Peer Specialist Training: Integration of Peer Support in Mainstream Mental Health

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# Table of Contents

1.0 Abstract .................................................................................................................. III

2.0 Introduction ............................................................................................................ 1

3.0 Literature Review .................................................................................................. 3

3.1 Peer Support Involvement in Mental Health ......................................................... 3

3.2 Recovery in Mental Health .................................................................................... 9

4.0 Method and Program Overview ........................................................................... 19

5.0 Conclusion and Areas of Further Development .................................................. 25

References .................................................................................................................... 28

Appendix A: Peer Training Manual ........................................................................... 29

Appendix B: Complete Program Overview- Prototype ........................................... 91
1.0 Abstract

Consumer involvement has become the holy grail of mental health services. Research shows that the use of consumer peer supporters delivers similar outcomes in recovery to mainstream mental healthcare. The effectiveness for peer support in outcome achievement is attributed to the flexibility, creativity, and ability to connect on a deeper level with their peers through the sharing of their own lived experience. Despite the evidence of the effectiveness of consumer providers, the mainstream mental health system is slow to integrate their usage. The purpose of this project was to develop a training program for peer specialists in mental health that embodies the recovery model, and allows for flexibility and creativity that makes peer supporters effective. The aim of this project is to provide a resource for agencies embarking on integrating peer specialists into their own service delivery system.
2.0 Introduction

Consumer involvement has become the holy grail of a recovery-orientated system. The belief behind this shift is that consumers possess a special ingredient received by way of tackling the journey of recovery on their own behalf. Consumers bring with them a breadth of knowledge that is useful to both their peers, as well as non-peer professionals working in co-ordination with peer specialists.

Currently consumer involvement is minimal in the formal mental health system. As agencies begin the process of integration peers into the fabric their delivery systems the need for skilled consumers has grown. Due to the complexities of bridging the gap between service recipient to service provider in a formal environment, training programs have begun to be developed to transfer necessary skills to peer specialists working in the field. Thus far these training programs have been theoretically based and do not meet the need peer providers. Theoretically based programs do not ensure skill attainment of providers and limit success to those that are able to transfer theory to practice. This creates a glass ceiling for consumers wishing to take on the valued role of peer specialists where only those that possess the characteristics valued by the formal system will succeed. In writing this training program I endeavoured to fill this gap by creating a program that focuses on the attainment of skills and allows people the flexibility to learn these skills in the manner that appropriate for them.

The purpose of peer specialists in mental health is that they have the ability to fill the gaps left by the formal health system. Consumers that possess
characteristics that differ from those of the formal system are the people of most value to any peer team. These people have the ability to connect with people that formal system can not engage. The purpose of this project is to investigate the role that consumers, as providers, play in a recovery-oriented system, as well as the skill set needed by providers to foster the recovery of others. The data acquired in this investigation will then be used to develop a training program and basic manual for use in agencies that would like to gain the value of peer specialists in their service delivery system.

My position in this project is that of an outsider. I have not received a diagnosis of a mental illness and I do not have any family members that have been diagnosed. My background in mental health is one of a formally trained social worker. This in itself presents a contradiction, because I argue simultaneously for an autonomous system and work to develop a peer support training manual to introduce “professional intervention” into a service that is to be independent of traditional formal mental health shackles. My intention in venturing forth with this project is to establish a program that is more of a spring-board as opposed to a train track. Essentially, this manual is intended to help people learn skills that they can put in their toolbox, but what they do with those skills is up to them. I hope that this program will take on the characteristics of a living document that can be changed and developed as peer supporters find their place within agencies. Therefore, this project will be generalist in nature to increase the utility of the manual in cross-agency usage.
3.0 Literature Review

3.1 Peer Support Involvement in Mental Health

Peer support is not a new idea in the field of mental health. In its traditional incarnation, peer support has been utilized in the form of self-help groups, which have received recognition for their healing and supportive power. Examples of these self-help groups include Alcoholics Anonymous, Narcotics Anonymous, bereavement groups, as well as groups formed to offer support to people faced with physical ailments (Lieberman and Snowden 1994). These groups are self-moderated and have limited, if any, professional involvement. They are groups formed and governed by the idea of mutual support, where all people involved give and receive support from the other members. That said, it has been found that despite the success of such groups in other realms, mental health services have been slow to get on board. The concept that mental health consumers could be beneficial as peers, similar to that of peers within alcoholism recovery, only began to be seriously addressed in the 1990's (Sherman and Porter, 1991; Nickle, Smith & Edwards, 1992). There have been very few mental health consumer groups in history that have formed and operated without professional involvement at the scale proposed in this document, making these groups therapeutic in nature as opposed to truly self-help.

In spite of the trend toward professional domination in the formal mental health system, a parallel movement has developed which is led by consumers. The
consumer/survivor/ex-patient movement developed in response to the lack of control over their own lives, which they experienced at the hands of the formal system. Consumers recognized that advocacy, community involvement, mutual support, and empowerment were pivotal to the transformation of a system fixated on illness to a system that was focused on personal healing (Raggins, 2010). Consumers seized the reins in controlling their lives and developed programs that met the needs of the client groups they were serving. This shift resulted in services based on mutual respect and personal power, the very essence of recovery. These programs have been in existence for over thirty years but they continue, for the most part, to run parallel to mainstream health care. The convergence of these two systems is happening, but it is a slow process, complicated by a culture of distrust on both sides. On one hand, there is the distrust of formal mental health practices and practitioners by members of the consumer/survivor movement. On the other, sadly, there is the distrust of the efficiency of the methods of the consumer/survivor movement without “professional” direction.

There are varying levels of consumer involvement in mental health, (Davidson, Chinman, Sells & Rowe, 2006). It is important to recognize that these levels are not self-contained units. Instead, they are steps along a continuum of naturally occurring involvement, such as friendship, to that of formal professional services. The first, and most involved realm, is consumer-operated services. These services are the most traditional methods of peer support, and began as part of the consumer/survivor movement. Originating as a response to unmet consumer needs, these centers are operated solely by consumers for consumers and function on the
level of mutual aid. Most of these services are provided at drop-in centers that give individuals a reciprocal relationship with other peers.

At the opposite end of the continuum are peer professionals. These individuals are both consumers and providers, but they have received formalized training through universities and colleges in psychiatry, psychology, nursing, or social work. While members of this group may or may not self-identify as a peer, they are governed by their professional role. Although their participation contributes to the goal of peer involvement in the mental health system, this relationship, by nature of professional governance, is not one of reciprocity as in peer-driven services. There exists a power differential between professionals and clients as the medical model clings to its throne.

The last level of peer support that has gained prominence in recent years, and the focus of this project, is that of peer specialists within traditional mental health systems. These individuals do not fit into the category of consumer-operated services because they function within the framework of traditional health care, and are governed by the organizational culture of these agencies. They work alongside traditionally trained mental health workers, however, unlike consumer professionals, these individuals do not possess the formalized training of a profession. They are people hired to provide services based upon their lived experience. The role that these individuals play is one of a tight-rope walker teetering between creative recovery involvement and agency protocol. These people are not nurses, doctors or social workers. They are peer specialists and, as the name
suggests, offer specialized services to their peers that traditional health care cannot. For that reason, room must be made for individuals in these positions to exercise their creative muscles. Traditionally trained individuals will need to understand that peer specialist creativity and intervention may take a different direction than a traditionally trained individual. Peer specialists are not peers providing traditional services. They are peers providing specialized services. Therefore, protocol for peer specialists must be one of harm protection for peer provider and service receiver, but not so rigid as to lose the creative ability that makes these services effective.

How effective are these services? Due to the newness of these peer involvement initiatives in the formal mental health system, the body of research is relatively small at this point. Solomon et al. conducted a randomized control trial involving two groups practicing intense case management. One group was traditionally trained non-peer providers, and the other was traditionally trained peer providers. When reviewed according to outcomes in functioning, symptoms, hospitalizations, quality of life, satisfaction and working alliance, no significant differences between conditions were found (Solomon Draine & Delaney, 1995). Another randomized control trial was preformed by Donnell et al in which case management was again studied, this time with three treatment conditions varying in the type of case management provided. The first condition was standard case management, the second client-centered case management, and the third client-centered case management with a peer advocate. This study examines outcomes of functioning, quality of life, burden of care, service satisfaction, number and duration of hospitalizations, crisis visits and compliance with treatment and services. Again,
the results of the study found that there were no significant findings on measures of functioning, disability, quality of life, service satisfaction or burden of care. However, participants receiving client-centered case management did report increased satisfaction with care (O'Donnell et al., 1999). In a randomized control trial performed by Clark et al. (2000) the idea of peer-based case management was studied in comparison to standard case management and usual care. This study focused on the outcomes of psychiatric hospitalizations, arrests, emergency room visits, and homelessness. Participants involved in peer-based case management had fewer psychiatric hospitalizations and had longer community tenure than their peers under other conditions. However, the groups had no difference in other areas. Although these studies fail to find significance in outcomes, for the most part, in comparison to traditional service it is important to recognize that they did not find that traditional case management had significantly better outcomes than peer services. That means that peer services are as good as traditional services. The only difference found was the use of peer-based case management in community tenure and reduction of hospitalizations with an indication that satisfaction with care increased with consumer involvement. These results illustrate that, although traditional services and peer services have similar outcomes, there is a benefit of peer integration into traditional services. If the outcomes are the same why should an agency venture into the task of integrating peers into the standard of care in mental health? I propose that the benefit to having peer integration is not one that can easily be measured, but has more to do with the culture of our current system. Having peers being active participants in services leads to a culture of hope,
empowerment, and community and, at very least, recognizes the inherent dignity and worth of persons.

In 2003, the New Freedom Commission on Mental Health called for increased consumer involvement in the mental health system, and a transformation of the system from one driven by the values of professionals to one that is driven by equal partnership between those providers and receivers of service (New Freedom Commission on Mental Health, 2003). In this report, the Commission identified that employment of people who were previous service recipients as providers was a critical pathway to reaching this goal. Since then, the notion of peer providers has gained support in the recovery community for the potential benefits to both peers providing services and peers receiving services (Clay, Schnell, Corrigan & Ralph, 2005). As stated earlier in this document, the use of peers as providers does not on its own lead to better outcomes in current research. However, these studies focused solely on the outcomes of those receiving services and neglected to address the impact on those providing services. I suggest that this is where peer provided services surpass those of traditional services. As Hutchinson et al. suggest, the benefit to the employee can be explained by use of the “Helper Therapy Principle,” which proposes that “people that help others are in fact helped themselves” (Hutchinson et al., 2006). Peers that provide service often shift their identity from a person that is disabled to that of a validated, empowered person (Breton, 1991; Cox, 1991; Moxley et al., 1997). This growth of self-esteem is identified as fundamental in the healing process (Hutchinson et al, 2006; Copeland, 1997; Deegan, 1994; Moxley, 1994). Thus, it has a profound effect on the consumer
provider's personal growth and recovery. If the benefit of peer providers on service recipients is one of hope through the positive witnessing of experience, we can see how the utilization of peer providers would have an accumulating effect in recovery.

As the recovery model gains momentum in the mental health system, agencies are making efforts to integrate its principles into their operational procedures. We have witnessed a shift from the professional-driven agencies to a more collaborative approach. In order to continue collaborating and developing a new system in which consumer involvement is the norm, agencies must make room for quality consumer involvement, meaning consumers must be seen as professionals in their own right within main-stream health. This means the classification of peer specialist as a valued role within agencies, where their involvement surpasses one of tokenism to one of integrated service. This is a model where a peer support specialist’s voice will be as loud as that of any member of a mental health team.

3.2 Recovery in Mental Health

What is recovery? Recovery is a relatively new concept in mental health. Although recovery is not in its infancy, like a toddler it is still trying to gain its balance in a system dominated by the medical model. In the mid-1970's the concept of recovery gained momentum with the consumer/survivor/ex-patient movement, as individuals began organizing to lobby discrimination reduction and changes in mental health systems (Davidson, 2006). Mental Health Recovery is the idea that
people can, and do, get better and that a mental health diagnosis no longer means a loss of touch with reality with no hope of improvement.

Within the medical model the idea of recovery is a “a return to a normal state of health, mind, or strength” (Oxford Dictionary). Strength in this model has resulted in a history of belief among consumers and providers that people with mental health issues do not “recover,” the most one can hope for is a reduction of symptoms. The DSM-III used as a guiding force in mental health in the 1980’s states “A complete return to premorbid functioning is unusual - so rare in fact that some clinicians would question the diagnosis” (DSM-III). The Vermont longitudinal study of persons with long-term mental illness: Long term outcomes of people who met the DSM-III diagnosis for schizophrenia (Harding, 1987) study was a significant blow to the strong-hold this idea had taken in mental health. The Vermont study was a longitudinal study conducted of patients confined in the Vermont state hospital in the 1950’s. Patients were re-diagnosed based upon the DSM-III diagnostic criteria for schizophrenia, and then followed for 32 years. The study states that one half to two thirds of the individuals studied had “achieved considerable improvement or recovered.” These findings are contrary to the rarity of recovery described in the DSM-III. In yet another series of longitudinal studies initiated by The World Organization begun in 1967, it was concluded that as little as 25% and as many as 65% of samples showed partial to complete recovery, in the sense that there was a decrease in symptoms associated with a diagnosis of severe schizophrenia, and a resumption of valued roles in society which are considered to be within the normal range (Davidson et al. 2005; Davidson & McGlashan, 1997; McGlashan, 1988).
Despite evidence to the contrary, the idea of recovery in mental health is still received with scepticism in the professional community. Part of the reason for this may be the permeation of the medical model and the definition of recovery as an abatement of symptoms. A study conducted with psychiatry residents showed that, although there was an interest in the concept of recovery, the participants verbalized that there were low expectations of the magnitude of improvement (Buckley et al., 2007). As Davidson (2005) states, frequently the idea of recovery is vocalized by professionals in the community but the meaning of this word is not universal, and there is no single definition of the word which takes precedence. The lack of universality in definition has led to confusion in how recovery-oriented practice is utilized within the system, and frequently this perception misses the mark of true recovery-oriented practice. This issue, as Davidson so eloquently puts it, is the equivalent of packaging the “same wine in a new bottle” meaning moulding the recovery model to fit current practice, as opposed to transforming current practice to fit a recovery model. As a result, recovery-orientated practice remains the elusive holy grail of the mental health system.

As discussed previously, the definition that comes to mind when referring to recovery is the partial or complete abatement of symptoms. This definition of recovery is not the same as the one used by either the consumer/survivor movement or psychosocial rehabilitation services. As Anthony (1993) states “Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability”. Nowhere in his definition does Anthony suggest that an abatement of symptoms is required. Deegan
(1988) also argues that recovery does not mean an abatement of symptoms, which is illustrated when she states that “Recovery refers to the... real life experience of persons as they accept and overcome the challenge of the disability” These definitions suggest that recovery is not an end result, but a process without a definite end point. It is the journey of becoming a whole person, lumps and bumps included, and navigating the world on one’s own terms. With this definition of recovery it is easy to see that stigma can be a death blow, and that recovery can be possible for all individuals. These definitions show us the value of consumer involvement in mental health, and the transformation that this involvement can cause in the formal health system.

The consumer movement places specific focus on the centrality of stigma as the number one barrier to recovery. The Oxford Dictionary defines stigma as “a mark of disgrace associated with a particular circumstance, quality, or person.” As a result, advocacy has been a central theme within the movement. Stigma has been shown to negatively affect treatment and health outcomes of mental health consumers (Hinshaw & Cicchetti, 2000; Link & Struening, 2001; Perlick & Rosenheck 2001; Davidson, 2003). Stigma degrades a person’s sense of self and self-worth. This annihilates a person’s ability to fight for, and be an active participant in, their own recovery. Without the will to constantly fight up-hill in the battle against their illness, the individual will slide down and be at its mercy.

In the article “My Mother’s Schizophrenia: What I didn’t know helped me” Steve Einhaus (2009) shares his story about his diagnosis, explaining that it was a
blessing for him to not know about his mother’s illness. For him, the lack of that knowledge throughout his childhood allowed him to develop the tools he saw necessary for him to survive his own diagnosis later in life. He states that the three benefits of this lack of knowledge about his mother’s illness during his childhood are that he did not stigmatize himself or buy into the lie that because he had a mental illness he was helpless, and that when his own psychotic break occurred he became reflective, questioning his past and identity (Einhaus, 2009). All of these “blessings,” he states, have to do with the reduction of stigma. This reduction of stigma is what allowed him to succeed in his recovery.

A study by Mann and Himelein (2004) evaluated stigma of people with schizophrenia and depression by surveying 116 undergraduate university students. What they discovered was that the students held more negative views towards people with schizophrenia than they did towards people with depression. This was directly related to the participant’s perception of treatment success with either disorder. Participants believed that depression had more positive treatment outcomes than schizophrenia and, therefore, they held less stigmatizing views towards people with depression. Ergo, if the participants believed that people with the illness had a strong chance of getting better, they held less stigmatizing views of the individual. The researchers suggest that the “Decade of the Brain” that occurred between 1980 and 1990 shifted the focus of causality of mental illness from environmental stimuli to that of a brain disease (Davidson, 2003). Although useful for clinical research this, in fact, has been more detrimental to treatment outcomes of consumers, due to perception of an incurable illness acquired by faulty genetics.
The generalizability of this study is low due to the fact that undergraduate university students are not representative of the population as a whole. Undergraduate students are generally younger, more socially conscious, and Caucasian. However, the findings of significance are useful because one can hypothesize that the general public would, in fact, hold greater stigmatizing beliefs than the sample of university students. This suggests that people receiving a diagnosis of schizophrenia would hold similar internalized beliefs when seeking treatment.

How does stigma contribute to the concept of recovery and, subsequently, peer support? Stigma attacks the very foundation of recovery. It seriously impedes an individual’s sense of hope by attacking directly one’s sense of self. Corrigan explains this concept through the use of Labelling Theory. He suggests that individuals adopt the stereotypical beliefs of society when diagnosed (labelled) as mentally ill. These beliefs become personally relevant to the individual, and may take the form of self-fulfilling prophecies. If society views a mentally ill individual as incompetent and dangerous, the individual will adopt coping strategies to avoid this stigma and the resulting rejection by society. In the case of a mental health consumer, this may take the form of secrecy and social withdrawal, further enhancing their internalization of the stigma as their social networks shrink and societal attachment dwindles (Corrigan, 2005).

Ragins (2010) states that there are four key components in Recovery; hope, empowerment, self-responsibility, and achieving meaningful roles. Stigma then
becomes the primary force behind the crippling fear people experience as a result of a mental health diagnosis. Ragins goes on to explain that recovery-oriented practice means a revolution in the way mental health professionals define recovery. Similar to the arguments of Deegan (1988) and Anthony (1993), Ragins states that recovery is gaining control of the illness as opposed to the illness controlling you, and this can happen regardless of symptom level (Ragins, 2010). As discussed earlier, abatement of symptoms is not a measure of recovery in this model. In essence, recovery is a person's ability to “get a life of their own choosing and the process taken to do so.” In order to do this we must change our belief that mental health consumers need to be cared for to the belief that, like everyone else, they need to be cared about.

Traditional mental health practice has been based on the medical or biomedical models. The biomedical model is pathological in nature and reduces all of the complexities of individual strife to biological causes. (Hall, 1996). The whole person is not taken into account in these models (Horsfall, Stuhlmiller, & Champ, 2000). These approaches ignore the social or psychological factors that contribute to illness. They focus on the history of the person and how it relates to the present situation. In evaluating the past people continually focus on things beyond their control. These models examine the deficits of an individual and what they do not possess for health.

Conversely the strengths perspective is forward focused and positive in nature. It attends to the characteristics and abilities a person or community
currently possess and how those things can be used to achieve goals and aspirations (Saleebey, 2002). It fosters self-efficacy and promotes hope by believing in a person’s strengths and abilities to achieve their goals. In focusing on the future, the strengths perspective, promotes movement and hope in a person’s life because a person can exercise control and impact their own outcome. The strengths perspective is in alignment with the key components of recovery, hope and empowerment and is an integral part of recovery-oriented practice.

So where does peer support fit into recovery? As discussed previously, consumers have experienced many forms of disempowerment at the hands of society. Consumers have been looked at as people that need to be cared for their own good, and have been treated as such. If we work from Ragins’ components of recovery, this caretaker mentality removes all accountability in a person’s life. In caretaking we remove all expectations that an individual has the ability to care for themself. At different points in our lives all individuals have periods of time where caretaking is valuable. However, this is not a permanent state. In mental health people have been told two things consistently. One, the professionals know best so you should do what they say. Two, this will never change and you will never get better. These two messages stop people from taking responsibility for their lives, kill any hope for the future, make them feel powerless to do anything about it, and tells them that their role is that of a mental patient that needs to be cared for. Conversely, peer support is human-centered as opposed to illness-centered. Consumers are able to see people that have gotten better and taken on valued roles in society in spite of the effects of their illness. Peer supporters foster the individual’s ability to choose
and recognize a person’s own expertise in their lives. They do not have the baggage of history that the medical model has to contend with, and can relate to the individual as one person to another. Establishing peer support as a valued role in mental health gives people the ability to help others and places them in a position in which they feel they make a difference. Supported peers can gain a sense of hope for their own lives while positively influencing others in similar situations. The components of recovery, hope, empowerment, self-responsibility, and the achievement of meaningful roles are intricately connected, and peer support has the ability to navigate these intricacies with little effort for both peer and peer supporter.

Mowbray and Moxley (1997) discuss what they view as the reason for peer-run support programs when they state that

“consumers have the ability to form creative, non-traditional, and more beneficial alternatives or adjuncts to formal mental health services...since the consumer-controlled program is developed and delivered by consumers, it has the potential of contributing something very different in rehabilitation and community support than what individuals with professional training can do in existing structures.”

Although they are speaking to the validity of peer-operated resources, one can see the usefulness of peer supporters in a recovery-oriented system. That being said, most of what makes peer supporters valuable is the fact that they are respondent in nature and are not constrained by current service systems. So how do we then integrate peer support into mainstream health without loosing the very essence of what makes them effective? I believe that in order to maintain the
benefits of peer support, autonomy must be maintained for peer specialists. This means peer specialists need to be able to contribute their areas of expertise with as much weight as professionals of other disciplines such as psychiatrists, social workers, and nurses. They must have the ability to change, grow and adapt their professional role based upon the need of the people they serve and the services they deliver.
4.0 Method and Program Overview

In creating this manual I embarked on a journey to create a program that encompassed the needs of agencies wanting to integrate peer specialists into the fabric of their service delivery. In this venture I had four tasks:

1. Identify the competencies that peer specialists need to be successful in their role.
2. Create a system in which these competencies can be evaluated, and personal growth can be encouraged to promote success.
3. Create a program that embodies the idea of a recovery-oriented system and the benefits of peer integration into traditional mental health services.
4. Create a program that can grow and change to be responsive to individual and system needs.

In my search for competencies for peer specialists I found very little. Most literature on the subject is generalist and suggests that the things that make peer specialists effective are their alignment with recovery, their ability to connect on a more personal level based on shared lived experience and the utilization of helping skills. The one study I did find that addressed competencies was conducted by Campbell, Dumont, and Einspahr (1999). In this study, a literature review was conducted and 73 statements of peer competencies were identified by the researchers, which were then ranked based upon importance by nineteen peer
supporters and clustered into domains using concept mapping. This study was focused on competencies of peer supporters within client-operated programs. However, I argue that the purpose of integrating peer-specialists into mainstream health programs is to replicate the benefit seen in peer-operated services. It stands to reason that the same competencies that make peer-supporters effective in peer-operated services would apply to mainstream health. Therefore, I have used these competencies as the foundation of the modules in this program. The domains identified in order of importance are: Encouraging independence, beliefs supporting recovery, interpersonal skills, peer-based program support, understanding how peers cope, advocacy, legal rights and antidiscrimination, and training for work and family life. Due to the fact that this study clustered statements into domains, my task becomes to operationalize these statements into coordinating skills.

Traditionally, training has been group-based. This serves two functions in agencies. Firstly, conducting group training is cost-effective and time-constrained. Groups can also serve as support for the individual, and a sounding board for ideas and discussion that may assist in learning. Many training programs recognize this trend and have developed programs to be administered in a group setting. However, this method has its limitations. Agencies relying solely on group training may have to wait until the minimum number of candidates has been met. This method also does not allow for individualization of training and progression. Facilitators cannot meet the needs of every individual in the group. Also, fixed timelines constrain people who may need more practice to be successful, and disheartens those that do not.
Individualized training allows agencies more flexibility. Candidates can work at their own pace and utilize their own learning style. Agencies do not have to wait for a required number of candidates to initiate training because training can start as soon as someone is interested. Even so, this method also has drawbacks. Without proper support individuals may not progress through the program and, as a result, they may not acquire the necessary knowledge. There is a component of self-responsibility, as candidates are required to work on things without the momentum of the group. If timelines are loosened, agencies cannot predict the amount or level of training individuals will possess at any given time.

What I propose is a middle ground between group training and individualized training. I suggest that the best way to get the benefits of both methods is to use a competency-based training protocol that individuals will work through at their own rate with the help of an advanced peer mentor. In this way, individuals will have the flexibility of tailoring their own training but, at the same time, ensuring that competency and personal growth requirements are met. Thus, the focus for the individual is on how am I going to learn this and how the mentor can help me learn this. This approach will make this program focused on the active learning of the candidate. Candidates will start the program under the mentorship of one individual, and continue that relationship through into their working career with the agency. If people leave the agency, new mentors must be found. As time passes and skills grow the duty of the mentor will wane. However, they are still a means of support to their peers. People will progress through the program into mentorship training and they themselves will become the mentors. The hope is that
this method will allow for agencies to meet their candidates where they are at skill-wise, recognizing skills individuals have previously learned, and fostering the development of new skills while mirroring recovery-oriented practice.

In starting this program there will not be advanced peer specialists that have completed the training to mentor others through the program. Therefore, agencies will have to select a non-peer ally to mentor to the first group of candidates in their training endeavors. It is important that this non-peer ally understands the purpose of the program, and has reviewed the entire manual, paying special attention to the mentoring components. Mentors will be the most valuable assets to the successfulness of the program.

In going the individualized route, candidates may miss out on the benefits of group trainings. I believe this should be addressed by the implementation of training teams. These teams should be made up of both candidates and mentors, and should have the ability to get together periodically throughout the program to address any issues that might arise. The numbers of these groups will vary depending on agency and level of peer involvement. By the very nature of this program, the individual will be working and learning simultaneously, and these meetings may become multi-purpose and take on the role of department meetings in addition to training support.

The program is structured using the philosophy of competency-based learning. Competency-based learning, as opposed to traditional methods, focuses on practical skill acquisition. This means the completion of the module only happens
when an individual has mastery of the skill in that module. In this program, modules are set up with a knowledge component and a practical or skill component. Each of these components has a statement that indicates what is expected for competency in that section. Evaluation of competency will be achieved by utilizing a candidate self-evaluation and a performance checklist. In most cases, how the individual satisfies the requirements for competency will be flexible. For example, if the competency is to describe the role of a peer specialist, an individual may choose to write a job description or answer questions asked by their mentor.

The program is focused on growth and skill building. Candidates do not fail competencies, they identify areas for growth. Each module contains within it a section dedicated to activities for growth. These are ideas of activities that individuals can do to acquire the skills needed to gain competency. Unless candidates are challenging a section based upon prior learning, I am going to recommend a minimum of two activities per section be completed. Depending on the individual, more activities may be needed to progress to a level of success. This is where flexibility and adaptation come in. Mentors must assist candidates in recognizing growth potential, and what they need to gain success. This could mean using the provided activities, or it could also mean developing new activities.

This program is intended to essentially be on the job training. Candidates will train and work simultaneously, however, roles individuals play will be based on their current skill set and acquired strengths. For example, an individual that has very little exposure to peer specialists and training may be responsible for being
part of a team that plans and conducts recreational outings, whereas an individual who has progressed through training and gained experience may make home visits. The goal of this is to prevent delay in the rewards of hard work and tailor people’s job roles to their strengths and abilities. That being said, all individuals will start this program at different levels and will possess different established skill sets. That is, if someone was a house cleaner for ten years, that experience prepares him or her for different roles than someone who has a hobby of building model ships. The goal is to not take a plumber and expect them to be an electrician. As part of the program, candidates will build themselves a profile that describes current skill sets, goals, and hobbies to help aid in job role definition.
5.0 Conclusion and Areas of Further Development

Mental Health has typically been the domain of medical professionals. As time progresses social work has taken on a larger role in the traditionally medically driven system. I believe this role is pivotal in the transformation to a recovery-oriented system. Social work brings with it the knowledge and skills to work with a person in their environment and an understanding of the interplay of societal and environmental factors that affect wellness. This is an area that the consumer/ex-patient movement has indicated is lacking in the current system.

My interest in peer support stems from the belief that our role as social workers is to “work ourselves out of a job”. The social work profession focuses on strengthening communities and individuals so that they can naturally care for their own members. This is an area that I think professionals have failed those with a diagnosis of a mental illness. The current system has created an ingrained belief in the professional dependence of consumers that is not concordant with social work values. I think that this dependence has exacerbated the negativity in consumers lived experience and the loss of hope that has been indicated as undermining to the recovery process. I believe that the community has the potential to naturally care for the healing of it’s members if professional recognize the potential and allow room for them to do so.
In this project I undertook the task of developing a basic Peer Specialist Training Program. As I worked through the process, it became apparent to me that the introductory level of the program needed to be only part of a wider, and more elaborate, training program to fully meet the goal of true integration of peer specialists in mainstream mental health. Included in the appendix section of this document is a prototype of the complete curriculum that I see this manual as a part of. If peer specialists are to be recognized as professionals, I propose that there needs to be multiple levels of training to remove the glass ceiling on growth potential of people diagnosed with mental illnesses.

Research in the area of competencies of peer supporters is lacking. I discovered only one study that elaborated on the competencies required by peer supporters for them to be effective in their role beyond the “possession of helping skills.” Further research is required to discover what key ingredients must be possessed so that future training can reflect these skills. This program, as I stated earlier, is intended as a springboard. In its infancy there will be growing pains and adaptations will be required. Evaluation of this program is necessary, first to discover if the program has the desired outcome, and build on the peer specialist’s recovery-oriented skills. Secondly, it needs to address the concerns of participants as they work through the program. As the body of knowledge grows and changes, so will this manual.

Peer specialist integration into mainstream mental health is both possible and necessary to promote recovery and transform our current system to one of
healing. This will enable consumers to take back the power that has been lost at the hands of a misguided system. In writing this program it has become obvious to me the extent of which the belief of the medical model has permeated our interactions within the mental health system and the language of the profession itself, regardless of the clinician’s view of recovery, which directly contributes to the stigma that is experienced by service recipients. The old adage “sticks and stones may break my bones but words will never hurt me” is untrue. I suggest that sticks and stones will break bones, but words will break souls. In creating this program I ventured to embark on a task which is, as Mahatma Gandhi states, “being the change we wish to see in the world.” Our mental health system is not yet one of healing and hope, but I hope it will be soon. The integration of peer specialists will speed up this process. My goal in this project is to use recovery-friendly language and set up a curriculum that recognizes people’s worth and abilities, setting limits based only on the dreams and dedication of an individual as opposed to pre-ordained beliefs of the capacity of illness.
References


Appendix A

Peer Specialist Training
Introductory Level
Marcie Nugent
**Table of Contents**

How to use this Manual  
Guides  1  
Mentors  2  
Meet your Mentor  2  
Training Team  3  
Abilities Chart and Learning Form  3  
Activities for Growth  4  
Red Flags  4  
Flash Cards  4  
Self Evaluation Checklist  5  
Performance Checklist  5  
Words to Remember  6  
Self Evaluation Checklist  7  
Performance Checklist  8  

Introduction to Peer Specialists  9  
What is a Peer?  9  
What is a Peer Specialist?  9  
What is the Role of a Peer Specialist?  10  
What can I do as a Peer Specialist?  10  
Self Evaluation Checklist  14  
Performance Checklist  15  

Helping Through Hope  16  
Care Giving  17  
Recovery Help  17  
Self Evaluation Checklist  21  
Performance Checklist  22  

Strengths and Resilience  23  
The Strengths Perspective  24  
Principles of Strengths Perspective  24  
What are Strengths and how do we find them?  26  
Words to Remember  28  
Self Evaluation Checklist  31  
Performance Checklist  32  

Learning Progressions  33  
Learning Styles  33  
Steps to Learning a New Skill  34  
Self Evaluation Checklist  42  
Performance Checklist  43  

Agency Orientation  44  
Self Evaluation Checklist  48  
Performance Checklist  49
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is Recovery Anyways?</td>
<td>50</td>
</tr>
<tr>
<td>Medical Model Vs Recovery Model in Mental Health</td>
<td>50</td>
</tr>
<tr>
<td>Recovery Components</td>
<td>51</td>
</tr>
<tr>
<td>Personal Medicine</td>
<td>52</td>
</tr>
<tr>
<td>Self Evaluation Checklist</td>
<td>55</td>
</tr>
<tr>
<td>Performance Checklist</td>
<td>56</td>
</tr>
<tr>
<td>Communication</td>
<td>57</td>
</tr>
<tr>
<td>Types of Communication</td>
<td>59</td>
</tr>
<tr>
<td>Understanding and Listening Skills</td>
<td>59</td>
</tr>
<tr>
<td>Words to Remember</td>
<td>61</td>
</tr>
<tr>
<td>Self Evaluation Checklist</td>
<td>64</td>
</tr>
<tr>
<td>Performance Checklist</td>
<td>65</td>
</tr>
<tr>
<td>Myself as a Peer Specialist</td>
<td>66</td>
</tr>
<tr>
<td>Self Evaluation Checklist</td>
<td>69</td>
</tr>
<tr>
<td>Performance Checklist</td>
<td>70</td>
</tr>
<tr>
<td>Ethics</td>
<td>71</td>
</tr>
<tr>
<td>What are Ethics?</td>
<td>71</td>
</tr>
<tr>
<td>Confidentiality and Privacy</td>
<td>72</td>
</tr>
<tr>
<td>Avoid Dual Relationships</td>
<td>75</td>
</tr>
<tr>
<td>What is a boundary?</td>
<td>75</td>
</tr>
<tr>
<td>How do we make people aware of our boundaries?</td>
<td>76</td>
</tr>
<tr>
<td>Respect people's individuality and honour what makes them unique.</td>
<td>76</td>
</tr>
<tr>
<td>Self Evaluation Checklist</td>
<td>83</td>
</tr>
<tr>
<td>Performance Checklist</td>
<td>84</td>
</tr>
<tr>
<td>Appendix 1: Abilities Chart</td>
<td>85</td>
</tr>
<tr>
<td>Appendix 2: Learning Form</td>
<td>86</td>
</tr>
<tr>
<td>Appendix 3: Flash Cards</td>
<td>87</td>
</tr>
</tbody>
</table>
Congratulations on starting your career as a peer specialist. Some of you may already be working, and some of you may be hoping to start working soon. You can benefit from this manual at any stage of your career. This is the introduction manual to being a peer specialist. It is meant to be on-the-job training that you can work through to acquire new skills and expand your job role.

Lets get started!
How to use this Manual

Domain: Orientation
Area of Growth: Knowledge
Competency Definition: Candidate has read and understand the different components of this manual

This manual is an introduction to becoming a peer specialist. In the process of working through the manual, you will first gain an understanding of what peer supporters are and what their roles could be in agencies. After this, you will start defining your present skill set as a peer supporter and clarify those roles you already possess the skills to do. Then it is time to build on those skills and abilities and expand the tools you have in your helper’s box.

Guides

Guides are the sections that the manual is split up into. It is called a guide because it helps guide you through the material. Each guide has boxes at the beginning that identify the domain that that guide belongs to, what kind of growth it is targeting and a competency definition.

A Domain is the larger category the guide is part of. In the abilities chart all the domains covered in this manual are listed with the individual guides that are part of them so you can see how everything fits together.

There are two different areas of growth that a guide can cover. The guide may target knowledge, or skill/practical growth. Knowledge guides help you to understand information they cover things like theory or ideas. Practical or skill guides cover how to use the information you learned in your work with your peers.
**Competency Definitions** are statements that will let you know what you should be able to do at the end of each guide. These are the goal of each guide. Whether or not you are ready to complete the guide is based on this statement.

**Mentors**

*Mentors* are your lighthouse. They are there to help guide you through your process of learning. These people are advanced peer specialists who have worked their way through learning this process, and have developed a strong skill set, including skills needed to help someone like yourself, to learn and grow as a peer specialist. A Mentor should be a member of the agency that you are training with. They are someone you can talk to and ask any questions you may have. They are not your Supervisor! If you are lucky enough to be one of the first people in your agency to start the journey of a peer specialist there might not be an advanced peer specialist to mentor you. That is fine, what you then need is a Peer Ally. This person’s role is to support your learning and answer questions that you have from a peer specialist’s perspective. Your Supervisor’s role is to lay out the expectations of the job you have been hired for and help you meet those expectations. A Mentor is completely focused on your learning and growth. Your Supervisor and Mentor are two parts to your training team. As you progress through the orientation section, you will come to a point where Mentors will be talked about in more detail. If you have one already that is great, if you do not, the guide to finding a Mentor is below.

**Meet your Mentor**

Now is the time to find a mentor if you have not already done so. Remember that your mentor is a very important person in your journey as a peer specialist. They are the person who will help lead you through your training, and answer your questions.

What to do

1. Talk to the person that supervises the peer specialists at your agency about who would be available to be a mentor.
2. Ask the individual if they will be your mentor.
3. Get together with your mentor so that you can get to know one another.
4. Complete the mentor agreement found at the back of this manual.
5. Discuss with your mentor the possibility of a training team and how they are set up at your agency.
Training Team

As discussed earlier, your Supervisor and Mentor are two parts of your training team. You are the first part. Your training team fulfills a number of functions. The first is a support system for you to access when you need help, or to tell you are doing a good job. They are also people with skills that you can learn from. Training teams can take on different forms, and they can include other peer specialists or other employees of the agency. Training teams can work together to learn skills as a group or encourage people as they learn on their own. What your training team looks like will be dependant on your agency.

Abilities Chart and Learning Form

This chart is to help you keep track of your own development, while showing you how what you are doing fits into the bigger picture of the identified key ingredients for peer specialists. Peer supporters in the United States developed these ingredients so that other peers would know what things make a good peer supporter, and so agencies know what peer supporters can do. Everything you do in this manual is part of developing the knowledge and skills to become an effective peer specialist.

Think about making a cake. The first thing you need is a kitchen and tools to make the cake such as bowls, measuring cups, an oven, etc. Then you need the ingredients to make a cake: eggs, milk, and flour. You mix them all together using the tools in your kitchen and you get a cake. The cake is all the abilities set out by the peer supporters in the United States as important. The kitchen and the tools in it are skills and abilities you have already acquired by living your life. This manual will help you to identify and collect the ingredients, and figure out how you can use the tools in your kitchen to make a cake.

The chart allows you to track your work. As you complete different sections, you put them in your chart with the date completed. If you look at the chart, you will notice that there are blanks in each domain. It is impossible for one manual to contain everything you could learn. For example, agencies have workshops, conferences, and in-services that you can attend to help you learn skills for your toolbox. If it fits, take credit for it. You earned it. Put them in the blanks under the domain that they contribute to. If you are having trouble finding a place for it, talk to your mentor. There is a Learning Form to fill out for any learning you do that is not a module in this manual. Be specific! What exactly did you learn, and how is this useful to you in your work?
Activities for Growth

Activities for growth have been created to help clarify specific areas of the module. These activities allow you, as a candidate, to direct your own learning based on what method you learn best by, and help explain topics that may not be clear for you. These are not all the activities you can do. If you have an idea, fill out the planning page at the back of this book and discuss it with your Mentor. The goal is to do activities that help you learn, grow and develop new skills.

Each activity has a concept that it targets, materials needed to perform the activity, how to do the activity, questions to answer and then a debriefing section. You as a candidate can work on activities on your own, or with other members of your training team. Follow the directions and answer the questions for each activity.

The final section of the activity is the debriefing section. This section is meant to help link the activity with the concepts you have learned. This section should be reviewed with your mentor or with your training team so that you can discuss what you learned.

Red Flags

Red flags are things that may come up in working with people that do not fit into what you have just learned exactly. They are situations where the idea you have just learned about gets overridden by a different idea. The most common idea that will override another is safety for yourself or your peer.

Red flag sections are set up to give you the opportunity to link the material to real life situations. They contain a situation that can cause confusion because it is an exception to the rule. The red flag section will explain why the situation is an exception to the rule and points you to the section of the manual where that kind of situation is talked about and gives you ways to help you decide what to do in real life.

Flash Cards

At the end of each section there is a list of words that you were introduced to in that guide. These words are listed under the heading Words to Remember. Spend some time writing out the definition of that word, as you understand it. In the
back of this manual there are flash cards with all the new words you learned in the manual. You can cut these cards out and write the definition of the word on the back and use them to help you learn the vocabulary. If flash cards are not a method that works to help you learn write the definition of the word on the card and it will become a glossary for you to reference in the future. If you would like to do both and have access to a photocopier, photo copy the pages before you write the definitions on the cards and

**Self Evaluation Checklist**

The **Self Evaluation Checklist** form is included after each guide once you have completed the guide and learning activities you will be told to complete the Self Evaluation checklist. This tool is meant to help you identify what you have learned in the process of working through the material. Complete this checklist and then discuss it with your mentor or training team.

At the bottom of the Self Evaluation checklist there is a question that asks you if you have any questions that haven't been answered. If you find you still have questions discuss them with your training team or mentor and try to get the answers. They can help you identify other activities you could do that would help or even talk it out with you. Once you have answered all the questions you have you are ready to move on to the performance checklist.

**Performance Checklist**

The performance checklist is the final step to completing a guide. The performance checklist lists the things that are required for completion of that guide specifically. This step is completed with your mentor. In order to complete a guide you must be able to meet all the statements on the list. You can do this by using one of the activities for growth you did when you were working on the guide, do a different activity, or answer questions from your mentor. Be creative. The requirements are listed on the checklist. There are no surprises. It is not a test. Do not fear if you start the performance checklist and you are having trouble meeting the requirements you can go back and work on that area and try again when you are ready. Your mentor or training team can help you find ways that could help.
Words to Remember

Guide:

Mentor:

Activities For Growth:

Red Flag:

Training Team:

This is the end of the planned activities for this section. Now you decide whether or not you are ready for completion.

Fill out the Self Evaluation Checklist:
Do you have an answer for every question?
Have you completed all the activities to the best of your ability?

Meet with your mentor and complete the Performance Checklist
Self Evaluation Checklist

Guide: How To Use This Manual

Competency Definition: Candidate has read and understands the different components of this manual

1. Between 1-5 how confident am I that I know about the subject? __________

2. What activities have I done to grow in my knowledge and skills in the area and what have I learned?

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<th>Activity for Growth</th>
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3. What are my area(s)of strength in this guide?

4. What area(s) can I grow in?

5. What questions do I have that have not been answered?
Performance Checklist

**Competency Definition:** Candidate has read and understands the different components of this manual

- Candidate has a mentor and has developed a plan for working through the level
- Candidate can describe what they must do to complete a guide
- Candidate has created definitions for words to remember that accurately define the word

**Candidate Comments:**

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**Mentor Comments:**

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________________________________________________________________________________

**Date Completed:**

________________________________________________________________________________

_________________________  __________________________
Candidate Signature        Mentor Signature
Introduction to Peer Specialists

**What is a Peer?**

A **Peer** is someone who shares some common thing or experience with another person, and they are equal in some way. For example: a peer to a social worker could be another social worker; a peer to a teenager would be another teenager; a peer to someone who is recovering from alcohol dependence is someone else who is recovering from alcohol dependence, and the list goes on. This manual has been created for people who are a peer to people in the process of recovering from mental health issues and have a desire to help others in their recovery journey.

**What is a Peer Specialist?**

A **Peer Specialist** is a person who has acquired skills through their lived experience that wants to help other people in their recovery journey. This means that every peer specialist is different, because they have different lived experiences and different skills. Peer Specialists are not Psychiatrists, Social Workers or Nurses. Their skills are different, and this difference allows them to fill in the areas that these professions do not, and offer different services to people in recovery. Peer Specialists are people who understand that a person’s path to recovery is their own, because they themselves have been there.
**What is the Role of a Peer Specialist?**

The role of a Peer Specialist is to provide services that are different from those of mainstream Mental Health Services. They have the ability to adapt, change and be creative because they have different skills they have acquired over their lifetime. They can be a role model for people because they are living proof that things can, and do, get better. They also teach other mental health professionals what is like to be in recovery from their first-hand experiences, and they help their peers find their voices and advocate for ways to make things better for people with a mental illness.

**What can I do as a Peer Specialist?**

Peer Specialists can do many things to help people. The key is finding a job that fits your strengths and abilities. Types of Social Support and Associated Peer Recovery Support Services¹ are:

1. **Emotional**: Demonstrate empathy, caring, or concern to help people build self esteem and confidence.
   - Ex. Peer-monitoring, Peer lead support groups.

2. **Informational**: Share knowledge and information and/or provide life or vocational skills training.
   - Ex. Parenting class, job readiness training, wellness seminar.

3. **Instrumental**: Provide concrete assistance to help others accomplish tasks.
   - Ex. Childcare, Transportation, help accessing community health and social services.

4. **Affiliational**: Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.
   - Ex. Recovery centers, sports league participation, alcohol- and drug – free socialization activities.

---

¹ Adapted from “What are Peer Recovery Support Services” Us department of Health and Human Services
Below are some additional ideas of roles peer specialists can take on in an agency; though this is not all of them, so be creative:

- Sit on agency committees to be a representative for their peers.
- Lead groups on topics that are of interest to their peers.
- Help a peer learn to grocery shop or how to take the bus.
- Plan recreational activities for peers.
- Make an agency newsletter.
- Be an ear for peers that need someone to talk to.
- Help people look for different housing.
- Go with peers to activities in the community so they feel comfortable.
My Shadow

Concept: What is a Peer Specialists Role?

Materials:

- A Peer Specialist in the field
- List of Questions

What to do:

- Find one or more Peer Specialist that is willing to have you shadow them. Like a shadow, your job is to follow them on their activities as a Peer Specialist so that you can see what it is they do.
- Plan times that work well for both of you. Try to pick times when the peer specialist has multiple things that they are doing. **Note:** if the peer specialist’s plans include meeting with other peers they must ask their peers permission for you to come.
- Spend at least 10 hrs with a peer specialist while they work.
- Ask lots of questions!
- Complete the questions included with this activity and debrief with your learning team or mentor.

Questions:

1. What did your Peer Specialist do during the day?
2. In what ways did you see them helping them with their recovery?
3. How did they talk to their peers?
4. Were there any times that you could see where you could use your skills and abilities to help?
5. What did you learn by doing this activity?

STOP! This next section is for discussion with your mentor or training team.

Debrief:

This activity was designed to give you the opportunity to see a peer specialist in action so that you can see examples of how they work with people. It is also a chance for you to start envisioning yourself in the role of peer specialist. Use this opportunity to discuss your experience with your training team or mentor. Did any questions come up for you while you did this activity?
Have you heard about Peer Specialists?

**Concept:** Role of a Peer Specialist

**Materials:**
- Knowledge you have learned about peer specialists.
- Any supplies you may need to complete your public service announcement.

**What to do:**

You have been asked by your agency to get the word out about peer specialists and what they do to the public. Create a public service announcement to teach people about peer specialists. You can make a poster or write a jingle, it is up to you. Once you have completed it, show your public service announcement to your training team or mentor.

**Questions:**

1. Why did you choose to do your public service announcement the way you did?

---

This is the end of the planned activities for this section. Now you decide whether or not you are ready for completion.

**Fill out the Self Evaluation Checklist:**
Do you have an answer for every question?
Have you completed all the activities to the best of your ability?

**Meet with your mentor and complete the Performance Checklist**
Self Evaluation Checklist

Guide: Introduction to Peer Specialists

Competency Definition: Candidate can explain what a peer specialist is and what they do

1. Between 1-5 how confident am I that I know about the subject? __________

2. What activities have I done to grow in my knowledge and skills in the area and what have I learned?

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3. What are my area(s) of strength in this guide?

4. What area(s) can I grow in?

5. What questions do I have that have not been answered?
Performance Checklist

Competency Definition: Candidates can explain what a peer specialist is and what they do

☐ Candidates can describe to their mentor or training team how Peer Specialists are different to traditionally trained individuals
☐ Candidates can describe how they are the same as traditionally trained individuals
☐ Candidates can name ten jobs that they could do as a Peer Specialist

Candidate Comments: ________________________________________________________________
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Mentor Comments: ________________________________________________________________
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Date Completed: ________________________________

_________________________  __________________________
Candidate Signature        Mentor Signature
You have started on this career path because you want to help people, but what is it to help someone? Helping, in our case, is to assist someone with something that is his or her responsibility. When we help people, we do four things: we offer hope that things can and do get better, we have empathy for what they are going through and the challenges they face, we give them the opportunity to learn and grow to be able to navigate their lives under their own terms, and we help them see the possibilities for the future.

There are different levels of helping you can use when working with your peers. Each of these helping methods has a time and place to be used. We have two main methods of helping: the first is care giving and the second is recovery help.
**Care Giving**

At different times in our lives, everyone comes to a point in which they need care giving. When we care give, we take the burden of responsibility off of the person because they cannot, at that point in time, do it for themselves. For example, if you break your leg, someone would be providing care giving by going to get you your groceries. Care giving gives a person a break, a chance to regroup, so that they have the strength to tackle the responsibility again. Sometimes we care give just to show we care about someone. It can be an act of kindness freely given by the person who is providing the care giving, but if you are care giving as an act of kindness, the person you are providing the care to possesses the ability and skills to do it themselves if they need to. For example, you go to your grandmother’s house and you offer to make the coffee. If she needed to, your grandmother could make the coffee but you are doing it to be nice, to show you care. Remember there is a time and a place for care giving, but it is not a permanent solution, it is a break and breaks don't last forever.

**Recovery Help**

Recovery help differs from care giving in one major way. When we provide recovery help, we do not take the burden of the responsibility from the person. We give them support and help them learn things to make the responsibility easier for them to manage. For example, a person is carrying a heavy box. Care giving would be to take the box from them and carry it yourself. One way we could offer recovery help could be to take one end while the other person carries the other. Another method of recovery help would be to get the person a cart so that they can push the box instead of carrying it. Do you see the difference? In the care giving example, the person did not have to worry about the box because you did the work for them. However, in the last two examples you assisted them, but they were still moving the box. When you take a corner of the box you are lightening the load while they build the strength to carry it themselves. When you get them a cart you are providing them with tools, or a different way of doing things, so that they can do it themselves.
What Ways Can I Help?

**Concept:** Different ways to help

**Materials:**
- Examples included below
- Pen or pencil

**What to do:**

1. Read the examples of a situation you maybe asked to help your peer with.
2. Think of a way you could help by care giving and write it down
3. Think of a way you can help with recovery help
4. Discuss your ideas with your mentor or training team.
Example Situations

1) Sally moved away from home and has never grocery shopped before.
Care Giving:

Recovery Help:

2) Bob doesn’t know what bus to take to get to the theatre
Care Giving:

Recovery Help:

3) Jim wants to join a gym but does not know anything about the gyms in your area.
Care Giving:

Recovery Help:
4) Janice spent her grocery money on a new purse and does not have enough money for groceries.

Care Giving:

Recovery Help:

Debrief:

Questions for Discussion

1) Which method of helping was the easiest to come up with, care giving or recovery help?
2) Why do you think that is?

This is the end of the planned activities for this section. Now you decide whether or not you are ready for completion.

Fill out the Self Evaluation Checklist:
Do you have an answer for every question?
Have you completed all the activities to the best of your ability?

Meet with your mentor and complete the Performance Checklist
Self Evaluation Checklist

Competency Definition: Candidate will be able to describe the difference between care giving and recovery help and when each one is used.

1. Between 1-5 how confident am I that I know about the subject? __________

2. What activities have I done to grow in my knowledge and skills in the area and what have I learned?

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3. What are my area(s) of strength in this guide?

4. What area(s) can I grow in?

5. What questions do I have that have not been answered?
Performance Checklist

**Competency Definition:** Candidate will be able to describe the difference between care giving and recovery help and when each one is used.

- Candidate can give three examples of care giving help
- Candidate can give three examples of recovery help
- Candidate can describe when care giving help is used
- Candidate can describe when recovery help is used

Candidate Comments: 

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Mentor Comments: 

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Date Completed: ________________________________

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Candidate Signature  Mentor Signature
Strengths and Resilience

“Life is not about how fast you run, or how high you climb, but how well you bounce.”–Unknown

Think of a ball. If you throw a ball against an obstacle, it bounces off the obstacle and changes direction. This is the general idea of strengths and resilience. Think of the ball as an individual. Like a ball is filled with air, an individual is filled with strengths. The strengths inside an individual, just like the air inside the ball, help the person to rebound when met with an obstacle, and allow them to try again. A person’s ability to rebound is called resilience. As the quote above suggests, a person’s ability to get back up after being knocked down is the biggest key to success. Have you ever tried to play with a ball that does not have enough air? What does it do when met with an obstacle if it even reaches its target at all? It stops. Its ability to rebound is not the same. Personal strengths are important for people to feel that they possess the ability to succeed (self-efficacy) and if met with an obstacle the ability to get back up and try again (resilience).

Every individual has strengths. However, these strengths are affected by person’s environment. If you take a ball out into the cold, the air inside shrinks and the ball does not bounce well. If you take a ball out on a warm summer’s day the ball bounces just fine. When people are in an environment that is warm, they have people who love them and they love back and there are things they are good at. They can draw on these strengths and fill the ball, and if they meet an obstacle they have the tools to bounce back. However, if a person is in a cold environment their strengths do not fill their ball and bouncing back becomes more difficult. Every person has strengths, but sometimes they need encouraging or help connecting to
the strengths in their environment. These ideas are part of a theory called the **Strengths Perspective**.

In this module we will discuss the ideas contained in the strengths perspective, what strengths are, how we identify them and how do we encourage them in our peers.

**The Strengths Perspective**

The **Strengths Perspective** is a theory that was created by Dennis Saleebey. As stated above, the strengths perspective is the idea that individuals, groups and communities have strengths that they can draw on to meet life’s challenges. There are six principles that Saleebey talks about being the core of the strengths perspective. In this section we will first list them, and then talk about each one separately.

**Principles of Strengths Perspective**

1) Every individual, group, family and community has strengths.

2) Trauma and abuse, illness and struggle may be injurious but they may also be sources of challenge and opportunity.

3) Assume that you do not know the upper limits of the capacity to grow and change and take individual, group and community aspirations seriously.

4) We best serve peers by collaborating with them.

5) Every environment is full of resources

6) Caring, caretaking and context

**Every individual, group, family and community has strengths.**

In order to practice this principle, you may have to take on the role of investigator. The person in front of you has the strengths and your role is to help them locate them. Sometimes these things are hard to see, but they are there and ready to be used. Do they have family or friends that they are close to? Have they had experiences that they have lived through that they could draw power from? Is there a group in the community that this person is a member of?
Trauma and abuse, illness and struggle may be injurious but they may also be sources of challenge and opportunity.

People that live through tough times did so because they adapted and called on their strengths to get them through. Bad things still happened and they were still hurt, but despite what trauma they experienced or how they were abused they did what was needed to survive. If we practice this principle, we help people look for the power they used to survive these circumstances and take pride in their survival. Saleebey calls this “Survivors pride”.

Assume that you do not know the upper limits of the capacity to grow and change and take individual, group and community aspirations seriously.

“According to all known laws of aviation, there is no way that a bee should be able to fly. It’s wings are too small to get its fat little body off the ground. The bee, of course flies anyway. Because bees don’t care what human’s think is impossible.” (A Bee Movie, 2007)

As we discussed earlier, all individuals and families possess strengths. We as an outsider cannot truly know what all these strengths are and how a person can grow and change. Humans are adaptable. Ten years ago would you have thought you would be the person you are today? If bees lived their lives based upon what the scientists thought to be true would they fly? People do miraculous things everyday; they just have to do them. This means that people have the ability to grow and adapt based upon what life sends their way, and have the power to do great things. Be careful not to sell them short.
We best serve peers by collaborating with them

Collaboration means that everyone contributes their ideas, thoughts, and knowledge to the process and that everyone’s ideas are valuable. Have you ever had someone in your life that has made plans for you without talking to you first or spoken on your behalf and gotten it wrong? How did it make you feel? If we do not collaborate with our peers we are missing out on all that they have to offer and we are damaging our relationship with them.

Every environment is full of resources

The environment in which we live has things that we can use to help us get through tough times. These resources can include people that we care about or care about us, a community we belong to, a place to get food or find shelter. These resources can occur naturally like family or friends or they can be created like soup kitchens.

What are Strengths and how do we find them?

Strengths are the tools that a person possesses to navigate through life. Strengths are different for every person but they fall into a few similar categories.

Red Flag  Difference between dreams or aspirations and safety issues.

- Sometimes things are not straightforward. What happens if my peer thinks, for example, that they can fly? Well according to this principle, the aspiration of flying should be taken seriously. The question is how do they think they can make this happen. If the peer says, “Well, if I jump off a building I can fly” the likelihood that they will succeed is zero and the chance of death or serious injury is very high. This then becomes a safety issue and will be covered in more depth in later modules. However if the response is “well if I learn to be a pilot I will be able to fly” this is dream and aspiration.
- Questions to ask in this situation:
  - What is the worst thing that could happen if they pursue this idea? If death or serious injury is your answer it is a safety issue.
  - Am I unsure what to do? If so ask for help from your mentor or someone in charge at your agency.
Strengths are tools individual's can use to tackle life's challenges. For example:

Five things to do to be a strengths-based peer:

1) Focus more on conversation skills than interviewing skills
2) Send a clear message that you are not there to make negative judgments or try to change them but rather to help them achieve their own dreams as best you can
3) Engage in activities you both enjoy
4) Be sensitive to cultural factors...honor diversity and seek to assist people to get involved in things that hold meaning for them.
5) Include joy, humor, and laughter in your helping relationship
**Words to Remember**

Strengths Perspective

Collaboration

Strengths

Resilience

Self-efficacy
Movie Night

Concept: Identifying Strengths

Materials:

- A movie you want to watch with a main character that has to tackle a problem (ex. Forest Gump, a Beautiful mind, Lord of the Rings, the Matrix, Anne of Green Gables)
- A TV and video equipment
- The questions for this activity and paper and a pen to take notes

What to do:

- Watch the movie and pay special attention to one character.
- Answer the questions from the list about that character

Questions:

1. What movie did you watch?
2. What character did you use?
3. What was their obstacle?
4. What personal attributes did this character have that helped him/her tackle his/her problem? (Thoughtful, friendly, kind, etc.)
5. What resources were available to the character to help him/her tackle the obstacle?
6. Do we know of any experiences the character had in his/her past that helped him/her tackle his/her obstacle?
7. Were there any people in his/her life that helped them tackle his/her obstacle?
8. Did the character try more than one thing to tackle the obstacle? Did they all work? If they didn't work what did they do?
9. If you could ask the character questions what questions would you ask to help you discover their strengths?
10. What did you learn in this activity?
STOP! The next section is to be discussed with your learning team or mentor.

Debrief:

Everyone has strengths. In this activity you could only watch the character and had to do some interpreting of what you saw. This only allows us to find the strengths that are out in the open. When we work with our peers, we need to investigate and ask questions to find out what strengths they have, the resources they can draw from and how they would use these things to help them tackle their own obstacles.

Sing Your Praises

Concept: Strengths

Materials:

- Art supplies

What to do:

1. Do some thinking about what your strengths are
2. Create a poster showing your strengths.
3. Share your poster with your training team or mentor.

This is the end of the planned activities for this section. Now you decide whether or not you are ready for completion.

Fill out the Self Evaluation Checklist:
Do you have an answer for every question?
Have you completed all the activities to the best of your ability?

Meet with your mentor and complete the Performance Checklist
Self Evaluation Checklist

Knowledge Competency Definition: Candidates will be able to describe Strengths, Resilience, and Strengths Perspective

Practical/ Skill Competency Definition: Candidates will be able to identify strengths in an individual

1. Between 1-5 how confident am I that I know about the subject? __________

2. What activities have I done to grow in my knowledge and skills in the area and what have I learned?

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</tbody>
</table>

3. What are my area(s) of strength in this guide?

4. What area(s) can I grow in?

5. What questions do I have that have not been answered?
Performance Checklist

Knowledge Competency Definition: Candidates will be able to describe Strengths, Resilience, and Strengths Perspective

Practical/ Skill Competency Definition: Candidates will be able to identify strengths in an individual

- Candidate can describe what strengths are
- Candidate can describe what resilience is
- Candidate can describe what the strengths perspective is
- Candidate can identify strengths in an individual

Candidate Comments: _________________________________________________________________

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Mentor Comments: _________________________________________________________________

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Date Completed:_________________________________________

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Candidate Signature  Mentor Signature
Our biggest task in recovery is to learn different skills in order to reach our goals. This is why it is important for us to understand how people learn and what we can do to help them learn new skills. This module will help you understand the different styles of learning, and techniques we can use to help our peers learn new skills.

There are many different ways of learning material and skills. When we learn a skill we all have a preference for a certain style. This does not mean we cannot learn if the material is presented in a different way than our preference, it just means that we find it easier to learn when the material is presented to us in a manner that suits our style.

**Learning Styles**

1) **Visual Learners (See-ers)**

These learners have a preference for seeing their material. They usually say things like “I see what you are saying,” and pictures, charts, and maps work well for these learners.
2) **Auditory Learners (Hear-ers)**

These learners have a preference for hearing their material. They usually say things like “I hear what you are saying,” and talking them through the steps, and repeating back work well for these learners.

3) **Kinesthetic or Tactile Learners (Do-ers)**

These learners have a preference for performing an activity. Experimenting and doing parts of skills work well for these learners.

When working with your peers try to include all methods of learning where you can. This will allow your peer to get the information in different ways, and increase their learning. If a peer shows obvious preference, you can tailor activities and information to make it easier for them.

Have you ever heard the saying “take baby steps”? What this statement means is that people find it easier to learn things when they are broken down into smaller chunks. These chunks are called **progressions**. Being able to break skills down into progressions allows us to move forward in learning a new skill, even if we are not ready to do the whole skill at this time. In doing small chunks of a skill first, we have a higher likelihood of success and are able to build our confidence in doing the skill prior to doing it.

In order to break down a skill into progressions, we need to fully understand what is involved in doing a skill. Everything we do has multiple steps, and most of these steps we do not think about individually when we do the skill because we have done it before and have confidence in doing it. However, when we are learning something new we do not know what the steps are, and how to do them. In the next section we will walk through the steps of learning a new skill.

---

**Steps to Learning a New Skill**

**Step 1: Identify the skill**

This seems like an easy task, but it can be tricky. If someone is having difficulty keeping his or her house clean we may be tempted to identify the skill as keeping the house clean, but think for a moment what is involved in doing that. People have to be able to take out the garbage, remove soap scum, wash dishes, organize, and wash floors. The skill of clean apartment is a good skill for someone who already knows how to do all of these skills, but if they do not it will be overwhelming and they will have difficulty succeeding. It would be similar to asking
you to fly a plane when you have never been inside a plane. We may have to come back to this and make changes based upon what we discover in the other steps.

**Step 2: Write out steps involved in the new skill.**

Remember when you do this section to be very specific. When you buy an item that has to be assembled there are instructions included. Your planned skill should be similar. Pretend that you are writing the steps for someone who has no experience. This can be done with your peer.

*Example 1: Write Cat*

- Find paper.
- Find pen or pencil.
- Put both on a hard surface.
- Pick up pen/pencil.
- Put pen/pencil between your thumb and forefinger writing tip down in writing hand.
- Arrange paper in front of you on a hard surface.
- Hold paper with non-writing hand.
- Place tip of pen on paper.
- Move the pen on the paper to create a “C.”
- Lift pen off the paper.
- Move the pen over leaving a space after the C you have written.
- Place tip of pen/pencil on paper.
- Move pen/pencil to form an “A.”
- Lift pen off the paper.
- Move the pen over leaving a space after the A you have written.
- Place tip of pen/pencil on paper.
- Place tip of pen/pencil on paper.
- Move pen/pencil to form a “T.”
- Lift pen off the paper.

**Step 3: Evaluate the skill and identify prior learning that they could use.**

Everyone has skills that they have developed though their own life experiences. People can use these skills when they are tackling new skills because they are sources of strength and areas of comfort. Think about yourself becoming a peer specialist. I am sure there are things that you already knew how to do and could do well. Maybe you have been involved in planning a recreation group in the past, but now as a peer specialist you are being asked to book a space, advertise, and anticipate the cost of the project. Your prior learning makes it easier for you to plan the activity, but you still have to learn how to book spaces, advertise, and anticipate cost.
If we again look at Example 1 we see that this activity is written out for someone who has never written before but has seen someone else write. This person also knows what a pen and a paper are and roughly how to hold a pen. Let us now adapt the example for someone who can write the alphabet but not the word Cat.

*Example 2:*

- Get pen and paper and find a surface to write on
- Write C A T

Do you see how many less steps Example 2 has? If you were to give the directions in Example 2 to an individual who has never written before, they would most likely feel overwhelmed and struggle with the skill. However, when given to the individual who has experience in writing the directions are enough for them to accomplish the skill.

This step can sometimes be tricky, and that is why it is important to start with the most specific steps of a skill. Ask your peer what parts they know how to do or have done before and what parts are new to them. Sometimes you will find that your peer has experience doing all the steps, just not together. That is good. They are ready for the next step.

**Step 4: Break down the skill into smaller skills if you can.**

This step is where we break down the skill into smaller chunks and focus on the things that the individual needs to learn in order to do the larger skill. Let us go back to Example 1 and break it down into smaller skills.

*Example 1: Write Cat*

- Find paper.
- Find pen or pencil.
- Put both on a hard surface.
- Pick up pen/pencil.
- Put pen/pencil between your thumb and forefinger writing tip down in writing hand.
- Arrange paper in front of you on a hard surface.
- Hold paper with non-writing hand.
- Place tip of pen on paper.
- Move the pen on the paper to create a “C.”
- Lift pen off the paper.
- Move the pen over leaving a space after the C you have written.
- Place tip of pen/pencil on paper.
- Move pen/pencil to form a “A.”
- Lift pen off the paper.
• Move the pen over leaving a space after the A you have written.
• Place tip of pen/pencil on paper.
• Place tip of pen/pencil on paper.
• Move pen/pencil to form a “T.”
• Lift pen off the paper.

The larger skill is writing the word CAT. What could we do to help this person learn this skill? What could be the smaller chunks? Maybe in talking with our peer we discover that they are having trouble making the pen do what they want it to do because they have not written before. That could be a smaller chunk. Now what do we do with that chunk to help them feel confident and comfortable making the pen do what they want it to do? This part takes some creativity. Think back to when you learned to write. What did you do to learn it? Did you practice holding the pen? Did you practice drawing shapes on the page? Did someone do an outline of the letters for you to trace? All of these things are ways that this skill could be learned. Maybe you have some different ideas. Do what works for your peer. If it does not work, change what you are doing. Listen to your peer. Below is one example of how this skill could be broken down.

*Example 3: Smaller skills*

Skill 1: Learn to hold a pencil or pen.
Skill 2: Learn to use the pen or pencil on paper.
Skill 3: Learn to write a C.
Skill 4: Learn to write an A.
Skill 5: Learn to write a T.
Skill 6: Learn to write C A T together.

Remember if your peer has prior learning, recognize it. For example, if they can already write a C it is not necessary to spend a lot of time doing learning activities for that skill. These skills are all peer-directed, and you can only make suggestions. Your peer has to decide what it is that they want to do. Unwillingness to do progressions is not necessarily unwillingness to learn, it may be fear or it may also be unwillingness to learn your way. Both are valid reasons and both indicate we, as peer specialists, need to change what we are doing. Sometimes people just want to try the whole skill with you helping them along the way. Go ahead and do it that way, just remember that your end goal is independence and, therefore, you will have to slowly and gently do less and less so that they can do it alone.

**Step 5: Practice Practice Practice, Build Build Build.**

Have you ever heard the saying practice makes perfect? In order for people to feel confident and comfortable doing things they need to gain the experience of
doing them and yes doing them poorly, this is part of learning. I suggest we change the saying to practice makes possible. It is not necessary for people to be perfect; it is necessary for people to be comfortable and confident in performing a skill. Confidence and comfort come from experience, and practice allows us to gain the experience.

It may seem silly that the title of this step is practice practice practice build build build. Why repeat the words? The reason we repeat the words is because practice and building need to be repeated until the individual is confident and comfortable with the skill.

**Red Flag** What happens if I don’t know the skill that the peer wants to learn?

• It is not possible that everyone knows how to do everything. Not knowing how to do what your peer is trying to learn does not mean you cannot help. Be honest with them. Tell them you are not that familiar with what they are trying to learn, but you will help them to find out. For example, if your peer would like to go to university but you have not gone to University, you may not know what would need to be done for that to happen. Who would know? Where could you find this information? Your role may change to one of assisted fact finding. Finding information is also a skill.
How do we get there?

**Concept:** Individualized learning

**Materials:**
- Your self and another person
- A place you both have gone (museum, gym, library, Doctor’s office, etc)
- Paper and writing tools

**What to do:**

1) Decide on a place that you both have been but not together.
2) Decide on a starting point (ex. Where you are now, your home, etc).
3) Think about the route you would take to get there. Do not discuss this with your partner yet. How would you get there? Would you walk, bike, take the bus, or drive?
4) Decide how you would give someone directions to get to this place from your starting point without going with them. Would you draw a map would you tell them?
5) Using the method of drawing or telling you decided on above draw a map or write out specifically how you would get to the location you decided on.
6) Compare your directions with your partner.

**Questions:**

1) How did you give directions to your location?
2) What method of transportation would you use?
3) How were yours and your partner's directions similar?
4) How were your directions different?
5) Did both sets of directions get you to the location?
6) What did you learn in this activity?

**STOP!** The next section is to be discussed with your learning team or mentor.

**Debrief:**

This activity was designed to show that although two people can start at the same location and have the same endpoint or goal in mind they might not take the same route to their end point. Both people in this activity reached their destination, but they did so based upon their choices and their experiences,
which were not the same. Is it necessary to take the same route? If you were to think of the endpoint of a clean apartment how would you get there? Where would you start? In what order would you do things?

When working with a peer to plan a route to their goals ask yourself.

- Will their route get them to their endpoint?
- Do they want suggestions? If you don’t know ask them.
- Do you have any suggestions from your own experience that they might be able to use?
- Is there anywhere they could go to get information?

**Break it Down**

**Concept:** Progressions

**Materials:**

- Pen or pencil
- Piece of paper
- A pair of shoes with laces

**What to do:**

1. Write out the steps to tying your shoe
2. Give your steps to someone and ask them to follow the steps exactly to see if you missed any steps.

**Plan it out**

**Concept:** Progressions

**Materials:**

- Pen or pencil
- A piece of paper
- A pair of shoes with laces

**What to do:**

1. Look at the steps you created in the last activity.
2. Can you think of any ways you could help someone learn to do this?
3. Plan out 4 different activities or methods you could use to help someone learn to tie their shoes.
4. Discuss your plans with your training team or mentor.
This is the end of the planned activities for this section. Now you decide whether or not you are ready for completion.

Fill out the Self Evaluation Checklist:
Do you have an answer for every question?
Have you completed all the activities to the best of your ability?

Meet with your mentor and complete the Performance Checklist
**Self Evaluation Checklist**

**Knowledge Competency Definition:** Candidate will be able to describe what progressions are and why they are important.

**Practical/ Skill Competency Definition:** Candidates will plan out progressions.

1. Between 1-5 how confident am I that I know about the subject? __________

2. What activities have I done to grow in my knowledge and skills in the area and what have I learned?

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</table>

3. What are my area(s) of strength in this guide?

4. What area(s) can I grow in?

5. What questions do I have that have not been answered?
Performance Checklist

Knowledge Competency Definition: Candidate will be able to describe what progressions are and why they are important

Practical/ Skill Competency Definition: Candidate will be able to plan out progressions

- Candidate can identify the steps to doing a skill
- Candidate can describe why adaptations need to be made in working with their peers.
- Candidate can create a plan of different activities or methods that could be used to teach a skill.

Candidate Comments:______________________________________________________________
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Mentor Comments:______________________________________________________________
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Date Completed:______________________________________________________________

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Candidate Signature        Mentor Signature
Agency Orientation

**Domain:**
Agency Integration

**Area of Growth:**
Knowledge/Practical

**Knowledge Competency Definition:**
Candidate will be able describe the set up of their agency and the roles people play within it.

**Practical/ Skill Competency Definition:**
Candidate will be able to establish their own role in an agency.

Part of being successful and comfortable in any job is the ability to fit in and feeling like you belong. There are many things involved in being part of a work environment such as knowing who to ask if you have questions, where things are, what the values of the agency are, and rules of conduct, and just who the people are and what they do at the agency.

Every agency is different. This section aims to help you, as a peer specialist, to get to know your agency and how you may fit into the agency. Most agencies have a method of welcoming and educating new staff members. This section will help you to work through the information you are given.
Tour

Concept: Get to know your agency

Materials:
- An employee who has worked at the agency for longer than a year.

What to do:

Go on a tour of your agency with an employee as a guide. Your goal is to get to know where things are at the agency you work for.

Questions:

1. Where are the washrooms?
2. Where is my supervisor’s office?
3. Who else has offices and where are they?
4. Where is a phone I can use?
5. Is there a computer I can use? Is there a password?
6. Where do I eat lunch?
7. Is there a kitchen area to store and prepare a lunch?
8. Is there a break room?
9. Is there a place where resources such as books are kept?
10. Where are the supplies kept?
11. Where do I get my mail?

Interview

Concept: Get to know your agency.

Materials:
- Pen and paper or tape recorder for notes.
- Your direct supervisor.

What to do:
Meet with your supervisor and interview them using the following questions. If you have more questions feel free to ask them. Discuss what you have discovered with your mentor or training team.

Questions:

1. What is the mission statement of your agency?
2. What are the different roles people play in the agency?
3. What is your role at this agency?
4. How can I contact you?
5. What are the important phone numbers I should know?
6. Who do I talk to if I need supplies?
7. Who do I talk to about my pay cheque or benefits?
8. What is the protocol if an emergency happens?
9. Who can I talk to if my supervisor is not available and I need help?
10. Where do I find out what is going on at the agency? (Events, training)
11. Do I have a designated area to work?
12. Where do I store my things?
13. How will I receive feedback on my work?
14. What are the hours I work?
15. How do breaks work at this agency and when are they?
16. If I am sick or unable to make it to work what do I do?
17. If I am having trouble with a peer what should I do?
18. If I am having trouble with an employee what should I do?

Shadow

Concept: Getting to know your agency

Materials:

- Two employees that hold roles other than peer specialist at your agency.

What to do:

Spend half a day with each of them to get to know what it is they do at the agency.

Questions:

1. Who did you shadow?
2. What is their role?
3. How does it differ from your role as a peer specialist?
4. How is it the same?
This is the end of the planned activities for this section. Now you decide whether or not you are ready for completion.

Fill out the Self Evaluation Checklist:
Do you have an answer for every question?
Have you completed all the activities to the best of your ability?

Meet with your mentor and complete the Performance Checklist
**Self Evaluation Checklist**

**Knowledge Competency Definition:** Candidate will be able to describe the set up of their agency and the roles people play within it.

**Practical/ Skill Competency Definition:** Candidate will be able to establish their own role in an agency.

1. Between 1-5 how confident am I that I know about the subject? __________

2. What activities have I done to grow in my knowledge and skills in the area and what have I learned?

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3. What are my area(s) of strength in this guide?

4. What area(s) can I grow in?

5. What questions do I have that have not been answered?
**Performance Checklist**

**Knowledge Competency Definition:** Candidate will be able to describe the set up of their agency and the roles people play within it.

**Practical/ Skill Competency Definition:** Candidate will be able to establish their own role in an agency.

- Candidate has a mentor and has developed a plan for working through the level
- Candidate can describe what they must do to complete a guide
- Candidate has created definitions for words to remember that accurately define the word

Candidate Comments:________________________________________________________

___________________________________________________________________________

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Mentor Comments:__________________________________________________________

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Date Completed:_____________________________________________________________

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Candidate Signature       Mentor Signature
What is Recovery Anyways?

**Medical Model Vs Recovery Model in Mental Health**

**Medical Model**

Within the medical model the idea of recovery is “a return to a normal state of health, mind, or strength” (Oxford Dictionary). Strength in this model has resulted in a history of belief among consumers and providers that people with mental health issues do not “recover,” the most one can hope for is a reduction of symptoms.

The medical model is the traditional model in mental health. People who follow the medical model are heavily focused on medications as the way to health, and focus little energy on the other components of an individual.

Terms associated with the medical model: patient, treatment, compliance, non-compliance, diagnosis, and symptoms.
The Recovery Model

This model is more holistic than the medical model. People who subscribe to the Recovery Model view individuals as whole persons whose mental illnesses do not define who they are. The recovery model recognizes that the journey to wellness is different for different individuals. This journey is not linear; it is not a set progression through steps. Recovery is, in fact, non-linear and people cut their own path, sometimes taking steps that appear to be backward or even stopping for a period of time. This is part of the process, and people are entitled to navigate their life on their own terms.

Recovery Components

In the mid 1970s the concept of recovery gained momentum with the consumer/survivor/ex-patient movement, as individuals began organizing to lobby discrimination reduction and changes in mental health systems (Davidson, 2006). Mental Health Recovery is the idea that people can, and do, get better and that a
mental health diagnosis no longer means a loss of touch with reality with no hope of improvement.

The definition that comes to mind when referring to recovery is the partial or complete reduction of symptoms. This definition of recovery is not the same as the one used by either the consumer/survivor movement or psychosocial rehabilitation services. As William Anthony states “Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability” (Anthony, 1993 pg 17). Nowhere in his definition does Anthony suggest that a reduction of symptoms is required. Deegan also argues that recovery does not mean a reduction of symptoms, which is illustrated when she states that “Recovery refers to the... real life experience of persons as they accept and overcome the challenge of the disability (Deegan, 1988 pg 11). These definitions suggest that recovery is not an end result, but a process without a definite end point. It is a process of becoming a whole person, lumps and bumps included, and navigating the world on one’s own terms.

As we see above recovery is difficult to define as it can mean different things to different people and the definition that each person creates is based upon how they look at the world. Recovery is a personal journey and as such needs to be defined by people in their own way.

Recovery-oriented individuals recognize that psychotropic medications are part of the recovery process; the larger part is all the other things we do to get and stay well. Patricia Deegan calls these additional components personal medicine. Personal medicine is where you, as peer specialists, will work the most with our peers.

**Personal Medicine**

Deegan defines personal medicine as the “self initiated non-pharmaceutical self-care activities that served to decrease symptoms, avoid undesirable outcomes such as hospitalization, and improve mood, thoughts, behaviors, and overall sense of wellbeing.” (Deegan, 2005 pg 32). In short, personal medicine is any thing in our lives that allows us to get and stay well.

**Categories of Personal Medicine:**

1. Activities that bring meaning and purpose to ones life
2. Specific self care strategies

As peer specialists, our main goal is to help our peers in their recovery through the use of their own personal medicine.
Words to Remember

Recovery Model:

Medical Model:

Personal Medicine:

Activities for Growth

Definition of Recovery

Concept: What is Recovery?

Materials:

- Craft supplies

What to do:

- Decide on what your personal definition of recovery is.
- Create a poster that shows what recovery means to you.
- Show your poster to your training team or mentor and explain what it means to you.

Personal Medicine

Concept: Personal Medicine

Materials:

- Pen or pencil
- Paper
What to do:

1. Brainstorm the things that you have built into your recovery to help you get and stay well in addition to medication that you were given by your doctor.
2. Write a list of these things and divide them into two sections. Things that give your life purpose and specific coping strategies.
3. Discuss what you learned in this activity with your training team or mentor.

This is the end of the planned activities for this section. Now you decide whether or not you are ready for completion.

Fill out the Self Evaluation Checklist:
Do you have an answer for every question?
Have you completed all the activities to the best of your ability?

Meet with your mentor and complete the Performance Checklist
**Self Evaluation Checklist**

**Guide:** What is Recovery Anyways

**Knowledge Competency Definition:** Candidate will be able to describe what recovery is in mental health.

1. Between 1-5 how confident am I that I know about the subject? 

2. What activities have I done to grow in my knowledge and skills in the area and what have I learned?

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3. What are my area(s) of strength in this guide?

4. What area(s) can I grow in?

5. What questions do I have that have not been answered?
Performance Checklist

Knowledge Competency Definition: Candidate will be able to describe what recovery is in mental health.

- Candidate has a personal definition of recovery
- Candidate can describe how personal medicine differs from pill taking.
- Candidate can identify their own personal medicine

Candidate Comments: ________________________________________________________________

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Mentor Comments: ________________________________________________________________

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______________________________________________________________________________

Date Completed: ____________________________

_________________  _____________________
Candidate Signature  Mentor Signature
Communication

Communication is the heart and soul of being a peer specialist. How we communicate and how we respond to the communication of others is directly linked to how effective we will be in our relationships with our peers. So if communication is so important. What is it?

**Communication** is a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior (Merriam Webster Dictionary, 2010). There are a few key points in this definition that we need to remember. The first is that communication is exchanged. That means that communication happens in two directions. The second is that it is not only language it is also body language and behavior. The third point is that it is a process. Below is a diagram depicting the process.
The process of communication is pretty straightforward. The communicator sends their message either verbally or non-verbally, and then the other person receives the message and interprets its meaning (Decodes). They then respond to the message based upon their interpretation, sending this response message back to the other person. If communication is so simple, then why is it so difficult to make yourself understood and to understand other people?

Although the process is simple, there are places where things can go wrong. If you notice in the diagram there are wavy lines through the entire process labeled noise. Noise are things that can interrupt the process and lead to people decoding what is said differently than the sender intended, just like in a noisy room it is difficult to hear what someone is saying. Noise can be caused by a lot of different things; it can be the television in the background or the receiver being preoccupied with the party they are supposed to be planning.

The second place that communication could go wrong is in the decoding process. We decode what is being communicated based upon our knowledge and how we see the world. This works well when the person we are communicating with has similar knowledge and ways of viewing the world, but that is not always the case. Culture can play a part in the communication process. Different cultures have different methods of communicating. The first, and most obvious, is language. If someone is not speaking the same language as us, we usually know fairly fast that we do not understand him or her. This can be subtler though. What if they are speaking the same language, but they are using a different meaning of a word or they are using body language differently than we do. For example, there are cultures that view eye contact as a sign of disrespect. If you were from a culture that believes that maintaining eye contact shows you are listening and respect what the person is saying, how would you decode it if your peer did not make eye contact when talking
to you? It is important to be aware of the possibility of misunderstanding, and check with your peer that you are getting it right.

**Types of Communication**

**Verbal**

Verbal communication is what we say and how we say it. This is the type of communication that most of us think of when we think of communicating.

**Nonverbal**

Nonverbal communication is how we communicate without using words. This is usually what is referred to as body language. Body language includes facial expressions, body position, and behaviour. We portray a lot of our feeling and thoughts through our body language. Have you ever had someone ask you if there was something wrong without you having to say anything? The reason they could was because you were showing your emotions through your body language and they were reading and interpreting that body language. In this instance, they read and interpreted it correctly but because this is based on interpretation it is not an exact science. Can you think of a time where someone made an interpretation of your body language and they were not correct?

Sometimes we are not fully aware of our body language. People tend to read body language first and if it tells them something different than what your words they will believe the interpretations of your body language over what you are saying. For example, you are talking to a peer and you only have fifteen minutes before your next appointment. Throughout the conversation, you keep checking the clock. Your peer asks you are you in a hurry (reading non-verbal cues) and you respond no. Your peer reads that you are not fully present by your nonverbal cues, and even though you told them you were not in a hurry verbally, they believe their interpretation of your non-verbal cues.

**Understanding and Listening Skills**

**Attending**

Attending skills are used in a conversation to show that you think that what the individual is telling you is important. You do not have to agree with what they are saying, you are making a commitment to listen carefully and attempt to understand. Attending can be done in three ways:
1. Nonverbal attending: Eye contact, nods, etc.
2. Prompting: Asking for more details, “could you give me an example?”
3. Paraphrase: Restate using your own words. This allows you to check that you understand what your peer is saying.

**Questioning**

Questioning is an important skill to learn in order to be an effective communicator. It allows us to get more information, and check if we understand what is being said. There are three different kinds of questions we can ask: closed, open and clarifying.

**Closed Questions**

These questions are used to request very specific answers from our peers. They can be answered in one or two words. For example, “Do you want to go to the park?” or “What time is it?”

**Open Questions**

These questions call for more input from your peer, and allow you to explore the topic more thoroughly. For example, “What do you think would be the steps to taking the bus to the store?” and “What do you think are the most important factors in finding a good apartment?”

**Clarifying Questions**

Who, What, Where, How, and sometimes Why questions are used to get more information from our peers so that we can more fully understand what they are trying to say. For example, “What do you mean when you say that people are out to get you? Could you give me an example?”

In this section we have learned a lot of information regarding communication. Due to the fact that communication is something that we do, it is important for us to practice our skills and receive feedback. If you are studying alone, this may be a section that you should practice with your mentor or another peer specialist. If you have a training team this would be a very good section to do as a group. The Activities for Growth in this section are created to help you practice the communication skills you have learned. Please do all of them and ask for feedback.
**Words to Remember**

Communication:

Nonverbal Communication:

Verbal Communication:

Open Question:

Closed Question:

Clarifying Question:

---

**Activities for Growth**

**Direct me**

*Concept:* Clear Communication

*Materials:*

- Yourself and another person
- Blindfold
- A pencil
- Paper

*What to do:*

1. Blindfold your partner.
2. Put the pencil and paper in front of them.
3. Give your partner the directions that they are only to do what you tell them to do.
4. Direct your partner using words only to pick up the pencil and draw something of your choosing without telling them what they are drawing. (Ex. If you would like them to draw a square say draw a line to your right, then draw a line down, etc.).

Questions:

1. How difficult was it for you to get your partner to do what you wanted them to do successfully?
2. How close was their final drawing to what you intended it to be?
3. Did you have to clarify any of your directions? If yes which ones? And how did you do it?
4. What did you learn from this activity?

20 Questions

Concept: Closed Questioning

Materials:

- Yourself and another person

What to do:

1. Tell your partner to think of an object and why it is important and not to tell you what it is
2. Use closed questioning (questions that can be answered yes or no) to try to figure out what object your partner is thinking about and why it is important. Ask only 20 questions.
3. Once you have used your twenty closed questions write down what you have discovered.
4. Now repeat the exercise using up to 20 open ended questions.
5. Switch

Questions:

1. Which method of questioning did you find more useful?
2. Did you find it difficult to only ask closed questions?
3. What did you learn by doing this exercise?
This is the end of the planned activities for this section. Now you decide whether or not you are ready for completion.

Fill out the Self Evaluation Checklist:
Do you have an answer for every question?
Have you completed all the activities to the best of your ability?

Meet with your mentor and complete the Performance Checklist
Self Evaluation Checklist

Guide: Communication

Knowledge Competency Definition: Candidate will be able describe how communication works.

Practical/ Skill Competency Definition: Candidate will be able to demonstrate the use of communication skills

1. Between 1-5 how confident am I that I know about the subject? __________

2. What activities have I done to grow in my knowledge and skills in the area and what have I learned?

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3. What are my area(s) of strength in this guide?

4. What area(s) can I grow in?

5. What questions do I have that have not been answered?
Performance Checklist

Knowledge Competency Definition: Candidates will be able to describe how communication works.

Practical/ Skill Competency Definition: Candidate will be able to demonstrate the use of communication skills

- Candidate can describe the communication process
- Candidate can describe what nonverbal communication is
- Candidate can use closed, open and clarifying questions and can identify which one they are using.

Candidate Comments: ______________________________________________________

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Mentor Comments: _______________________________________________________

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Date Completed:____________________________

________________________________________  __________________________________
Candidate Signature                   Mentor Signature
In the Introduction to Peer Specialist module, you learned that being a peer specialist means to help your peers using your lived experience and the skills you have developed while on your own recovery journey. In this section, you will work on recognizing your own strengths and showing your employer what you can do. At the end of this section you will develop a profile that will help your employer put you in a role that uses your strengths and abilities. This section also allows you to explore who you are and how you got to be that person. It differs from other sections, as it is almost completely activity-based. Take your time and work through each activity.
What is My Story?

Concept: Lived Experience

What to do:

- Think of a way that you would like to tell your story (write it, sing it, draw it, etc)
- Spend some time thinking about how you got to be the person you are today.
- Tell your story in the way you think it needs to be told.

Things to Consider:

- What were some key things you learned? How did you learn them?
- What strengths did you use on your recovery journey?
- Were there any people that helped you on your journey?
- What would you hope to share with someone who is on his or her own journey?

Market Yourself

Concept: Peer Role Clarification

Materials:

- Profile Guide
- Pen and paper

What to do:

In this activity you will identify your own skills and abilities and create a peer specialist profile for your workplace. This profile will be used to help match you with peers and a peer role. Create a profile for your self using the profile guide to guide you. Once you have completed your profile discuss it with your training team or mentor.

Profile Guide

Name:
Strengths I possess?
What past experiences have I had that I think would be helpful as a Peer Specialist?
What skills have I learned?
What is my definition of recovery?
What are my hobbies and interests?
What roles could I see myself in as a Peer Specialist? Why?

This is the end of the planned activities for this section. Now you decide whether or not you are ready for completion.

Fill out the Self Evaluation Checklist:
Do you have an answer for every question?
Have you completed all the activities to the best of your ability?

Meet with your mentor and complete the Performance Checklist
Self Evaluation Checklist

Guide: Myself as a Peer Specialist

Practical/ Skill Competency Definition: Candidate will be able to create a personal profile recognizing their prior learning and strengths

1. Between 1-5 how confident am I that I know about the subject? __________

2. What activities have I done to grow in my knowledge and skills in the area and what have I learned?

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3. What are my area(s) of strength in this guide?

4. What area(s) can I grow in?

5. What questions do I have that have not been answered?
**Performance Checklist**

**Practical/ Skill Competency Definition:** Candidate will be able to create a personal profile recognizing their prior learning and strengths

- Candidate has created a personal profile
- Candidate’s personal profile identifies his/her strengths
- Candidate’s personal profile identifies prior experience and skills they learned in that experience.
- Candidate’s personal profile identifies possible Peer Specialist possible roles that they have the skills to perform.

Candidate Comments: ____________________________________________________________

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Mentor Comments: ______________________________________________________________

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Date Completed: _________________________________________________________________

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Candidate Signature        Mentor Signature
Ethics

**What are Ethics?**

**Ethics** are essentially a code of conduct for individuals. In a professional environment, a code of ethics is a pre-established set of rules that has been created to reduce the likelihood of harmful situations from arising between the helper and the helped. It also provides direction for how to proceed if a situation were to arise. Most agencies have a code of ethics that they require their members to follow. It is a set of shared values that they all agree on. These codes have been developed over time and yes, as a result of things going wrong. Each item is there for a specific reason: to keep everyone safe and the work we do possible.

Because peer specialists are relatively new in mental health, there is not a unified code of ethics specifically for them. However, in most helping professions the codes have similar themes. Psychosocial Rehabilitation has a code of ethics, and recognizes peer specialists as an important part of a recovery-oriented health system. In later manuals, we will discuss psychosocial rehabilitation in more depth. At this point, it is important to note that this code exists and that it, and other information, can be accessed on the website

Three Basic Ethical Principles for Practice

1. Confidentiality and privacy.
2. Avoid dual relationships.
3. Respect people’s individuality and honor what makes them unique.

Discussing your ethics with your peer from the beginning helps prevent surprises from happening, and minimizes the result of hurt feelings between you and your peer due to you having different understandings of your role. Below we will discuss the three basic ethical principles and why they are important.

Confidentiality and Privacy

The first principle we will discuss is confidentiality and privacy. What confidentiality means is that we will do our best to keep the information we learn about our peers in the process of helping them private. Everyone has a right to privacy. When we are in a helping relationship, we are told things that are personal and special to our peers. We are told this information so that we can help them. It is not information that they want everyone to know, and they will pick and choose whom they tell it to. That being said, there is information that is shared with a peer’s helping team. However, for the most part, what is shared and with who is negotiated with your peer prior to that information being shared with two exceptions.

Exceptions to Confidentiality

1. If a peer tells you they are going to harm another individual.
2. If a peer tells you they are going to harm themselves.

As discussed in earlier modules, there is a difference between goals and safety issues. At all times safety is the most important. Be up-front and honest with your peer from the beginning that these are times you will not ask permission to share this information. However, even if you must share this information you will only share it with the people you need to keep them and others safe. For example, if a peer tells you they are planning to end their life, you would tell your supervisor and their psychiatrist. You will not tell Bob, the cashier at the coffee shop.

In negotiating confidentiality with your peer it is important for you to lay out, in writing, what you have discussed and ensure that you and your peer both have a copy so that there is no misunderstanding. A confidentiality agreement can change over time, as what your peer is working on changes. Therefore be sure to review the agreement with your peer frequently and ask them specifically if you need to talk to someone about them. Below is an example of an agreement you can use.
Confidentiality Agreement

I ___________________________ have discussed my confidentiality and privacy with my peer specialist ___________________________ on this day ___________________________.

My peer specialist is part of my recovery team helping me reach my recovery goals and will share information with the other members of my recovery team. These people are:

Name of Person | Where they Work
---|---

There are people that I would like for my peer specialist to be able to talk with only about some things. These people are:

Name of Person | What Information
---|---

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I know that my peer specialist will not be able to share information about me with people that are not on this list unless I am in danger of harming others or myself. If that should happen, then they will share information with people that need to know to keep everyone safe.

I know that if I would like to change this agreement I can by talking to my peer specialist.

Peer

Date

Peer Specialist

Date
Avoid Dual Relationships

Having dual relationships means having more than one type of relationship at the same time. If we have more than one type of relationship with an individual, it makes it difficult to know what we can expect from a person. In each kind of relationship there are different acceptable ways of acting with each other. When we are in a helping role it is important to keep this role clear so that our peer knows what part we play in their lives.

The three most important things to avoid to keep your relationship a helping relationship are:

- Sexual and romantic attachments.
- Aggression and assault.
- Exploitation (using someone else to benefit you).

In order for us to be successful at keeping our relationship one of helping and avoid dual relationships we need to respect our boundaries.

What is a boundary?

Boundaries are important in everyone’s life. Even if you have not heard the term before, you have set boundaries. Do you remember a time where you were asked to do something that you did not feel comfortable doing and had to say no? Or maybe you had trouble saying no in the situation and did what you were asked to do, but were thinking all the while “I should have said no?” In both situations you were dealing with your personal boundaries. In the first situation, you were able to set a boundary or limit and, in the second, your boundary was violated. Boundaries help us define who we are as a person and let people know what they can and cannot expect from us. Setting boundaries or limits does not come easy for people.

Imagine, if you will, Canada. When we think about Canada we can envision a rough shape. We know that the country spans from the Pacific Ocean to the Atlantic Ocean, and that the United States is on the bottom. The water on the two sides serves as a natural boundary for Canada, whereas the boundary between the United States and Canada had to be created and defined. Without these boundaries how would we know where Canada ends and the United States begins? This is similar to personal boundaries, because without clearly defined boundaries people have to guess where we stand.

In every relationship it is important to be able to set boundaries in order to keep the relationship one of mutual respect. If Bob continually asks Jim to do things that he is uncomfortable with and Jim does not set boundaries, it can lead to strain on the
relationship because Jim will become upset and feel he is being taken advantage of. We establish boundaries in any relationship we have, and sometimes it is easier than others.

**How do we make people aware of our boundaries?**

The best way to make people aware of our boundaries is to be up-front and honest. This means that if a situation arises when your boundaries are being pushed, you are reminding them of something you have already told them instead of stating new information. If it becomes necessary to clarify our boundaries with people, remember:

1. Our boundaries are ours and people cannot be expected to know what they are without being told.
2. Because our boundaries are ours if we need to clarify our boundaries we need to use I statements (I feel uncomfortable when I am asked to do that because I...) not you statements (you make me feel uncomfortable when you....).

**Respect people’s individuality and honour what makes them unique.**

This principle applies to treating everyone as an individual who is worthwhile. People should not be treated differently because of their cultural background, how they look, whom they love, what their gender is, or what their religion is. These differences are what make individuals unique and should be celebrated. We are all people with the same goal, recovery.

The main principle that anyone in a helping role can agree on is that we are there to help, not harm, the people we are working with. This sounds pretty simple, but sometimes we make decisions and we do not play the tape to the end before we choose what we will do. This means we do not look ahead to see what the consequences are, whether good or bad. When you are making a decision regarding a client, ask yourself three main questions.

1. Will this help or harm?
2. Who is it helping? My peer or someone else?
3. If I were to do this what are the consequences?
Words to Remember

1. Value:

2. Ethic:

3. Confidentiality:

4. Dual Relationship:
Activities for Growth

A Peer Specialist Should Be

Concept: Values Clarification

What to do:

Listed below are 20 character traits. Which character traits do you feel are the most important for a peer supporter to have? Rank the following character traits 1 being the most important and 20 being the least important.

___ Honest
___ Playful
___ Self-Confident
___ Orderly
___ Aggressive
___ Courageous
___ Cooperative
___ Creative
___ Loyal
___ Responsible
___ Caring
___ Self-directing

___

Adapted from “Ethics and Values Clarification” by Glen Finch
http://frank.mtsu.edu/~u101irm/ethicslp.html
Independent
Rational
Curious
Spontaneous
Friendly
Flexible
Open minded

Questions:
1. Why did you put each in the order that you did?
2. Are there any traits you think should be removed all together?

Make a Decision
Concept: Ethical Decision Making
Materials:

   Ethical Decisions Questionnaire

What to do:
Read the description of each situation a Peer Specialist could find themselves in and identify the ethic or ethics that need to be considered and what you would do in the situation to be ethical and why you would do things that way. Discuss your answers with your training team or mentor
Ethical Decisions Questionnaire

1. The peer you have been working with Sally has told you that she is thinking of harming herself and has asked you not to tell anyone.

Ethics(s)________________________________________________________

What do you do and why:__________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

2. Your peer Bob’s sister Jean calls you to find out how Bob is doing. Bob has not included Jean on his release of information sheet.

Ethics(s)________________________________________________________

What do you do and why:__________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________
3. Your peer Jess has told you that he is homosexual and you have a personal belief that homosexuality is wrong.

Ethic(s)__________________________________________________________

What do you do and why:___________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

4. Jackie, your peer, tells you that she is interested in dating you.

Ethic(s)__________________________________________________________

What do you do and why:___________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

5. Your peer Gordon is Buddhist and you are Christian and the topic of religion comes up when you are together.

Ethic(s)__________________________________________________________

What do you do and why:___________________________________________
_________________________________________________________________
_________________________________________________________________
Questions:

1. Were you able to decide what to do?
2. Are there any of the situations that could have different answers and still be ethical?

This is the end of the planned activities for this section. Now you decide whether or not you are ready for completion.

Fill out the Self Evaluation Checklist:
Do you have an answer for every question?
Have you completed all the activities to the best of your ability?

Meet with your mentor and complete the Performance Checklist
Knowledge Competency Definition: Candidate will be able to describe what a code of ethics is.

Practical/ Skill Competency Definition: Candidate will be able integrate helping ethics into their own decision making

1. Between 1-5 how confident am I that I know about the subject? __________

2. What activities have I done to grow in my knowledge and skills in the area and what have I learned?

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3. What are my area(s) of strength in this guide?

4. What area(s) can I grow in?

5. What questions do I have that have not been answered?
Performance Checklist

Knowledge Competency Definition: Candidate will be able to describe what a code of ethics is.

Practical/ Skill Competency Definition: Candidate will be able integrate helping ethics into their own decision making

☐ Candidate can make an ethical decision using each one of the ethics
☐ Candidate can describe what they can do if they don’t know what decision to make.
☐ Candidate can describe why ethics are important.

Candidate Comments: __________________________________________________________

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Mentor Comments: ____________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Date Completed: ____________________________________________________________

_________________________ ____________________________
Candidate’s Signature Mentors Signature
## Appendix 1: Abilities Chart

<table>
<thead>
<tr>
<th>Domain</th>
<th>Key Concept</th>
<th>Area of Growth</th>
<th>Complete</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation</td>
<td>How To Use The Manual</td>
<td>Knowledge</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Encouraging Independence</td>
<td>Helping Through Hope</td>
<td>Knowledge</td>
<td>○</td>
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<tr>
<td></td>
<td>Progressions</td>
<td>Skill</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Beliefs Supporting Recovery</td>
<td>What is Recovery Anyways</td>
<td>Knowledge</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strengths and Resilience</td>
<td>Knowledge/Skill</td>
<td>○</td>
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<td>Interpersonal Skills</td>
<td>Communication</td>
<td>Skill</td>
<td>○</td>
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<td>Peer Based Program Support</td>
<td>Introduction to Peer Specialist</td>
<td>Knowledge</td>
<td>○</td>
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<tr>
<td></td>
<td>Myself as a Peer Specialist</td>
<td>Knowledge/Practical</td>
<td>○</td>
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<tr>
<td>Understanding How Peers Cope</td>
<td></td>
<td></td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Legal Rights, Antidiscrimination Advocacy</td>
<td></td>
<td></td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Agency Integration</td>
<td>Agency Orientation</td>
<td>Knowledge/Practical</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ethics</td>
<td>Knowledge/Practical</td>
<td>○</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Learning Form

What I did:

When:

Where:

Did I gain knowledge or learn a new skill?

What I learned (be specific):

How can I use this in my work with my peers?

What domain does it fit into and why:
<table>
<thead>
<tr>
<th>Mentor</th>
<th>Activities For Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red Flag</td>
<td>Training Team</td>
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<tr>
<td>Strengths Perspective</td>
<td>Collaboration</td>
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<td>Strengths</td>
<td>Resilience</td>
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<tr>
<td>-------------------</td>
<td>-------------------------</td>
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<tr>
<td>Self-efficacy</td>
<td>Recovery Model</td>
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<tr>
<td>Medical Model</td>
<td>Personal Medicine</td>
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<tr>
<td>Value</td>
<td>Ethic</td>
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<td>---------------</td>
<td>-------------</td>
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<tr>
<td>Confidentiality</td>
<td>Dual Relationship</td>
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## Introductory Level

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<thead>
<tr>
<th>Domain</th>
<th>Key Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation</td>
<td>How To Use The Manual</td>
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<tr>
<td>Encouraging Independence</td>
<td>Helping Through Hope</td>
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<td></td>
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<td>Beliefs Supporting Recovery</td>
<td>What is Recovery Anyways</td>
</tr>
<tr>
<td></td>
<td>Strengths and Resilience</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>Communication</td>
</tr>
<tr>
<td>Peer Based Program Support</td>
<td>Introduction to Peer Specialist</td>
</tr>
<tr>
<td></td>
<td>Myself as a Peer Specialist</td>
</tr>
<tr>
<td>Understanding How Peers Cope</td>
<td></td>
</tr>
<tr>
<td>Legal Rights, Antidiscrimination and Advocacy</td>
<td></td>
</tr>
<tr>
<td>Agency Integration</td>
<td>Agency Orientation</td>
</tr>
<tr>
<td></td>
<td>Ethics</td>
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### Advanced Level

<table>
<thead>
<tr>
<th>Domain</th>
<th>Key Concept</th>
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</thead>
<tbody>
<tr>
<td>Orientation</td>
<td>How To Use The Manual</td>
</tr>
<tr>
<td>Encouraging Independence</td>
<td>Community Integration</td>
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<tr>
<td>Beliefs Supporting Recovery</td>
<td>Promoting Recovery</td>
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<tr>
<td>Beliefs Supporting Recovery</td>
<td>Wellness Recovery Action Plan</td>
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<tr>
<td>Interpersonal Skills</td>
<td>Advanced Communication</td>
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<tr>
<td>Peer Based Program Support</td>
<td>Myself as an Advanced Peer Specialist</td>
</tr>
<tr>
<td>Understanding How Peers Cope</td>
<td>Coping Strategies</td>
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<tr>
<td>Legal Rights, Antidiscrimination</td>
<td>Advocacy</td>
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<tr>
<td>Advocacy</td>
<td>The Mental Health Act</td>
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<tr>
<td>Agency Integration</td>
<td>Canadian Psychosocial Rehabilitation Association</td>
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<td>Mediation and Negotiation</td>
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<td>Agency Integration</td>
<td>Advanced Ethics</td>
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### Mentor Level

<table>
<thead>
<tr>
<th>Domain</th>
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<tbody>
<tr>
<td>Mentoring</td>
<td>Feedback</td>
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<tr>
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<td>Identifying strengths</td>
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<td>Identifying growth potential</td>
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<td>Learning styles</td>
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<td></td>
<td>Adapting Learning</td>
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<tr>
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<td>Adapting Evaluation</td>
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