, such as AA, RCSP grantees pioneered a menu of peer services based on the value of one person helping another. The age-old tradition of "giving back" was deeply rooted in the culture of these programs.

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

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

Through its Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

1. Health—Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
2. Home—A stable and safe place to live.
3. Purpose—Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.
4. Community—Relationships and social networks that provide support, friendship, love, and hope.

SAMHSA's Working Definition of Recovery includes the following ten recovery principles:

1. Recovery emerges from hope
2. Recovery is person-driven
3. Recovery occurs via many pathways
4. Recovery is holistic
5. Recovery is supported by peers and allies
6. Recovery is supported through relationship and social networks
7. Recovery is culturally-based and influenced
8. Recovery is supported by addressing trauma
9. Recovery involves individual, family, and community strengths and responsibility
10. Recovery is based on respect

Contemporary Peer Support

Peer recovery support services are inherently designed, developed, delivered, evaluated, and validated by peers in long-term recovery. They are non-clinical, strength-based, and recovery-focused. PRSS target recovery outcomes such as improved health and wellness, an increased sense of self-efficacy or empowerment, and increased success and satisfaction in a range of community settings such as work, home, and school, instead of merely focusing on symptom reduction.

Peer Support as Social Support

Recovery values and principles guide the design and development of PRSS. PRSS use both practice-based evidence and evidence-based practice to plan delivery of services and program offerings. Research indicates that recovery is facilitated by social support, and four types of social support have been identified, as summarized in Table 1. Although the categories are discrete, the actual supports may not be; one support activity may involve two or more kinds social support. For example, a wellness class can support emotional health and be a great opportunity to meet new friends in recovery while learning a beneficial daily practice. And if a parent receives a voucher for childcare so s/he can attend, then all four social categories have been met, with a synergistic effect in enhancing recovery.

Table 1. Types of Social Support and Associated PRSS

Type of Support	Description	Peer Support Service Examples
Emotional	Demonstrate empathy, caring, or concern to bolster person's self-esteem and confidence.	Peer mentoring Peer-led support groups Yoga, kick boxing
Informational	Share knowledge and information and/or provide life or vocational skills training.	Parenting class Job readiness training Wellness seminar advocacy training
Instrumental	Provide concrete assistance to help others accomplish tasks.	Child care vouchers Bus passes Help accessing community health and social services
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.	Sober Softball, Bowling league Alcohol- and drug-free dances, movie nights Lunches Celebrations and rituals

There are several key characteristics of PRSS. They:

- Are person-centered and strength-based. They help individuals to identify existing recovery capital and build future capital.
- Are relationship-oriented, garnering a sense of trust, confidence, authenticity and efficacy, based on shared experience.
- Support an individual in defining and directing his or her own recovery plan, backed with guidance, structure, support, and navigation assistance from a peer.
- Engage individuals in a timely and expeditious manner, at critical points of recovery vulnerability and throughout various stages of the recovery process.
- Support re-engaging individuals back into appropriate supports and services in a timely manner, in the event of relapse.

There are four stages of recovery: pre-recovery engagement, recovery initiation and stabilization, recovery maintenance, and enhanced quality of life in long term recovery (William L. White, 2010). PRSS can be delivered across all of those stages, regardless of whether or not a person uses clinical treatment services. PRSS can:

- Be offered before an individual enters treatment or when they are waiting for a service opening.
- Coincide with treatment services, enhancing engagement and retention and providing a connection to community while a person is in treatment.
- Help people manage their own recovery following treatment by continuing to develop recovery skills, access resources, and provide opportunities to further enrich their recovery through volunteer work in recovery support settings.

From safe use sites, syringe services programs, peer recovery support centers, management check-ups, and family support, peer support extends way beyond the bounds of acute treatment and aftercare planning.

Peer Recovery Coaches, Peer Support Specialists, and Other Peer Roles

The unique value of PRSS lies in the understanding of the word peer: Peers do not offer professional services or make assessments but rather connect with others on the basis of their shared lived experience. Connection is key. Peers cannot exist in isolation; the word peer connotes a process that happens between two or more people who have a shared experience. When peers connect through an understanding of the shared nature of their experience, a relationship begins to form that allows people to collaborate and heal in new ways. Peer recovery support works within a long tradition of wounded healers—individuals who have suffered and survived an illness or experience who use their own vulnerability and the lessons drawn from that process to minister to others seeking to heal from this same condition (William White, 2006). Social researcher Brene Brown discusses vulnerability as the birthplace of innovation, creativity, and change. The shame, despair, and defensiveness that can be key obstacles to recovery in traditional treatment settings are dissipated with empathy, hope and optimism of peer support. According to Brown, “The two most powerful words when we're in struggle: Me, too” (Brown, n.d.)

Many people in recovery have a desire to “give back” after some time in recovery and RCOs offer many opportunities for service. Some peer leaders who give back by providing peer recovery support services have done so as volunteers. Often these positions provide opportunities for leadership development, a key goal for many peer recovery centers. Additionally, people in early recovery learn “soft skills” of the workforce that make for desirable employee attributes and can be transferred into other areas of future employment. Peers volunteer for tasks that support the smooth, welcoming operations of a center such as greeting visitors, answering phones, attending town meetings and other community events, contacting legislators, serving on advisory councils, and contributing to policy decisions.

In a few projects, peer leaders receive stipends for their work and are not considered staff. In some projects, however, peer leaders are paid for their services as staff. In a more professionalized role of a peer provider (e.g. certified peer specialist, peer support specialist, recovery coach) a peer practitioner uses their experience of addiction and recovery (their own or family member) plus skills learned in formal training “to deliver services in behavioral health settings to promote mind-body recovery and resiliency” (SAMHSA-HRSA Center for Integrated Solutions, 2014)

There are a variety of roles that peers play within PRSS programs. Two that have become most prominent are peer recovery coach and peer recovery support specialists. In most early writings, the terms recovery coach and peer specialist are synonymous. According to Borkman (as cited in White, 2004), both “draw their legitimacy not from traditionally acquired educational credentials, but rather, through experiential knowledge and experiential expertise. White and Sanders (W. White & Sanders, 2004) add:

> Experiential knowledge is information acquired about addiction recovery through the process of one’s own recovery or being with others through the recovery process. Experiential expertise requires the ability to transform this knowledge into the skill of helping others to achieve and sustain recovery. Many people have acquired experiential knowledge about recovery, but only those who have the added dimension of experiential expertise are ideal candidates for the role of [recovery coach.] The dual credentials of experiential knowledge and experiential expertise are bestowed by local communities of recovery to those who have offered sustained living proof of their expertise as a recovery guide.

Over the past decade, the definitions of the roles of peer recovery coaches have become more defined as training and certification across the country has become institutionalized (although training requirements vary by state). Some unique characteristics of peer recovery coaches include:

- The peer recovery coach highlights his/her lived experience, which professionals do not.
- Peer recovery coach fulfills all four types of social support.

- Peer recovery coaches act as a liaison to both the recovery community and to other systems and services by (1) directly initiating the individual to recovery community environments and accompanying them as needed and (2) helping the individual navigate services and systems, especially those lacking a strong recovery orientation.
- Peer recovery coaches act as a recovery and empowerment catalyst: guiding the peer's recovery process and supporting the peer's goals and decisions, rather than arranging and coordinating services or "doing for."
- In many cases, individuals in long-term recovery performing service roles as peer recovery coach strengthen their own recovery, especially those who may be experiencing recovery challenges as a result of job loss, a death in family, empty nest, divorce or economic crisis.

These roles are summarized in Table 2.

Table 2. Peer Roles

Role	Task	Setting
Peer Recovery Coach	Serve as guide and mentor to person seeking or already in recovery. Help identify and remove obstacles and barriers, support connections to recovery community and other resources useful for building recovery capital, respect path of recovery chosen by person seeking support.	Peer recovery support centers, telephone support, inpatient and outpatient addiction treatment programs, behavioral health organizations, community health centers, medication assisted treatment and recovery facilities, jails, recovery residences, places of faith-based support, educational settings, community and home settings, web-based and social media support –as determined by organizational policies, job description, source of funding
Peer Recovery Interventionist/ Crisis Interventionist	Provide support and guidance to person at critical intercept point along recovery support continuum linking person to treatment or other recovery support services as requested by person being supported	Hospitals, emergency rooms, courts, child welfare offices, schools, police and other first responders' departments
Peer Recovery Support Staff/ Peer Leader	Facilitate the development of peer to peer affiliational, emotional, informational, and instrumental recovery support. Provide training, education, and peer leadership development.	Peer recovery support center, recovery community organizations, community venues

Peer Navigator	Provide support and guidance accessing appropriate services from complex medical and treatment systems Support application process for health insurance and other entitlement benefits	Hospitals, community health centers, emergency rooms, crisis centers, peer recovery support centers, homes, community venues
Forensic Peer Specialist	Provide support as mentor, guide, resource connector to person involved with criminal justice system while incarcerated, on probation or in lieu of probation, or in re-entry process	Jails, prisons, jail diversion programs, drug courts, community –based programs
Peer Mentor/ Peer Advocate	Provide support and guidance similar to recovery coach. Job tasks may be more focused on special population with common lived experiences (Moms Mentoring Moms) or context specific (courts, jails)	Peer recovery centers, telephone support, inpatient and outpatient addiction treatment programs, behavioral health organizations, community health centers, medication assisted treatment and recovery facilities, jails, recovery residences, places of faith-based, support, homes, community venues, social media
Family Peer Support/ Family Recovery Coordinator	Provide support, education, intervention, and resource connections to families impacted by addiction	Courts, Peer Recovery Support Centers, Community venues, telephone support, homes, web-based and social media support
Firestarters	Peer leaders who implement recovery support based on tribal elders' knowledge	Native American communities, Wellbriety Movement
Promotoras – Bilingual Peer Specialists	Common culture community-based health education and recovery support (recovery coaching)	Spanish speaking communities: homes, community venues, health centers
Recovery Support Specialist	Over-arching role supporting people along the recovery continuum—either before, during, after, or instead of, treatment depending on job description. May include tasks of recovery coach, recovery interventionist, community health worker, systems navigator	All the above and safe use sites, housing complexes, community outreach events, government positions, corporate positions, healthcare, insurance industry

Although the roles of peer supporters are many and diverse, within primary and behavioral healthcare, common values and practices can be identified. A consortium of stakeholder organizations, led by the International Association of Peer Supporters, developed practice guidelines for peer supporters that acknowledge the diverse settings in which peer supporters work and the wide variety of tasks peers are asked to perform. These are summarized in Table 3.

Table 3. Peer Supporter National Practice Guideline *(International Association of Peer Supporters, 2013)*

Principle	Ethical Guidelines	Practice	Practice Guidelines
Peer support is voluntary	Recovery is a personal choice. The most basic value of peer support is that people freely choose to give or receive support. Being coerced, forced or pressured is against the nature of genuine peer support. The voluntary nature of peer support makes it easier to build trust and connections with another.	**Support choice**	Peer supporters do not force or coerce others to participate in peer support services or any other service. Peer supporters respect the rights of those they support to choose or cease support services or use the peer support services from a different peer supporter.
Peer supporters are hopeful	Belief that recovery is possible brings hope to those feeling hopeless. Hope is the catalyst of recovery for many people. Peer supporters demonstrate that recovery is real—they are the evidence that people can and do overcome the internal and external challenges that confront people with mental health, traumatic or substance use challenges. As role models, most peer supporters make a commitment to continue to grow and thrive as they "walk the walk" in their own pathway of recovery. By authentically living recovery, peer supporters inspire real hope that recovery is possible for others.	**Share hope**	Peer supporters tell strategic stories of their personal recovery in relation to current struggles faced by those who are being supported. Peer supporters model recovery behaviors at work and act as ambassadors of recovery in all aspects of their work. Peer supporters help others reframe life challenges as opportunities for personal growth.
Peer supports are open minded	Being judged can be emotionally distressing and harmful. Peer supporters "meet people where they are at" in their recovery experience even when the other person's beliefs, attitudes or ways of approaching recovery are far different from their own. Being nonjudgmental means holding others in unconditional positive regard, with an open mind, a compassionate heart and full acceptance of each person as a unique individual.	**Withhold judgment about others**	Peer supporters embrace differences of those they support as potential learning opportunities. Peer supporters respect an individual's right to choose the pathways to recovery individuals believe will work best for them. Peer supporters connect with others where and as they are. Peer supporters do not evaluate or assess others.
Peer supporters are empathetic	Empathy is an emotional connection that is created by "putting yourself in the other person's shoes." Peer supporters do not assume they know exactly what the other person is feeling even if they have experienced similar challenges. They ask thoughtful questions and listen with sensitivity to be able to respond emotionally or spiritually to what the other	**Listen with emotional sensitivity**	Peer supporters practice effective listening skills that are non-judgmental. Peer supporters understand that even though others may share similar life experiences, the range of responses may vary considerably.

	person is feeling.		
Peer supports are respectful	Each person is valued and seen as having something important and unique to contribute to the world. Peer supporters treat people with kindness, warmth and dignity. Peer supporters accept and are open to differences, encouraging people to share the gifts and strengths that come from human diversity. Peer supporters honor and make room for everyone's ideas and opinions and believe every person is equally capable of contributing to the whole.	**Be curious and embrace diversity**	Peer supporters embrace diversity of culture and thought as a means of personal growth for those they support and themselves. Peer supporters encourage others to explore how differences can contribute to their lives and the lives of those around them. Peer supporters practice patience, kindness, warmth and dignity with everyone they interact with in their work. Peer supporters treat each person they encounter with dignity and see them as worthy of all basic human rights. Peer supporters embrace the full range of cultural experiences, strengths and approaches to recovery for those they support and themselves.
Peer supporters facilitate change	Some of the worst human rights violations are experienced by people with psychiatric, trauma or substance use challenges. They are frequently seen as "objects of treatment" rather than human beings with the same fundamental rights to life, liberty and the pursuit of happiness as everyone else. People may be survivors of violence (including physical, emotional, spiritual and mental abuse or neglect). Those with certain behaviors that make others uncomfortable may find themselves stereotyped, stigmatized and outcast by society. Internalized oppression is common among people who have been rejected by society. Peer supporters treat people as human beings and remain alert to any practice (including the way people treat themselves) that is dehumanizing, demoralizing or degrading and will use their personal story and/or advocacy to be an agent for positive change.	**Educate and advocate**	Peer supporters recognize and find appropriate ways to call attention to injustices. Peer supporters strive to understand how injustices may affect people. Peer supporters encourage, coach and inspire those they support to challenge and overcome injustices. Peer supporters use language that is supportive, encouraging, inspiring, motivating and respectful. Peer supporters help those they support explore areas in need of change for themselves and others. Peer supporters recognize injustices peers face in all contexts and act as advocates and facilitate change where appropriate
Peer supporters are honest and direct	Clear and thoughtful communication is fundamental to effective peer support. Difficult issues are addressed with those who are directly involved. Privacy and confidentiality build trust. Honest communication moves beyond the	**Address difficult issues with caring and compassion**	Peer supporters respect privacy and confidentiality. Peer supporters engage, when desired by those they support, in candid, honest discussions about stigma, abuse, oppression, crisis or safety.

	fear of conflict or hurting other people to the ability to respectfully work together to resolve challenging issues with caring and compassion, including issues related to stigma, abuse, oppression, crisis or safety.		Peer supporters exercise compassion and caring in peer support relationships. Peer supporters do not make false promises, misrepresent themselves, others or circumstances. Peer supporters strive to build peer relationships based on integrity, honesty, respect and trust.
Peer support is mutual and reciprocal.	In a peer support relationship, each person gives and receives in a fluid, constantly changing manner. This is very different from what most people experience in treatment programs, where people are seen as needing help and staff is seen as providing that help. In peer support relationships, each person has things to teach and learn. This is true whether you are a paid or volunteer peer supporter.	**Encourage peers to give and receive**	Peer supporters learn from those they support and those supported learn from peer supporters. Peer supporters encourage peers to fulfill a fundamental human need -- to be able to give as well as receive. Peer supporters facilitate respect and honor a relationship with peers that evokes power-sharing and mutuality, wherever possible.
Peer support is equally shared power	By definition, peers are equal. Sharing power in a peer support relationship means equal opportunity for each person to express ideas and opinions, offer choices and contribute. Each person speaks and listens to what is said. Abuse of power is avoided when peer support is a true collaboration.	**Embody equality**	Peer supporters use language that reflects a mutual relationship with those they support. Peer supporters behave in ways that reflect respect and mutuality with those they support. Peer supporters do not express or exercise power over those they support. Peer supporters do not diagnose or offer medical services, but do offer a complementary service.
Peer support is strengths-focused	Each person has skills, gifts and talents they can use to better their own life. Peer support focuses on what's strong, not what's wrong in another's life. Peer supporters share their own experiences to encourage people to see the "silver lining" or the positive things they have gained through adversity. Through peer support, people get in touch with their strengths (the things they have going for them). They rediscover childhood dreams and long-lost passions that can be used to fuel recovery.	**See what's strong not what's wrong**	Peer supporters encourage others to identify their strengths and use them to improve their lives. Peer supporters focus on the strengths of those they support. Peer supporters use their own experiences to demonstrate the use of one's strengths, and to encourage and inspire those they support. Peer supporters encourage others to explore dreams and goals meaningful to those they support.

			Peer supporters operate from a strength-based perspective and acknowledge the strengths, informed choices and decisions of peers as a foundation of recovery. Peer supporters don't fix or do for others what they can do for themselves.
Peer support is transparent	Peer support is the process of giving and receiving non-clinical assistance to achieve long- term recovery from severe psychiatric, traumatic or addiction challenges. Peer supporters are experientially credentialed to assist others in this process. Transparency refers to setting expectations with each person about what can and cannot be offered in a peer support relationship, clarifying issues related to privacy and confidentiality. Peer supporters communicate with everyone in plain language so people can readily understand and they "put a face on recovery" by sharing personal recovery experiences to inspire hope and the belief that recovery is real.	**Set clear expectations and use plain language**	Peer supporters clearly explain what can or cannot be expected of the peer support relationship. Peer supporters use language that is clear, understandable and value and judgment free. Peer supporters use language that is supportive and respectful. Peer supporters provide support in a professional yet humanistic manner. Peer supporter roles are distinct from the roles of other behavioral health service professionals. Peer supporters make only promises they can keep and use accurate statements. Peer supporters do not diagnose nor do they prescribe or recommend medications or monitor their use.
Peer support is person-driven	All people have a fundamental right to make decisions about things related to their lives. Peer supporters inform people about options, provide information about choices and respect their decisions. Peer supporters encourage people to move beyond their comfort zones, learn from their mistakes and grow from dependence on the system toward their chosen level of freedom and inclusion in the community of their choice.	**Focus on the person, not the problems**	Peer supporters encourage those they support to make their own decisions. Peer supporters, when appropriate, offer options to those they serve. Peer supporters encourage those they serve to try new things. Peer supporters help others learn from mistakes. Peer supporters encourage resilience. Peer supporters encourage personal growth in others. Peer supporters encourage and coach those they support to decide what they want in life and how to achieve it without judgment.

Peer Support Settings

In addition to the variety of roles that peers have, peers also work or are placed in a variety of community and neighborhood settings.

Recovery Community Centers, Peer-to-Peer Centers, and Other Peer-run, Peer-led, or Peer-directed Settings

Recovery community centers and peer-to-peer centers are locations established and run by RCOs to be sites for the day-to-day practice of recovery. The organizational culture and climate of an RCO sets the context in which recovery can occur. Within RCOs:

- **Recovery lives.** RCOs are sanctuaries permeated with hope. For some RCOs, this means that the organization is an easily identified place in the community—an office or recovery community center—where individuals or families can go to receive recovery support services, such as mutual support groups, individual recovery coaching, and job coaching. Other RCOs are virtual, with telephone recovery support, Web-based and text-based support, and online education and advocacy. Still others may offer P-BRSS at locations throughout the community, such as emergency departments, community behavioral health centers, shelters for people without a home, faith-based organizations, or criminal justice agencies. Regardless of setting, the services and support that RCOs offer reflect the priorities of the local community. RCOs create places where recovery lives.
- **People belong**. Individuals do not need a behavioral health diagnosis to participate; RCOs accept everyone who is interested in recovery and support many pathways to recovery. People engaged with RCOs are not clients; rather, they are visitors, participants, peers, or members. RCOs do not provide mandated services (although they may partner with systems such as drug courts, probation, and parole that mandate participation); instead, they provide an opportunity for people to find their own pathways to wellness and to receive support from others who have been where they are.
- **People make positive, affirming connections.** An RCO is often a local hub where information about recovery originates and is disseminated. People make connections to other individuals and families and to the recovery community as a whole that help them build and maintain lives in recovery.
- **Individuals with lived experience lead, teach, and support.** RCOs offer training from the perspective of people with lived experience. Examples of training topics include recovery messaging, intentional peer support, creating cultures that support recovery, and the science of addiction and recovery.

RCCs run by RCOs offer a setting for PRSS in which there is: (a) a culture that values and understands the peer role; (b) a code of ethics appropriate for peer support; (c) supervision provided by peer director/coordinator with personal lived experience of addiction and recovery; and (d) policy and practices in place to support recovery.

Addiction Treatment Organizations

For many individuals, treatment is the first step toward a life in recovery. Treatment providers offer life-saving clinical services tailored to individual needs, including screening and detoxification; treatment planning and case management; individual and group behavioral counseling; evaluation and treatment for co-occurring mental health issues, such as depression and anxiety; and follow-up to prevent relapse.

In many communities, addiction treatment providers and RCOs work together to increase individuals' access to and success in treatment. Providers and RCOs partner to provide peer recovery support before, during, and after treatment. Additionally, RCOs advocate for policy changes at the local, State, and Federal levels—such as expanding support for and access to addiction treatment and recovery support services—that promote recovery and remove barriers to recovery.

PRSS are being added to behavioral health services systems in three sometime sequential patterns: as an encapsulated appendage/ adjunct to professional treatment services, as a part of the transformation of a particular system component, or integrated throughout a system-wide transformation process—with the third being the best option (White, 2009).

PRSS fill a need long recognized by treatment providers for services to support recovery after an individual leaves a treatment program. In addition, peer recovery support services hold promise as a vital link between systems that treat substance use disorders in a clinical setting and the larger communities in which people seeking to achieve and sustain recovery live. Using a non-medical model in which social support services are provided by peer leaders who have experienced a substance use disorder and recovery, these services extend the continuum of care by facilitating entry into treatment, providing social support services during treatment, and providing a posttreatment safety net to those who are seeking to sustain treatment gains (Center for Substance Abuse, 2009).

Medications are often an important part of treatment, especially when combined with behavioral therapies. Medication-assisted treatment for alcohol, opioids, and other drugs helps individuals manage withdrawal symptoms, prevent relapse, and treat co-occurring conditions. Treatment providers are working with individuals with lived experience, such as those involved in the MARS Project, to promote medication-assisted recovery.

Emergency Departments

Research has demonstrated that many illnesses and injuries treated in emergency rooms are alcohol- or drug-related. Once individuals are stabilized, emergency rooms are a crucial point for intervention with individuals with substance use challenges. The current opioid epidemic is leading to new approaches. For example, a Yale study demonstrated that starting medication-assisted treatment for opioid addiction in the emergency room, combined with brief counseling and a treatment referral, led to more individuals engaging in treatment (D'Onofrio et al., 2015).

Hospitals are working in partnership with RCOs to connect individuals with substance use challenges to peer recovery support while they are in the emergency room. For example, AnchorED was launched in an attempt to reduce the instance of accidental opioid overdose by connecting individuals who have experienced overdose with certified recovery coaches in emergency departments. The program ensures that individuals and their families know that substance use disorder is a medical condition and that recovery is possible. Certified peer recovery specialists are on call to all emergency departments 24/7 and called in when individuals are transported to a hospital emergency department having survived an opiate overdose. Recovery coaches engage with those who have survived an opiate overdose, listen, answer questions individuals may have about recovery support or treatment options, and provide information to family members. In its first year of operation, AnchorED recovery coaches saw 230 people and 83 percent engaged in recovery support after hospital discharge. Only five people were seen in the emergency room multiple times (Joyce & Bailey, n.d.).

Another example is the Highpoint Treatment Center ARCH Program, which began in October 2016. In its first three months, 81% of individuals being treated for overdose at the Brockton (MA) Hospital were evaluated, 39% placed in detoxification treatment, 21% placed in medication assisted treatment, and 34% enrolled a community support program. “The opiate users are responding to the peer model. They are opening up. They are accepting the help being offered. Perhaps it is because the opiate user does not feel judged, they are willing to have an open and frank discussion with someone who has ‘walked the walk’”(Harrington, 2017).

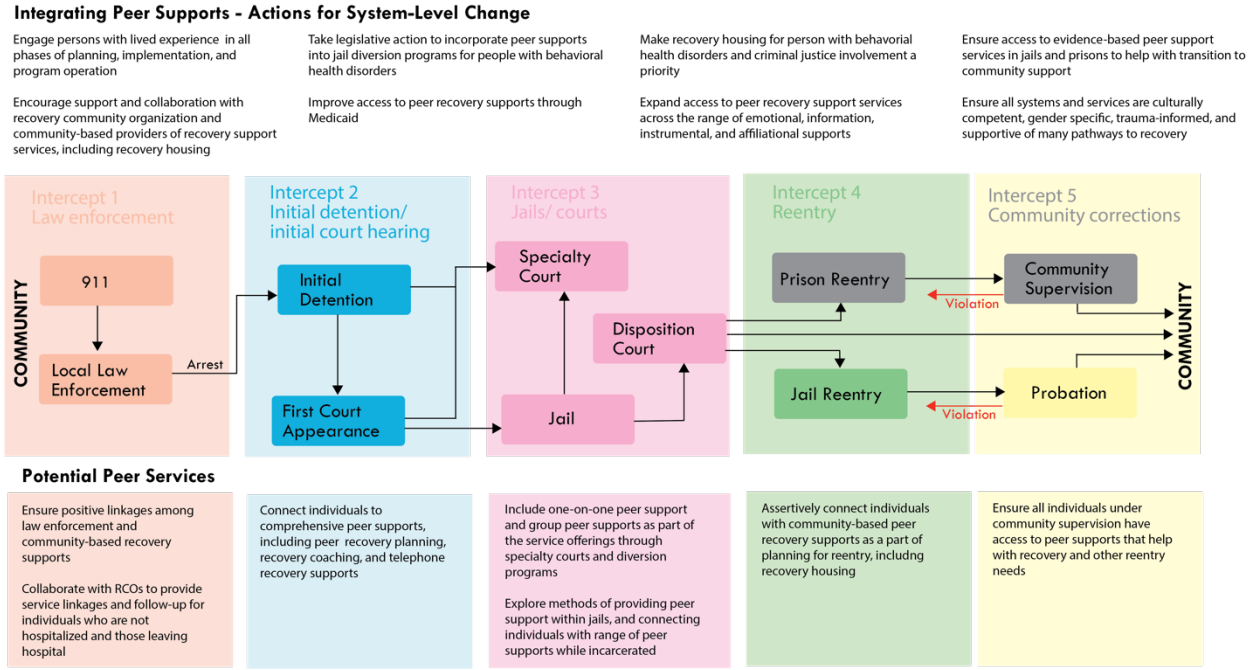
Criminal Justice Settings

Peer support in criminal justice settings help persons with substance use disorders access treatment and the path of sustainable recovery. According to the Sequential Intercept Model, there are five key points in the system where behavioral health services can meet the needs of people within the criminal justice system (SAMHSA GAINS Center for Behavioral Health and Justice Transformation, n.d.). These are summarized, along with potential peer supports for each, in Figure 1. The GAINS Center posits three responses that increasingly are being implemented:

1. Diversion programs, such as drug courts and family courts, to keep people with behavioral health disorders who do not need to be in the criminal justice system in the community.
2. Institutional services to provide constitutionally adequate services in correctional facilities for people with behavioral health disorders who need to be in the criminal justice system because of the severity of the crime; and
3. Reentry transition programs to link people with behavioral health disorders to community-based services when they are discharged.

Peer supports can be useful at each of these levels.

Figure 1. Peer Recovery Support Services at Critical Criminal Justice Intercepts (Adapted from SAMHSA GAINS Center, Sequential Intercept Model)



Police Assisted Addiction and Recovery Initiative
In an effort to support local police departments, a national coalition has been formed:
We also work to remove the stigma associated with drug addiction, turning the conversation toward the disease of addiction rather than the *crime* of addiction.

The Police Assisted Addiction and Recovery Initiative (PAARI) was started to support local police departments as they work with opioid addicts. Rather than arrest our way out of the problem of drug addiction, PAARI committed police departments:

- Encourage opioid drug users to seek recovery
- Help distribute lifesaving opioid blocking drugs to prevent and treat overdoses
- Connect addicts with treatment programs and facilities
- Provide resources to other police departments and communities that want to do more to fight the opioid addiction epidemic

Colleges, Universities, and High Schools

Collegiate Recovery Programs (CRPs) are an innovative and growing model of peer-driven recovery support delivered on college campuses. These services are provided within an environment that facilitates social role modeling of sobriety and connection among recovering peers. Recovering college peers help new students effectively manage the environmental risks present on many college campuses. Observational data suggest encouraging outcomes with

low relapse rates and above average academic achievement. The number of CRPs nationwide is growing.

The President's National Drug Strategy, a document issued yearly through the White House Office of National Drug Control Policy (ONDCP), emphasizes the importance of promoting recovery, regardless of pathway, i.e., whether or not professional treatment is sought (ONDCP, 2011).The Strategy calls for the expansion of peer recovery support services across community-based settings and explicitly notes the importance of fostering the development of recovery supports in academic settings, a goal that it shares with the U.S. Department of Education as detailed in a recent monograph (Laudet, Harris, Kimball, Winters, & Moberg, 2014)Dickard, Downs, & Cavanaugh, as cited in (Laudet et al., 2014).

Recovery high schools help students in recovery focus on academic learning while simultaneously receiving RSS. Such schools support abstinence and student efforts to overcome personal issues that may compromise academic performance or threaten continued recovery. The earliest known program opened in 1979, and the number slowly increased to approximately 35 schools in 15 states by 2015 (United States Public Health Service, Office of the Surgeon General, 2016).

Generation Found
http://generationfoundfilm.com/
From the creators of the groundbreaking film, *The Anonymous People*, comes *Generation Found*, a powerful story about one community coming together to ignite a youth addiction recovery revolution in their hometown. Devastated by an epidemic of addiction, Houston faced the reality of burying and locking up its young people at an alarming rate. And so, in one of the largest cities in America, visionary counselors, law school dropouts, aspiring rock musicians, retired football players, oil industry executives, and church leaders came together to build the world's largest peer-driven youth and family recovery community.

Independently filmed over the course of two years, *Generation Found* takes an unprecedented and intimate look at how a system of treatment centers, sober high schools, alternative peer groups, and collegiate recovery programs can exist in concert to intervene early and provide a real and tested long-term alternative to the "War on Drugs." It is not only a deeply personal story, but one with real-world utility for communities struggling with addiction worldwide.

Generation Found highlights how communities have come together find real solutions for adolescents and young adults seeking a recovery that works, including recovery high schools.

The Urgency of the Opioid Epidemic

Over the past decade, the US has seen the rise of opioid addiction and overdose deaths. Opioids are a class of drugs that include the illicit drug heroin as well as the prescription pain relievers such as oxycodone, hydrocodone, codeine, morphine, and fentanyl. Opioids interact with nerve cells in the brain and nervous system to produce pleasurable effects and relieve pain.

A few statistics:

- Of the 20.5 million Americans 12 or older that had a substance use disorder in 2015, 2 million had a substance use disorder involving prescription pain relievers and 591,000 had a substance use disorder involving heroin.
- It is estimated that 23 percent of individuals who use heroin develop opioid addiction.
- Four in five new heroin users started out misusing prescription painkillers.
- In 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills.
- 94 percent of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were “far more expensive and harder to obtain.”
- Drug overdose is the leading cause of accidental death in the US, with 52,404 lethal drug overdoses in 2015. Opioid addiction is driving this epidemic, with 20,101 overdose deaths related to prescription pain relievers, and 12,990 overdose deaths related to heroin in 2015.

(American Society of Addiction Medicine, 2016)

The opioid epidemic is, in some ways, accelerating the widespread adoption of peer supports.

In his acclaimed account of the opioid explosion sweeping the country, *Dreamland,* journalist Sam Quinones notes, “... heroin, so fearsome and scary, was emerging as a ferocious agent of change in America.” He remarks that once unthinkable strategies are now sought by those politicians and institutions that held tight to tough on crime and not in my neighborhood policies (Quinones, 2015).

To address this opioid pandemic, there have been efforts nationwide to shift from criminalizing addiction to calling for a public health response. Local communities are collaborating in new and innovative partnerships. First responders, district attorneys, mayors, sheriffs, court officials, medical directors, treatment providers, educators, families, and people in recovery are all at the same table seeking solutions to this complex problem. The value of, and need for, peer recovery support in non-traditional settings is a common call.

In his opening statement to the White House Symposium on Addiction Medicine, Michael Botticelli, Director of National Drug Control Policy under President Obama, said, “America must bring the power of medicine and public health to bear to reduce substance use and its consequences.

Each of these settings offers unique opportunities to promote recovery among individuals, families, and within the community.

With a greater understanding of what it is that peer practitioners do, and the places in which they work, we can now turn our attention to the supervision of peer practice.

Peer Practitioners' Experiences of Supervision

Recognizing that the peer practitioners' perspective of their supervision experience is valuable and vital to understand the current state of peer supervision, five discussion groups were convened. The peer practitioners who participated in these groups all provide direct addiction recovery support; they live in diverse geographical areas; and they work in a variety of settings. The results of the discussion groups are summarized in this section; response and reflections of participants are also included in subsequent sections, where appropriate.

From the discussion, it is clear that no common structure or system of supervision exists. In general, participants were confident when talking about their current supervision process. Phrases such as, "My supervisor has my back" and "He's always available" highlight the support many peer practitioners felt they were getting. Yet, expressed just as often was frustration about limits and lack of supervision, "My supervisor wears too many hats" and "I often get bumped when something else comes up."

Who is doing supervision. Supervision for peer practitioners is being provided by people with a wide range of job titles and organizational roles, from buddy coaches to executive directors, from peer coordinators to clinical supervisors. Whatever the title, every supervisor has multiple responsibilities, wears many hats, is pulled in many directions. In some instances, peer practitioners report to more than one supervisor with different skill levels and experience, such as a program director and lead coach, or a clinical supervisor and a recovery coach supervisor. Some receive no direct supervision.

Who *Should* Supervise?

There is ongoing conversation in the field on who is qualified to provide supervision to peers. One view is that peer practice is a field and as such supervisors should be those who have been in the positions/have the experiences of those whom they supervise (as in virtually every other field). This means, many believe that supervisors must be persons with lived experience. A second view is supervisory experience is more important than lived experience. And a third view is that persons with master's level, clinical experience must supervise to provide quality assurance, a view which is the most controversial.

Nonetheless, some peer practitioners have a clinician as their supervisor, and some are engaged in the process of clinical supervision, which is defined as:

> …[A] specific skills set which allows the supervisor to guide, train, mentor, teach and direct a counselor in becoming a skilled clinician. Good clinical supervision assumes that a clinical

> supervisor will observe counselors in the performance of their duties, provide feedback from the observation and guide the counselor to improve skills as needed while reassuring the counselor in those areas of competent practice (Northwest ATTC, n.d.).

One peer practitioner noted, “I have a clinical supervision [session] for one hour one time a week, a group supervision once a month for 3 hours total—one hour of a topic-case study and two-hour training (CEU’s toward re-accreditation). My peer supervisor is in contact a lot.”

A few peer practitioners mentioned that their [clinician] supervisors provided therapeutic intervention when they had personal problems impacting their work. In speaking about the benefits of having a supervisor with a clinical background who is well grounded in recovery principles, one participant said, “We consult on individuals I am coaching. She brings her clinical experience into the peer work and helps us to stay on the line of peer work versus counseling. She emphasizes clarification on peer role in case there are questions. She also can be my counselor if I need it.”

A clinical supervisor can also be helpful with concerns about participants who are experiencing situations beyond the peer practitioner’s expertise [but that can be true of any supervisor with more experience than the peer].

Participants describe being met with significant resistance from clinical staff at treatment centers. Peer support is not viewed as credible and a peer practitioner’s expertise and training is not valued. “You’re just a peer,” reflects the lack of organizational preparation and system change thinking necessary for peer recovery support to be welcomed and honored as the successful evidenced based practice it is.

The experience of having a clinician as supervisor as well as a lead peer as supervisor might speak to an organization's attempt to stay in the right lane for peer practitioners while addressing the complex needs of those seeking treatment or in early recovery. How to be a clinical supervisor providing non-clinical supervision to a non-clinical peer practitioner is one of the challenges of peer support offered in non-traditional settings.

There are essential differences between supervisors who have lived experiences in recovery and as a peer supporter, and those who do not. These can impact the ways in which a supervisor is able to serve as a role model, model other responsibilities, support trust, and help build knowledge. (Kopache, as quoted in (Daniels, Tunner, Powell, Fricks, & Asheden, 2015).

Including seasoned peer in supervision can help clarify peer provider’s professional development process (i.e., peer apprentice, advanced beginner, competent worker, experienced worker, and expert) (Chinman as quoted in Daniels et al. 2015)

Too often, individuals are promoted into supervisory positions based on clinical experience, which does not ensure they have had adequate training in the tasks of supervision. Additionally, experience in *clinical* supervision does not translate into good supervision within a peer context.
Regardless of “who” is tapped to supervise peer supports, there are some key tenets that must be in place, which will be described in the *Framing Supervision* section.

Types and structure of supervision. A broad spectrum of supervision structures exists. Formal supervision happens from “not at all,” to “as needed,” to “weekly one-to-one” meetings. Multiple formats are used to deliver supervision. In addition to individual scheduled weekly or bi-weekly meetings, group supervision also happens frequently and sometimes includes a training component as part of the support. Some people only receive group supervision, others refer to staff meetings as their supervision.

Whether people receive one-on-one only, group only, some combination of one-on-one and group, or buddy supervision, a common thread is that the supervision time is often shortened, rushed, or rescheduled due to overextended staff and limited resources. Creative structures seem to be arising that help address these limits. “[Supervision] is on a weekly basis with the center manager. We discuss members that are puzzling to me or have unnerved me, or that bring back my traumatic experience. Informal meetings happen to where we gather in a group when needed. I also have a buddy coach.”

The evolving nature of the practice of supervision is evident. One participant shared, “We have once-a-week meetings for an hour and a half (with one other peer). We figured it out along the way. Initially, we did not have much supervision. [Regular supervision] started two months ago. Before, we were told to make the position our own and that didn’t work without guidance and structure.”

Education and support. The process of supervision helped peer practitioners to development important skills such clear communication, asking great questions, modeling healthy boundaries, listening, and assisting others with problem solving. Supervisors offered professional development opportunities, resource information, and training support.

Peer practitioners also found ethical and advocacy discussions to be informative and instructive. One peer practitioner noted, “My supervisor asks great questions to help me see other perspectives…. In supervision, we talk about advocacy or ethics. I look at it as a gentle learning process.”

Benefits of supervision. peer practitioners see many benefits of supervision for themselves and those they support. They are appreciative of what supervisors have to offer and are eager to learn and grow in their ability to do their work well.

Peer practitioners who had access to more than one supervisor benefitted from the different skills of each. For example, supervision with a program manager helped develop the peer’s techniques and knowledge about area resources gathered over time.

A peer practitioner’s personal recovery can be impacted by providing peer support. Many participants said that conversations about self-care were part of their supervision. Participants

noted the benefits of good supervision on their own health, especially if there was an opportunity during supervision to focus on personal issues.

*Changes the peer practitioner would like to have in the supervision proce*ss. In responding to the question “If you were the supervisor what would you add or change,” peer practitioners spoke to the structure and nature of supervision, the administrative support needed to perform their job, and the attitudes and qualities peer practitioners would like to see in their supervisors.

Peer practitioners want consistent, available, supportive guidance. peer practitioners are on the front lines dealing with complex issues supporting people often in life or death situations. They want a chance to talk about their day, to share a joy, or lessen a burden. Key characteristics mentioned included having a supervisor/ more experienced person on site to support peer work, having weekly meetings (that are kept as scheduled, and long-enough for a quality supervision session), and brief daily check-ins before coaching begins. Phrases like open-door policy and informal check-ins as needed underscore the benefit of having a supervisor or other support on site and available when the unpredictability and immediacy of peer work cannot wait for a scheduled supervision time.

Peer practitioners want a relationship with their supervisor that is respectful and recognizes the intense nature of the work. The suggestions shared reflect principles of good supervision: do more listening than talking; develop a collaborative process; give clear direction; be kind; be patient. These ideas speak to the universal need to be seen, heard, and valued.

Peer practitioners want administrative support from their organizations. At present, they often are expected to provide peer support in a variety of settings with limited technology access under inadequate working conditions. These conditions include no private workspace, no confidential consulting space, and no desk or computer access. Administrative supports such as computer assistance and help with documentation are important to peer practitioners. Other suggestions for administrative improvements: have a dedicated place for the coaches to coach; avoid overloading coaches with work not funded; have a guidebook for procedures and forms; and create safety and boundary policies for coaches.

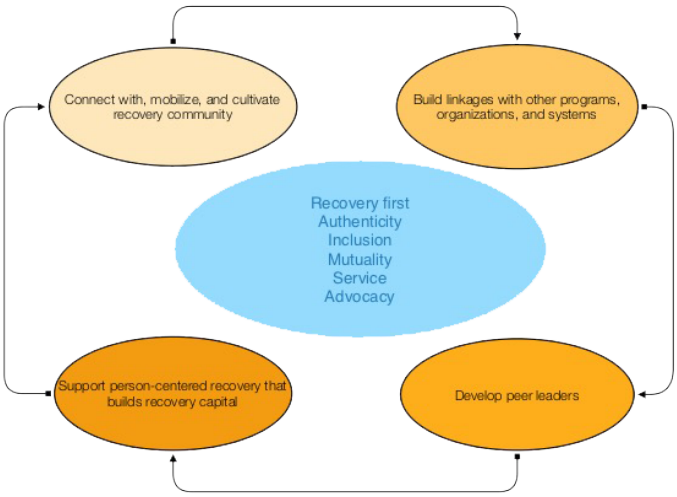
In addition to the above, peer practitioners are also looking to:

- Participate in huddles or groups that are not facilitated by a person tasked with supervision.
- Have a voice in organizational policies, procedures and programs.
- Be engaged when program changes are occurring, with enough time to ask questions about the reasons for and to prepare for a change.
- Increase communication with persons tasked with supervision and leaders of organization.
- See increased transparency, even if it the information being shared is negative.
- Have real retreats versus a staff meeting off site with some retreat feature.

- Participate in social activities on a regular basis with other staff that do not involve work.
- Participate in work-sponsored wellness activities involving exercise, stress management and education.
- Eliminate fear of negative consequences if, as an individual, s/he is experiencing compassion fatigue.
- Connect with other PRSS programs.

Framing Supervision

Figure 2. Peer Recovery Support Services Core Principles and Practices



When peer services were confined to RCOs, supervision was a question, as it is in all organizations, but it was not an *issue.* The rise and spread of PRSS to a variety of settings, especially clinical settings, and the push to reimburse such services under state, federal, and privately funded programs, has led to increasing concerns about the supervision of peer practitioners and peer supports. Some of the questions arise from outside of the recovery community (Can we trust those persons in recovery to do the work?). Others arise from within the recovery community (Can we trust the non-RCO settings to not exploit the peers? To keep the peer experience authentic?). Still others arise from peer practitioners themselves (Can I get the support I need to do my work?).

In addition, entities that pay (or might potentially pay) for peer services are driving much of the conversation about supervision. Regulations related to Medicaid reimbursement for peer services state that there must be a "competent mental health professional" providing (Center for Medicare and Medicaid Services 2007); it is clearly left to the discretion of states to determine how to interpret—and many have chosen to interpret it as a licensed social worker or health care professional providing clinical supervision.

To address all of these questions and issues, there are increasingly calls for guidelines, training, and protocols for supervision of peers.

For peer practice to be most effective, supervision of peer support needs to be patterned on the best practices of PRSS. Recovery values, principles, and core concepts (depicted in Figure 2) must be embedded in the supervision practice. For example, if processes with PRSS programs are about sharing power, participation, self-direction, and finding strengths and solutions, so too should be the processes of supervision of PRSS.

The supervision principles derived from recovery principles are summarized in Table 4.

Table 4. Supervision Premises, Principles, and Practices

Premise	Principles of Supervision	Practices of Supervision
Peer support is mutual and reciprocal.	Supervision is an act(ion) not a role.	• Be available/ accessible. • Validate and support. • Help to problem-solve and troubleshoot. • Help achieve and maintain quality of work.
Peer support is strengths-focused, person-centered & self-directed.	Supervision is a strength-based process in which there is mutual accountability.	• Use structures of supervision that empower peers. • Use a variety of diverse supervision modalities.
Peer support is a unique discipline.	Supervision enhances and develops the unique knowledge and skills necessary for successful peer practice.	• Engage peer practitioners in effective training and development. • Support ongoing career development. • Offer peer practitioners feedback and perspective on their work. • Use motivational interviewing to help peer identify areas for growth and development • Help peer practitioners clarify how and when sharing personal story/ lived experience is helpful.
	Supervision provides a safe space to address ethical dilemmas and boundary issues.	• Help peer to navigate ethical guidelines. • Assist in boundary-setting.
	Supervision engages peer practitioners in strengthening the PRSS program.	• Build an environment of trust and safety. • Use participatory processes and systems to ensure peer and recovery community inclusion. • Encourage and support new ideas.
Peer support thrives within a recovery-centered context.	Supervision fosters an organizational environment / culture that is conducive to recovery.	• Advocate for peer practice and peer supports. • Be a voice to educate, advocate about peers and peer needs within the organization. • Champion recovery within the organization. • Endorse/facilitate equality and mutual respect among all roles within organization. • Provide education about recovery to host organization.
	Supervision clarifies organizational systems, structures, and processes.	• Help peer practitioners understand and navigate organization's culture and navigate cultural norms. • Help peer practitioners understand and navigate the cultures, procedures, and rules for the other organizations and systems with which PRSS interact. • Clearly articulate rights and responsibilities. • Provide clear delineation of difference in roles of different staff, and between paid and volunteer staff.

		• Ensure the effective implementation of policies and procedures. • Assist with conformance, fidelity. • Encourage clear documentation appropriate for peer role. • Ensure appropriate, complete recordkeeping.
	Supervision supports self-care.	• Assist to manage time, balance workload. • Support recovery journey. • Foster wellness orientation.

In applying the eight principles, the goal is to ensure:

- A safe, trusting working relationship that promotes a learning alliance.
- Shared responsibility ensuring that the peer participant goals are addressed.
- An individualized approach based on individual learning needs and style.
- Congruence with the values and philosophy of the agency.
- Commitment to on-going peer-fessional development/ active promotion of professional growth and development.
- A rigorous process for addressing ethical and legal responsibilities.

The supervision principles are described in the section that follows.

Principle 1: Supervision is an Act(ion) Not a Role

The term *supervisor* is used commonly in most organizational settings to denote a person who oversees and guides work undertaken by others. The term reinforces hierarchical power structures that are antithetical to peerness; supervision that is *oversight* controverts mutuality and reciprocity in relationships. Thus, in peer settings, it is necessary to re-think, re-frame, and re-define the term in ways that emphasize guidance, mutual learning, and support.

Viewing supervision as action or a behavior rather as a role is such a re-framing. While some may see this as mere semantics, it is a crucial perspective to hold in a peer context. Supervision as an act detaches the tasks of supervision from role of supervisor. This changes the dynamic from superior-subordinate to colleague-partner in the work, which then allows for a shift in behaviors—from oversight, monitoring, and performance evaluation to support, guidance, and performance management.

In mutually supportive supervision, it is important to acknowledge the underlying power dynamics and to have an honest discussion about what each person gains and gives within the relationship.

Viewing supervision as an act also has benefits for the organization. Now removed from a singular role, the tasks can be shared among two or more persons with different (complementary) skills sets. (More on co-supervision in the *Practicing Principles* section.)

Three Core Elements of Supervision

There are three general elements to supervision: (1) supportive, (2) educative, and (3) administrative (Smith, 1996 - 2011). The process of supportive supervision helps to foster high morale and satisfaction; individuals receive feedback work, along with validation and support. The process of educative supervision ensures effective training and development; it includes providing regular space and time to reflect on peer practice; consistent opportunities to develop knowledge, skills and competencies. The administrative processes promote the effective implementation of policies and procedures and conformance to standards for high-quality practice. These functions, adapted to the context of PRSS, are depicted and summarized in Figure 3.

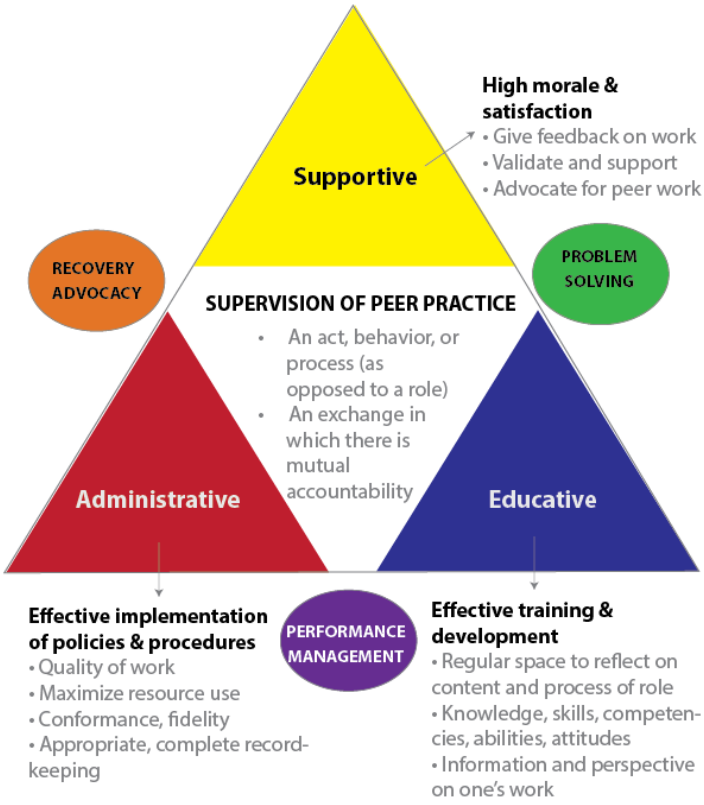


Figure 3. Core Elements of Supervision

Although they are described as discrete dimensions, in practice the functions are intertwined—a supervision task, such as discussing a recovery coaching session, may have elements of support (giving feedback), education (role playing to practice a new skill), and administration (ensuring that notes for the session are appropriately filled and filed). This interplay leads to three core responsibilities —problem solving, performance management, and recovery advocacy—that individuals do together during the supervision process.

This framework can be useful in identifying and clarifying the tasks of supervision.

Principle 2. Supervision is a Strengths-based Process in Which There is Mutual Accountability

If we start with the premise that peer support is strengths-focused, person-centered, and self-directed, it stands to reason that supervision of PRSS should also be. The goals of such supervision are to:

- Facilitate the development of a competent staff members who make good decisions;
- Identify competencies and amplify them through supervision;
- Share the responsibilities, challenges, and rewards of the tasks to be accomplished; and
- Assist peer practitioners to empower program participants to achieve their desired recovery outcomes (Lowe & Deal, 2014).

*Relationship-focused***.** This core principle is the foundation of the peer movement. If the relationship between the supervisor and the peer practitioner is limited due to lack of time, training, or multiple roles, the values of respect, trust, empathy, and collaboration will be also limited.

Strengths-focused and self-directed. In supervision, the process is as important as the content. The process should be designed to support reflection about the hopes, priorities, accomplishments, resilience, resourcefulness, creativity, and ongoing occupational developments, in order to address the difficulties and challenges in the work. Often, this is through appreciative inquiry, asking question that evoke the peer practitioner' expertise, and assist the peer practitioner to find the answers they need.

Person-centered. Each peer practitioner will have their own strengths and challenges while performing their work. If a supervisor is wearing more than one hat, only meeting infrequently or often unavailable, they will not identify these unique needs. If a need is not met, the peer practitioner will eventually fail. Supervision is best when it is adapted to meet learning styles and developmental needs of individual peer practitioners.

Ideally, the supervision process would involve: the peer practitioner deciding on the purpose, focus, and scope of a supervision session and assessing its usefulness; an emphasis on the practitioner's growth and development; a focus on what is working; encouragement of the practitioner's unique ways of working, when these are shown to be successful; and the practitioner gaining and increasing sense of confidence in their own decision making.

If there is a lack of supervision, the peer practitioner will not be supported in envisioning a meaningful and purposeful career path. More than 30 percent of the discussion group participants used self-degrading language when speaking, in spite of the length of time these participants reported being in recovery (the average fell between 5-8 years). This indicates a lack of role modeling of recovery, hope, and strength-based language.

Principle 3. Supervision Enhances and Develops the Unique Knowledge and Skills Necessary for Successful Peer Practice

Peer support is a unique discipline. Effective supervision supports and prepares individuals to be successful within the discipline by focusing on the knowledge, attitudes, behaviors, beliefs, skills and competencies that the peer practitioner has and needs. The foundation for this principle is a commitment to supporting, educating and developing peer practitioners. This means ensuring access to initial and advanced training and providing on-the-job support to supplement training.

Initial training required, additional training provided, and training desired. Peer practitioners receive a broad spectrum of training to support their work. Most peer practitioners in the discussion groups received initial recovery coach or peer specialist training. This was consistent across organizations, geographic areas, and the context that peer support was delivered. Many participants attended training based on the five-day *Recovery Coach Academy* developed by Connecticut Center for Addiction Recovery; others attended sessions based on the model developed by Georgia Council on Substance Abuse, *Certified Addiction Recovery Empowerment Specialist (CARES)*. The initial trainings are a step in the peer certification process required by some States. Although not all the peer practitioners in the discussion groups were certified, many were working towards certification or attended recovery coach training as a requirement for their position.

Opportunities for additional trainings were available for peer practitioners based on their organization's support and funding. Some trainings reflect the knowledge and skills needed to work in nontraditional settings. Other trainings offer skills and understanding of special populations peer practitioners are supporting. The list of additional trainings taken by participants indicates the specialized knowledge and skills peer practitioners need as the demand for peer support spreads across new systems.

Much is being asked of peer practitioners and they want to have the skills and knowledge necessary to offer the best support possible. Peer practitioners desire a broad array of trainings that speaks to the evolving nature and understanding of effective peer support. When asked about additional trainings they would like to receive, discussion group participants expressed an interest in more specialized trainings and trainings that delve deeper into topics covered in initial recovery coach trainings. For example, one person shared, *"*I would like more diversity training on different cultures. Training that dives in deeper for example, training for those hard of hearing or deaf, special populations and those from other cultures." Others spoke of a need to develop soft skills that support the ability to work effectively, *"*I would love to have monthly trainings about reflective listening, time management, emotional intelligence, integrated care, professionalism, and documentation.

Peer Support Core Competencies

SAMHSA led an effort to identify the critical knowledge, skills, and abilities (leading to core competencies) needed by anyone who provides peer support services to people with or in recovery from a mental health or substance use condition (SAMHSA, 2015). The core competencies were organized into 12 categories, which are listed below.

Category I: Engages peers in collaborative and caring relationships
This category of competencies emphasized peer workers' ability to initiate and develop on-going relationships with people who have behavioral health condition and/or family members. These competencies include interpersonal skills, knowledge about recovery from behavioral health conditions and attitudes consistent with a recovery orientation.

Category II: Provides support
The competencies in this category are critical for the peer worker to be able to provide the mutual support people living with behavioral health conditions may want.

Category III: Shares lived experiences of recovery
These competencies are unique to peer support, as most roles in behavioral health services do not emphasize or even prohibit the sharing of lived experiences. Peer workers must be skillful in telling their recovery stories and using their lived experiences as a way of inspiring and supporting a person living with behavioral health conditions. Family peer support worker likewise share their personal experiences of self-care and supporting a family-member who is living with behavioral health conditions.

Category IV: Personalizes peer support
These competencies help peer workers to tailor or individualize the support services provided to and with a peer. By personalizing peer support, the peer practitioner operationalizes the notion that there are multiple pathways to recovery.

Category V: Supports recovery planning
These competencies enable peer workers to support other peers to take charge of their lives. Recovery often leads people to want to make changes in their lives. Recovery planning assists people to set and accomplish goals related to home, work, community and health.

Category VI: Links to resources, services, and supports
These competencies assist peer workers to help other peers acquire the resources, services, and supports they need to enhance their recovery. peer practitioners apply these competencies to assist other peers to link to resources or services both within behavioral health settings and in the community. It is critical that peer practitioners have knowledge of resources within their communities as well as online resources.

Category VII: Provides information about skills related to health, wellness, and recovery
These competencies describe how peer workers coach, model or provide information about skills that enhance recovery. These competencies recognize that peer practitioners have knowledge, skills and experiences to offer others in recovery and that the recovery process often involves learning and growth.

Category VIII: Helps peers to manage crises
These competencies assist peer workers to identify potential risks and to use procedures that reduce risks to peers and others. Peer workers may have to manage situations, in which there is intense distress and work to ensure the safety and well-being of themselves and other peers.

Category IX: Values communication
These competencies provide guidance on how peer workers interact verbally and in writing with colleagues and others. These competencies suggest language and processes used to communicate and reflect the value of respect.

Category X: Supports collaboration and teamwork
These competencies provide direction on how peer workers can develop and maintain effective relationships with colleagues and others to enhance the peer support provided. These competencies involve not only interpersonal skills but also organizational skills.

Category XI: Promotes leadership and advocacy
These competencies describe actions that peer workers use to provide leadership within behavioral health programs to advance a recovery-oriented mission of the services. They also guide peer practitioners on how to advocate for the legal and human rights of other peers.

Category XII: Promotes growth and development
These competencies describe how peer workers become more reflective and competent in their practice. The competencies recommend specific actions that may serve to increase peer practitioners' success and satisfaction in their current roles and contribute to career advancement.

Principle 4: Supervision Provides a Safe Space to Address Ethical Dilemmas and Boundary Issues

Within PRSS programs, multiple parties have investment in the health and safety of both a person receiving support and the peer practitioner providing services. This means attention must be paid to ethical considerations and boundary maintenance.

Clinical, medical, judicial, and other non-traditional settings adhere to ethical codes that may or may not reflect recovery values and the unique value of peer support. When peer work is guided by a code of ethics that reflects recovery values then these values inform the ethical decision making. Peer practitioners are making decisions that have ethical dimensions and may push boundary limits daily. Supervision provides the platform to reflect on the decision-making process in actions taken and have meaningful conversations about ethical dilemmas and boundary issues.

Many peer practitioners have supported others, including friends and family members, at many points along the recovery continuum. This personal experience requires a shift in understanding and practice when peer support is provided in more formal settings.

Principle 5: Supervision Engages Peer Practitioners in Strengthening the PRSS Program

Peer practitioners often have a detailed knowledge of individual's experiences (good or bad) with a program, organization, or system, either from lived experience or from interaction with peer participants. This can lead to program improvement, if the ideas and resourcefulness of peer practitioners are routinely put to use. Their ideas can help to build a PRSS environment of trust, safety, and radical inclusion.

Principle 6: Supervision Fosters an Organizational Environment / Culture That is Conducive to Recovery

Peer support is not always appreciated or welcomed by other staff outside of the walls of an RCO. Peer practitioners report a culture and climate that misunderstands the unique contributions peers bring to support recovery. The role of the peer is sometimes devalued and even openly negated as shown in attitudes and comments.

Organizations seeking to improve recovery outcomes through peer support need to assess their culture, capacity, and commitment to a recovery-oriented (or recovery-centered) system. The strength of an organization's understanding of recovery values and principles, and a shift towards a recovery orientation system is key to successful peer practice.

Within the supervision process, peer practitioners can share how the organizational culture is conducive to recovery and how it imposes barriers. With that knowledge, those tasked with supervision can advocate for peers—both practitioners and participants—and educate others about peer strengths and needs.

Principle 7: Supervision Clarifies Organizational Systems, Structures, and Processes

Organizations and systems can be complex. Policies within them can be convoluted, and contradictory. And although recovery happens in community, it is often within organizations and systems that individuals find the services needed to support a life in recovery. Peer-to-peer support helps individuals to navigate those organizations and systems; supervision helps the peer practitioner to more fully understand, appreciate, and work within their own organization as well as other organizations and systems.

Peer practitioners are supporting people within a greater system that does not always have the infrastructure to meet the demands of the public health crisis they have been called to serve. They recognize that some of the major obstacles they face are systemic and complicated. These additional challenges were cited by discussion group participants: peers with complex medical, mental health, and SUD needs; lack of resources to refer participants; long waiting lists for access treatment; insurance problems; lack of training about insurance; and stigma. Often peer practitioners feel that it is their job to fill these gaps; good supervision helps them to problem solve around these issues, and be realistic (yet optimistic) about what can and cannot be done within the context of peer support.

This leads to the final principle.

Principle 8: Supervision Supports Self-care

Peer practice seeks to support people in their recovery (as opposed to support people in their treatment). To do so, peers themselves must have lived experience of addiction and recovery, and must continue in their recovery while being of support to others. Supervision should foster wellness and recovery.

The process of supervision should help the peer practitioner to manager his or her time, and balance the workload. Time management issues were mentioned as significant challenges by discussion group participants. One individual expressed the unrealistic expectations that can happen when funding is limited. “We only have enough funding for 16 hours a week and more work than that— event planning, administrative tasks, and telephone coaching. I can’t get it all done, and my director has an expectation that I should be able to.” Another peer practitioner stated, “Some of our funding was lost, and the coaches were expected to pick up the workload. There is no accountability, so I am leaving and taking a different job.”

It is important to keep in mind the concept of *occupational self-care*— assisting in developing a self-care plan to minimize burnout, compassion fatigue, vicarious traumatization, and substance use triggers (Martin & Jordan, 2017). It is important to have the peer practitioner understand that their peer work is not the same as their own recovery program. It is also important to avoid the person tasked with supervision taking the role of therapist, diagnostician, or sponsor. Several of the focus group participants identified their supervisor as “part of their support circle” or “someone I can bring my mental health problems to.” These statements indicate unhealthy or a lack of boundaries in supervision. Instead, the supervision process should model the PRSS practice of linking people to resources to help them have a better life, by helping the practitioner find the outside support they need to take care of self. It is the obligation of a supervisor to provide EAP information and/or additional resources when a peer practitioner indicates challenges with emotional health and personal wellbeing.

Pillars of Peer Support Supervision: Core Principles
The Pillars of Peer Support Supervision were development at the sixth of an ongoing series of summits known as the Pillars of Peer Support. The initial summit, held in 2009, produced the *Pillars of Peer Support Services*, primarily focused on mental health consumer-run services. Each subsequent summit addressed evolving issues related to peer practice and peer support.

In 2014, the summit addressed the development of pillars for the supervision of peer specialists. Invitees included representatives from states that were actively addressing supervision issues related to mental health peer support programs. Five pillars emerged:

1. Peer Specialist Supervisors are Trained in Quality Supervisory Skills.
2. Peer Specialist Supervisors Understand and Support the Role of the Peer Specialist.
3. Peer Specialist Supervisors Understand and Promote Recovery in their Supervisory Roles.
4. Peer Specialist Supervisors Advocate for the Peer Specialist and Peer Specialist Services Across the Organization and in the Community.
5. Peer Specialist Supervisors Promote both the Professional and Personal Growth of the Peer Specialist within Established Human Resource Standards (Daniels et al., 2015).

These pillars mirror the principles and practices (presented in Table 4) that the *Technical Expert Group on Supervision of Addiction Peer Supports* identified as critical for effective supervision of addiction peer supports.

Practicing the Principles

Currently, many peer practitioners face obstacles due to inadequacies of supervision, organizational policies that impact the nature of support, and/or the setting where support is offered. There is a general sense of lack that adds to obstacles and a sense of feeling devalued as a peer support worker: lack of policy regarding transportation, lack of policy regarding workload, lack of clear expectations, lack of clear job description, lack of funding for professional development, lack of communication, and unreasonable expectations on outcomes for peer practitioners.

Knowledge, Skills, and Attitudes for Strengths-based Supervision

The discussion group participants offered some examples about how inadequate supervision impacts their work. One peer practitioner mentioned her supervisor had no formal supervision training, which led to confusion and lack of direction. Inconsistent supervision and a sense that the peer role is not valued by the supervisor was also noted.

The discussion group participants reported extensive training available and/or required for their role. They also reported a broad spectrum of ongoing continued education available to them. This emphasis on education and training needs to extend to the role of the supervisor. Just as

the peer practitioner needs training and support, so do those tasked with supervision. There is clear evidence that those tasked with supervision of PRSS are not receiving the training and ongoing professional development needed for this multi-faceted role. If we require an initial 30–40-hour peer practitioner training, we must hold the same standards for those who do supervision (training and/or level of experience).

Supervision is a skilled process, requiring high levels of professional development. Those tasked with supervision must be well-trained and well-equipped. Table 5 summarizes the knowledge and skills identified by the Technical Expert Group.

Table 5. Knowledge and Skills for Individuals Engaged in Supervision of Peer Supports

Knowledge	Skills/ Proficiencies	Attitudes/ Approaches
Value and nature of peer support Culture of Recovery ● Recovery Principles ● Language ● Multiple pathways Best practices and evidence-base of peer services Peer ethical guidelines (and how differ from clinical ones) Core competencies of peer practice ● Recovery coaching process ● How personal stories/ lived experience ties into professional work Peer role and how it fits into the organizational context Science of addiction The components and value of a recovery oriented systems of care Recovery movement Trauma-informed practices and approaches Medicaid reimbursement for peer support	Motivational interviewing Cultural competence Active listening Articulate communication Provide concrete feedback Recognizing and responding to effects of trauma Shared decision making and problem solving Facilitation ● collaborative processes ● learning / learning community Goal setting and prioritization Task identification, prioritization and delegation Models self-care Advocacy Detailed record keeping and documentation practices Advocacy *Preferred* Lived experience of addiction and recovery Experience as peer	Models the core philosophies and principles of recovery Is authentic in interpersonal relations- self-aware and reflective Respects peer's life experience and role Recognizes mutuality in relationship Embodies recovery principles ● Focuses on strengths and assets ● Is person centered ● Shares power ● Encourages self-direction Is flexible Uses person- first, wellness-focused language Has predictable and consistent actions and responses Creates a safe and supportive context Commitment to building and fostering a culture of recovery

First and foremost, those taking on supervision tasks need a deep understanding of the nature of peer practice. The supervisor must have the knowledge of the peer specialist's role and work, as well as understand the principles and philosophy of recovery and the code of ethics for peer specialists in the state (Swarbrick in Daniels et al. 2015).

Often, individuals are promoted into supervisory positions based on clinical experience, which does not ensure they have had adequate training in the tasks of supervision. Additionally, experience in *clinical* supervision does not translate into good supervision within a peer context. Or peers are moved into supervisory roles with minimal or no supervision training. Individuals

tasked with supervision need training in basic supervision skills and specific skills related to supervising peer supports, and advanced training in strengths-based and solutions-focused supervision. They also benefit from supervision and professional development that applies the same principles described above.

SUD Supervisor Competencies

The publication *Substance Use Disorders Supervisor Competencies* (Martin & Jordan, 2017) describes 20 core competencies for peer supervisors organized into four categories:

Recovery-oriented Philosophy

1. Understands peer role
2. Recovery orientation
3. Models recovery principles
4. Supports meaningful roles
5. Recognizes the importance of addressing trauma, social inequity, and health care disparity

Providing Education and Training

6. Ongoing training
7. Professional system navigation
8. Applicable laws and regulations
9. Community resources

Facilitating Quality Supervision

10. Role clarity
11. Strength-based, person-centered supervision
12. Identify & evaluate peer competencies
13. Confidentiality
14. Ethics and boundaries
15. Quality supervision
16. Accessibility
17. Occupational equity and staff development
18. Staff safety

Performing Administrative Duties

19. Peer delivered services advocacy
20. Employment practices

These were developed via a multi-step process of: systematic review of the literature; analysis of literature by subject matter experts, who then generated competencies; survey of peers and supervisors; edits to competencies; review of draft document by administrators with peer/recovery experience; and edit of final competencies and production of self-assessment grids.

Resources such as *Substance Use Disorders Supervisor Competencies* can be helpful, with a caveat: Any competencies must be fully aligned with peer practice principles.

As in peer work, persons tasked with supervision need to acknowledge any limits they have. Self-monitoring and management, and seeking out their own supervision are essential. Without regular and ongoing supervision, the ability to reflect and discuss personal motivations, judgements, signs of stress or compassion fatigue will be missed.

Strengths-based Supervision: Structures and Modalities

Supervision structures take many forms depending on organizational resources and the context where peer support is delivered. Often the persons tasked with supervision have multiple responsibilities and are challenged to hold the needs of the peer practitioner and the needs of the organization simultaneously. Developing creative structures for supervision can assure that support for peer practitioners is available when needed and provide opportunities for other meaningful elements of supervision to happen consistently.

One-on-one Supervision

When one thinks of supervision, individual supervision is what is most commonly considered. If the process is truly one of inquiry, then questions asked are key: We live in the worlds our questions create (Hammond, 2013). Some key reflective questions for those tasked with supervision:

- How do I notice and celebrate success?
- What am I modelling about expectations for success and change?
- How often do we highlight what is working well?
- How do we talk about challenging issues?

In sessions, there needs to be a balance between a focus on growth and development aspects and the administrative aspects, which in turn balances an emphasis on the practitioner's perceptions and experience with a consideration of peer participants and their specific issues and needs. Together, the supervisor and practitioner collaboratively review and renew the process of supervision and make adjustments where necessary (Lowe and Deal 2014).

Set clear expectations. It is critical that both the supervisor and peer leader share their expectations about the process, method, and content of supervision. This can advance the development and maintenance of a trusting, safe relationship. The following information should be discussed early in the working relationship:

- Models of supervision.
- Supervision methods (e.g., direct observation, co-facilitating, coaching) and content.
- Frequency and length of supervisory meetings.
- Ethical, legal, and regulatory guidelines.
- Access to supervision in emergencies.
- Alternative sources of support when the primary supervisor is unavailable.

Co-supervision

Co-supervision allows different skills to be developed effectively, can balance supervision styles, and can support organization efficiency. For example, one person might focus on

administrative tasks such as documentation and human resource policies, while another can offer observations and reflective feedback for occupational development.

Co-supervision also allows for the combination of an experienced (lead) peer and a clinician to work together to support peer work. This combination can model respect and collaboration across disciplines, address role and boundary issues of peers as they relate to clinicians, and provide different perspectives on situations beyond the peer practitioner's expertise.

Co-supervision is beneficial when time and resources limit the availability of supervision. Lead coaches, buddy coaches, and mentors can bring expertise and experience of recovery values and principles and the nature of peer work to benefit both an organization and the peer practitioner being coached.

Group Supervision

There are many advantages to holding group supervision. Peer practitioners share their experiences with one another to gain support and build knowledge. Group process is excellent for in-service trainings and problem solving common concerns. Many supervisors provide both one on one supervision for individual growth and development and facilitate group supervision.

Technology offers opportunities for supervision and developing learning communities which are especially useful when providing supervision across large geographic areas. Facebook groups keep peer practitioners connecting and communicating with supervisors and with each other. Consider the possibilities when combining two or more of the current supervision structures and using the tools of technology.

Applying Principles Across Different Contexts

Increasingly, peer support is being offered at locations outside of the RCOs in which they originated, by organizations that may have only a vague notion of the workings of peer support. In these settings, peer practitioners often are placed in a team and in a culture that has limited understanding of the role and value of peer support.

In non-RCO settings, supervision tasks are not different than those within an RCO; however, there are nuances which may increase the challenges of supervision. Two examples:
(1) Help peer practitioner(s) understand organization's culture and navigate cultural norms.

- In all of the kinds of organizations, it is incredibly important that supervisors not only understand the culture of the organization in which the peer is placed but that they help the organization understand the culture of the peer organization as well. Moreover, we should not assume that this automatically happens in RCOs.
- However, in RCO settings, those tasked with supervision have greater control over the environment in which the peer is working.
- Other settings may or may not be recovery-oriented, or may just be beginning to evolve in that direction. This means that in supervision, more time may need to be spent

assisting the peer practitioner to understand the organization, its culture, and how peer support fits into it.

(2) Champion/be advocate for recovery within the organization and champion the peer role.

- RCOs, by their nature, understand recovery. It is the core mission of the organization, and all systems, structures, and processes flow from that mission.
- In other types of organizations, those tasked with supervision must understand both organizations and settings and communicate that understanding adequately within and between both organizations to support the peer in his/her placement. They may have to spend time educating others about recovery and the value of peer support in recovery. They may also have to advocate for policies that support the work of peer support.
- PRSS programs that are hosted by larger (facilitating) organizations may face the same issues of promoting recovery culture, in terms of needing to educate the staff of the larger organizations about recovery.

Persons who do supervision in non-RCO settings must engage in thoughtful, intentional support of peer practitioners to: (a) maintain the peerness of the PRSS offered, (b) ensure the wellbeing of those served, and (c) at the same time, facilitate the just and respectful treatment of peer recovery support staff.

The Language of Recovery

Patients and clients = clinical setting, language of addiction
Members, participants, partners = peer recovery setting, language of recovery

As we shift from a crisis-oriented, professionally directed, acute-care approach with its emphasis on discrete treatment episodes to a person-directed, recovery management approach that provides long-term supports and recognizes the many pathways to health and wellness, language is key. The Office of National Drug Control policy notes:

> Person-first language is the accepted standard for discussing people with disabilities and/or chronic medical conditions. Research shows that use of the terms "abuse" and "abuser" negatively affects perceptions and judgments about people with substance use disorders, including whether they should receive punishment rather than medical care for their disease. Terms such as "addict" and "alcoholic" can have similar effects. As a result, terms such as "person with a substance use disorder" or "person with an alcohol use disorder" are preferred…. The term "person in recovery" has a range of definitions but generally refers to an individual who is stopping or at least reducing substance use to a safer level, and reflects a process of change (Office of National Drug Control and Policy, 2017).

In a recovery-centered environment, language used is strengths-based, de-stigmatizing. When talking about people with whom peer supporters interact, the terms program participants, members, or peers are used rather than the terms clients, patients, or cases. When talking about individual who are of support to others, the terms peer providers, peer practitioners, peer supporters, and people with lived experience are the ones of choice.

In settings outside of RCOs, peer practitioners may have to be adept at code shifting—that is, at balancing the context and core emphasis on the language of recovery. Peer support in a hospital may reference "patient" while the peer practitioner refers to person as "the guy wanting some support." or even by first name, "Jim" while respecting confidentiality. Those tasked with supervision may need to assist in finding that balance.

Considering the Organizational Dimensions of Effective Supervision

To this point, this paper has focused primarily on the individual dimensions of supervision. It is important to note that organizational context, setting, and culture can have a profound effect on nature and quality of peer support, which in turn affects supervision. As peers move into new environs, establishing policies and practices that maintain the unique relational "peerness" of the role is essential. Therefore, there are also a few important considerations at the organizational level.

Prepare to Integrate Peer Support

The complexity of the multi-directional challenges experienced by the integration of the peer workforce in non-traditional settings cannot be overstated. Peers are being hired to work in systems that may not yet have fully developed their own culture, commitment, and capacity to fully integrate peer recovery support services. Peers are in settings that are ill-equipped to support them.

Fitting the best practices of peer support into other systems will be a mismatch without a careful and thoughtful approach.

Preparing the Organizational Culture

New resources, such as the *Peer Support Toolkit* (City of Philadelphia Department of Be...), can help organizations to prepare. The toolkit describes 11 practices to undertake *before* integrating peers:

P1. Communicate Senior Leadership's Commitment to a Recovery-Oriented Service Philosophy
P2. Solicit the Perspectives of People in Recovery, Family Members and Staff Early in Your Process
P3. Provide Resources, Ongoing Training and Continued Opportunities to Orient Current Staff
P4. Conduct an Agency Walk-Through
P5. Examine the Extent to Which Agency Language Is Recovery Oriented
P6. Anticipate, Address, and Reframe the Concerns of Existing Staff
P7. Conduct an Agency Self-Assessment
P8. Examine and Create Shared Expectations Related to Boundaries and Ethics
P9. Align Policies with a Recovery-Oriented Approach
P10. Clarify Expectations and Roles of New Peer Staff
P11. Clarify the Roles of Volunteer and Employed Peers

Review and Revise Policies and Procedures

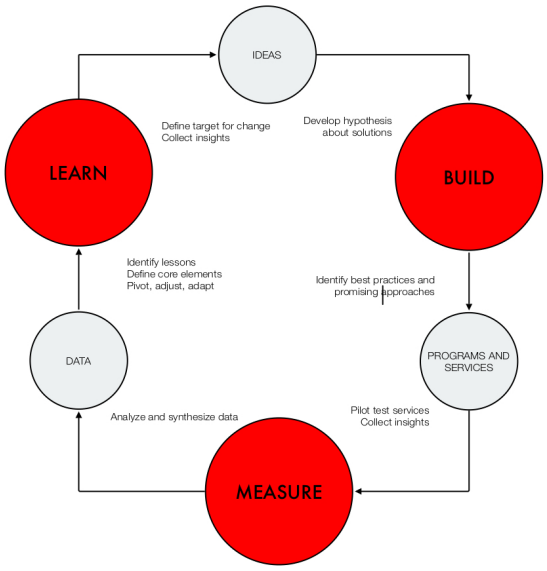
Organizations should review existing policies and procedures to ensure that they are consistent with and supportive of peer practice.

Currently, peer practitioners face many challenges in their work due to organizational policies, or lack of policies, related to peer support. In some cases, organizational requirements inhibit the ability of a peer practitioner to approach a person in a natural, relational manner. Required paperwork and documentation is overwhelming in some instances. One peer practitioner noted that by the time he got done with all the required paperwork in an emergency room initial session, the person he might have been able to help lost interest in talking. On the opposite extreme, no set policy about documentation resulted in a peer practitioner creating a system without direction or confidence that it would meet a funder's needs. Some participants discussed overwhelming documentation regulations; others mentioned the challenges being required to enter data on a computer system that is at a different location from where the peer support occurs. All of these examples are indicative of policies and procedures that are inconsistent with peer support.

Some key policies to review for alignment with recovery principles: requirements for being a peer practitioner (e.g., length of recovery, educational attainment); work hours and overtime policies, including safeguards that keep the peer practitioner from being over-used as a volunteer; ethics and boundaries; criminal history; access to resources that support self-care, and can help staff address grief, vicarious trauma, and compassion fatigue.

Using a risk management lens, and in consultation with peer practitioners (at minimum), review the organization's policies and procedures to identify potential risks to the organization, evaluate their prevalence, and select suitable techniques to deal with them—ways to avoid the risk, modify programs to reduce risk, and mitigate the impact of risks.

Figure 4. Program Development Cycle (Adapted from Lean Nonprofit framework)



Plan and Implement Appropriate Supports

Organizations must plan and deliver PRSS that are authentic and appropriate for setting and context, with fidelity to the selected peer support model(s). It is important to safeguard against using peer practitioners as a stop-gap, which may happen when a continuum of care is not fully funded.

Peer recovery support services must be tailored to match the assets, needs, and character of the communities in which they are located. This requires validated learning (that is, getting clear data about core assumptions about assets, issues, and needs), pilot testing, and measuring the results of the pilot, which in turn leads back to learning. This process is depicted in Figure 4.

The main point is to develop, test, and adapt/ innovate until the best program model for the organization is achieved. An organization will move through this virtuous cycle of learn, build, and measure until the approach has been proven.

There are a variety of methods that can yield important insights into the community in which you plan to implement a program or intervention, the population to be served, and the services to be provided: compile and analyze organizational data; engage key recovery community stakeholders, informants, gatekeepers, and leaders in dialogue; conduct a community assessment; consultant with peer practitioners and persons to be served. When done right, the learning process builds stronger relationships between the community and the organization or institution, clarifies the change(s) that need to happen to promote recovery within a specified group or population, and surfaces best approaches.

The Case Against Case Management in Peer Support – Five Key Points

Peer recovery support is steeped in values and principles that counter past and even current traditional addictions treatment strategies and language. Let's look at five key points that highlight why case management does not fit with the culture of peer recovery.

First, the term "case management."
People are not cases. Recovery is not a case. Peers do not manage each other.

Second, peer recovery is not more of the same.
A primary aim for the peer recovery movement is that we not become an appendage to the addiction treatment (or healthcare or social services) world. Peer recovery is not more of the same. It is fundamentally, profoundly different in the understanding of the nature of recovery and the value of lived experience. In recovery, we know that each person brings a wealth of experience and expertise to their own recovery journey. We use the expression, "Wisdom resides within." The path to wellness is a natural process. Each person knows what their recovery needs are and what types of resources and supports would help them achieve their goals. Peer recovery support is a walk with another on the path. And each path is uniquely chosen by each individual in recovery.

Third, recovery management is not synonymous with case management.
The term case management is used in the health and social services fields. Although a case manager may do similar tasks as a peer in offering support for a person's recovery management, the direction and the responsibility are not the same. There is often a sense of authority, a differential in power balance that happens by virtue of the case manager/client relationship. When the term is used in peer recovery support, that imbalance remains, often to the detriment of a person's recovery. When a person in recovery senses that another is

directing them, they are not given the chance to develop their inner resources, to build their own resilience, or to experience their strengths and value.

Mutuality and commonality are key in peer support. People heal in relationships. Peer recovery support offers the unique opportunity for respectful, trusting relationships to develop based on the credibility and vulnerability that only peers can offer. Peer support places the person in recovery at the center of their process and recognizes the right placement of responsibility. At the RECOVER Project, a peer recovery resource center in Massachusetts, a large banner greets everyone when they walk in: "What are you doing today for your recovery?"

Fourth, peer recovery views people as a resource not as a recipient or object.
In the Recovery Coach Academy developed by the Connecticut Community for Addiction Recovery and used nationally as a basis to train peer recovery support workers, the Spectrum of Attitudes is a foundational module. This module draws from the work of William Lofquist, a leader in the field of youth development. Lofquist proposes that people treat each other in one of three ways —as an object, as a recipient, or as a resource—and that these approaches hold true across all our everyday relationships, whether parent-child, teacher-student, supervisor-supervisee, spouse-spouse, therapist-client, recovery coach-person in recovery. The attitudes are not always consistent and fall across a continuum; they may shift and change depending on many factors. How a person is treated has a profound effect on their well-being.

> When people are viewed as an object, the attitude is one in which a person or a group of people know "what is best" for another group or person. Sometimes a person or group will even decide they have the right to determine what a person or other group may do, not do, and other limiting circumstances. People being treated this way know it, feel it, and respond with negative emotions and, depending of the imbalance of power, resignation or rebellion.
>
> When people are viewed as recipients, the first group still believes it knows best, but gives the other group the right to have input or make decisions because the actions of doing so is good for them. This leads to feelings of betrayal, manipulation, and indifference.
>
> When people are viewed as resources, there is an attitude of respect by the first person or group toward what the other person can do. This attitude and the behaviors that follow it can be closely associated with two matters of great concern: self-esteem and productivity. Creating a culture in which people are viewed as resources is a worthy goal (Connecticut Community for Addiction Recovery, 2012).

In traditional case management, people in recovery are often treated as a recipient of services or, depending on setting, even as an object. This negatively impacts self-esteem, confidence, and limits intrinsic motivation. Consider these common characteristics:

- The person is seen as the problem or an illness label.
- Language is grounded in stigma and doubt
- The impact of background, family, and environments is not considered.
- The helping relationship is infused with power inequality, distance, control, and

manipulation.
- There is a tendency to “fix” sickness-related problems with prescriptive solutions

Recovery supports are strength-based and forward facing. Positive feelings and resiliency is built when people are recognized as the resource they are and take the lead in planning for their recovery. Consider the following characteristics of strength based, resource-driven recovery planning:

- Every individual, group, family, and community possesses strengths, interests, abilities, knowledge, and capabilities.
- Language is optimistic and hopeful
- Every environment is full of potential resources.
- The helping relationship is one of collaboration, mutuality, and partnership.
- All human beings have the capacity to learn, grow, develop, and change.
- Every person is responsible for their own recovery.

Peer support in recovery recognizes and celebrates each individual as a resource, not only for their own personal growth, but as a valuable asset to the community as well.

Fifth, like recovery, recovery management is holistic and dynamic
Recovery is a journey. It is an unfolding, often surprising, process. People are told, “Grab a helmet and hang on. It’s a wild ride!” Managing recovery may be a misnomer, too. Multiple possibilities, multiple influences, multiple factors converge every day to shape one’s direction and next step.

Recovery capital is a concept presented by Granfield and Cloud (1999) that indicates the volume of internal and external assets people have that lead to the initiation and maintenance of recovery. These resources vary for each individual and can actually be different for a person at different life stages. Recovery capital includes assets and resources such as: access to basic needs, physical and emotional health, values, education, self-awareness, resiliency, financial resources, familial and social connectedness, and even community attitudes and policies. Equally vital is availability of recovery-oriented support services and accessible peer support relationships.

Research indicates that the greater one’s recovery capital the more likely addiction remission will be sustained (Kelly & Hoeppner, 2014). Part of recovery management is assessing one’s recovery capital, setting personal goals, planning for obstacles, envisioning desired results, and finding new meaning inherent in the challenges of life’s experiences.

Providing people in recovery a safe, supportive community and opportunities for growth and meaningful purpose are cornerstones of peer recovery support. Recovery management embraces the breadth and scope of resources available at peer recovery centers that include: social, emotional, instrumental and informational supports.

And always at the heart of peer support is the conversation between peers that begins with, “Me, too. I get it. You can do this.” Credibility. Authenticity. Vulnerability. Hope. Ease.

Conclusion

Peer recovery support services (PRSS) have emerged as important resources for engaging and supporting individuals and families in their recovery. As PRSS, and peer practitioners, move from recovery community organizations into new settings, these sites must:

- Plan and implement peer supports that are appropriate for the context, with fidelity to the selected peer support model(s).
- Prepare to integrate peer support.
- Ensure that policies and procedures are consistent with and supportive of peer practice and
- Enact supervision that is patterned on the best practices of PRSS.

Recovery values, principles, and core concepts must be embedded throughout.

Currently, many peer practitioners (regardless of setting) face obstacles due to inadequacies of supervision, organizational policies that impact the nature of support, and/or the setting where support is offered. This must change. The eight principles of supervision presented in this paper, along with corresponding supervision practices, knowledge and skills, are a guide for developing processes, structures, and training and development to create they quality supervision that peer practitioner want, need, and deserve.

References

American Society of Addiction Medicine. (2016). Opioid Addiction Facts and Figures. American Society of Addiction Medicine.

Brown, B. (n.d.). *Listening to shame*. Retrieved from https://www.ted.com/talks/brene_brown_listening_to_shame/transcript?language=en

Center for Substance Abuse. (2009). *What are Peer Recovery Support Services?* (No. HHS Publication No.(SMA) 09-4454). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Connecticut Community for Addiction Recovery. (2012). *Recovery Coach Academy Manual*.

Daniels, A. S., Tunner, T. P., Powell, I., Fricks, L., & Asheden, P. (2015). *Pillars of Peer Support Services Summit Six: Peer Specialist Supervision*. Retrieved from http://pillarsofpeersupport.org

D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., … Fiellin, D. A. (2015). Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial. *JAMA: The Journal of the American Medical Association*, *313*(16), 1636–1644.

Gagne, C., Olivet, J., & Davis, L. (2012). *Equipping behavioral health systems & authorities to promote peer specialist/ peer recovery coaching services*. {SAMHSA}.

Granfield, R., & Cloud, W. (1999). *Coming Clean: Overcoming Addiction Without Treatment*. New York: NYU Press.

Hammond, S. A. (2013). *The Thin Book of Appreciative Inquiry (3rd Edition)*. Thin Book Publishing.

Harrington, L. (2017, January 12). Letter of Support from Signature Healthcare Brockton Hospital.

International Association of Peer Supporters. (2013). National Ethical Guidelines and Practice Standards: National Practice Guidelines for Peer Supporters. Retrieved from https://na4ps.files.wordpress.com/2012/09/nationalguidelines1.pdf

Joyce, T. F., & Bailey, B. (n.d.). *Supporting recovery in acute care and emergency settings*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/recovery_to_practice/supporting-recovery-in-acute-care-emergency-settings.pdf

Kelly, J., & Hoeppner, B. (2014). A biaxial formulation of the recovery construct. *Addiction Research & Theory*, *23*(1).

Laudet, A., Harris, K., Kimball, T., Winters, K. C., & Moberg, D. P. (2014). Collegiate Recovery Communities Programs: What do we know and what do we need to know? *Journal of Social Work Practice in the Addictions*, *14*(1), 84–100.

Lowe, R., & Deal, R. (2014). *A Vision for Supervision: Strengths-based Questions for Reflective Conversations*. Victoria, Australia: St. Luke's Innovative Resources.

Martin, E., & Jordan, A. (2017). *Substance Use Disorder Peer Supervision Competencies*. The Regional Facilitation Center.

Office of National Drug Control and Policy. (2017). Changing Federal Terminology Regarding Substance Use and Substance Use Disorders. Retrieved from https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Memo%20-%20Changing%20Federal%20Terminology%20Regrading%20Substance%20Use%20and%20Substance%20Use%20Disorders.pdf

Quinones, S. (2015). *Dreamland: The True Tale of America's Opiate Epidemic*. New York: Bloombury Press.

SAMHSA. (2015, December 7). Core Competencies for Peer Workers in Behavioral Health Services. Retrieved from

https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies.pdf

SAMHSA GAINS Center for Behavioral Health and Justice Transformation. (n.d.). Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model. Retrieved from http://gainscenter.samhsa.gov

SAMHSA-HRSA Center for Integrated Solutions. (2014). Peer Providers. Retrieved from http://www.integration.samhsa.gov/workforce/peer-providers

Smith, M. K. (1996 - 2011). The functions of supervision. Retrieved June 8, 2016, from http://infed.org/mobi/the-functions-of-supervision/

United States Public Health Service, Office of the Surgeon General. (2016). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Heath: Executive Summary*.

White, W. (1990, October). *Keynote address: The Ethics of Competition*. Presented at the 21st Annual Chemical Dependency Fall Conference, Bloomington, MN.

White, W. (2006). *Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity*. Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. L. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. L. (2010). Nonclinical Addiction Recovery Support Services: History, Rationale, Models, Potentials, and Pitfalls. *Alcoholism Treatment Quarterly*, *28*(3), 256–272.

White, W., & Sanders, M. (2004). *Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities*. *http://www.williamwhitepapers.com/*.

Methodology

The project team used three primary processes to gather information on effective supervision from a variety of sources and stakeholders' perspectives.

Literature Review. Altarum staff reviewed literature from a variety of disciplines, related to substance use disorders, mental health, behavioral health, public health, community health, and peer support to identify and specify the components of established evidence-based practice and emerging promising approaches related to peer practice and supervision of peer supports. Sources included peer-reviewed journal articles, books, monographs, published reports, policy documents, training manuals, websites, online articles, and unpublished manuscripts. This diverse knowledge base gave rise to the need for an exploratory, formative approach to addressing the topic.

A body of empirical studies concerning effective general supervisory practice was found in journals related to business, social work, and psychology. Although there were few peer reviewed articles that focused on supervision of peer workers, peer practice, or peer support, there were published resources that addressed the topic. Information from these sources was synthesized for use in the discussions described below.

Technical Expert Group Discussions. A technical expert group of addiction recovery leaders and stakeholders was convened to:

- Describe the key elements of effective models for supervising addiction peer recovery support services.
- Examine how the different institutional cultures and settings in which peer workers are placed affect peers and peer services.
- Recommend best approaches for supporting the peer practice and the peer workforce.
- Develop guidelines for effective supervision.
- Outline components of effective training and professional development for peer supervisors.

Four meetings of the group were held across a 3-month period: one day-long, in-person meeting and three 2-hour virtual meetings. Before the convenings, group members were asked to review synopses of the literature review. Between convenings, they were asked to review and comment on meeting notes and frameworks developed based on group discussions.

One of the key tasks of the group was to develop a list of specific knowledge, skills, and attitudes of those tasked with supervision of PRSS, based on three distinct settings—RCO, clinical, and community-based non-clinical. After the third meeting, TEG members completed an online survey ranking the relative importance of each item on the list.

Peer Worker Group Discussions. Recognizing that the peer practitioners' perspective of their supervision experience is valuable and vital to understand the current state of peer supervision, five discussion groups were convened. The peer practitioners who participated in these groups all provide direct addiction recovery support; they live in diverse geographical areas; and they work in a variety of settings. The goal of the conversations was to gather information from the peer participants to understand:

- types and structure of current supervision practices;
- how supervision is beneficial to both the peer practitioner and services offered;
- obstacles peer practitioners face due to the setting where support is offered, organizational policies that impact the inherent unique nature of support, and/ or inadequacies of supervision;
- initial training required, additional training provided, and training desired; and
- changes the peer practitioner would like to have in the supervision process.

Selection Process. An email was sent to SAMHSA-funded peer recovery support program directors and staff with information on the discussion group. Directors were asked to disseminate the information, which included an invitation to take an initial screening survey, to peer support staff that met specific criteria.

There were 54 responses to the survey. In order to get as broad a range of input, participants for the discussion groups were selected based on three factors: (1) working as peer recovery support staff at the time of the discussion groups; (2) not being a person tasked with supervision, and (3) geographic location. Based on these factors, 29 respondents were invited to participate in one of five conference calls. There were 14 individual who attended the calls, with the remaining 15 either declining participation, not responding, or not attending the designated call.

Compilation of information gathered. Altarum staff compiled and synthesized the information gathered from the technical expert group meetings and the peer worker discussions to identify common themes and discern key topics for the report.

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