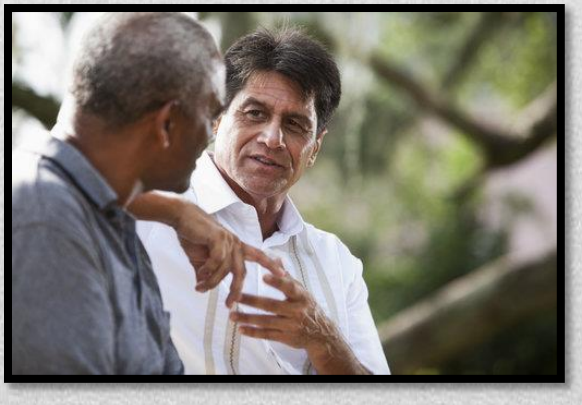
MISSION Peer Navigator Toolkit

Developed by:
Allen Ryba, CPS
Jennifer Harter, Ph.D.
Robert Walker, M.S.



MISSION Peer Navigator Toolkit

Available online at www.missionmodel.org

The views expressed in the following document do not necessarily reflect the official policies of the Massachusetts Department of Public Health, the University of Massachusetts Medical School, or Substance Abuse and Mental Health Services Administration (SAMHSA) nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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The MISSION materials mentioned within the document in addition to all versions of the MISSION treatment manual and their corresponding workbooks are available for download on the MISSION website at www.missionmodel.org. You may also contact the MISSION team through the website or Dr. David Smelson directly (see contact information below) regarding any questions about the MISSION Model and/or the materials.

For questions regarding the use of this material, please contact:

David A. Smelson, Psy.D.
Professor and Vice Chair of Clinical Research
Department of Psychiatry, University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655

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Acknowledgments

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This document was developed and written by Allen Ryba, CPS, Massachusetts General Hospital, Jennifer Harter, Ph.D., University of Massachusetts Medical School, and Robert Walker, M.S., Massachusetts Department of Mental Health. We are grateful for the valuable feedback we received from expert reviewers during the development of this document. Reviewers include: Alice Colegrove, DrPH, Bureau of Substance Addiction Services, Department of Public Health; Ayorkor Gaba, Psy.D., University of Massachusetts Medical School; Cheryl Kennedy-Perez, M.S.W., Bureau of Substance Addiction Services, Department of Public Health; and David Smelson, Psy.D., University of Massachusetts Medical School. We would also like to thank the University of Massachusetts research assistant, Kathryn Bruzios, M.S., for her assistance in the production of this document.

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Last but not least, we would like to acknowledge the individuals who agreed to receive MISSION: Housed services and who have entrusted their lives to the MISSION model of support. We are grateful for their willingness to take part in MISSION: Housed. Their participation has helped us inform and improve our program model and broaden the landscape of services and supports for homeless individuals with co-occurring disorders. We have learned greatly from the feedback we have received from them along the way.

What is Peer Support?

As has been noted by Miller and Moyers (2006),

> *"People possess substantial personal expertise and wisdom regarding themselves and tend to develop in a positive direction given the proper conditions and support."*

Peer support provides these essential conditions. It is support provided by someone who is in or has been in the same situation or a similar one, to someone who is presently struggling. Peer support is not based on a medical or clinical model, but rather on mutual and equal relationships. Power differentials, such as expert/novice or teacher/student, are avoided and labels are not used. Peers talk about "experiences", using every day, non-clinical language, and maintain the belief that each individual is in charge of his/her own life, and has the knowledge and wisdom to discover his/her individual path to recovery. There are four different types of peers who provide peer support, which are described in Table 1.

Table 1. Four Types of Peers	
Peer Support Specialists (PSS)	Peer support specialists (PSS) are people in recovery from substance use, mental health disorders, and/or homelessness who use their shared experience(s) to promote hope, resiliency, and positive change. Peer specialists work with people to support them in a variety of ways, including assisting them in exploring their own inner wisdom.
Recovery Coaches	Recovery coaches are people who promote recovery by removing barriers and obstacles to recovery, and serve as a personal guide and mentor for people seeking or already in recovery.
Certified Peer Specialists (CPS)	Certified peer specialists (CPS) are PSSs who have been trained in a unique set of skills and tools, and have passed a test which grants them certification by the state in which it was taken. The CPSs use these advanced skills to better help the people they serve.
Peer Navigators (PN)	Peer navigators (PN) have been in existence for quite some time helping people navigate various systems. They

	support peers with a variety of challenges such as peers with cancer, HIV/AIDS, physical challenges, veterans, and others.

A peer navigator in MISSION is a CPS who has a high level of recovery experience and training, and serves several specific roles and responsibilities. They use their work and life experience to provide guidance, education, and support to PSSs. PNs share culturally relevant resources and knowledge using their experience both professionally and personally. They work with administrators to educate them on peer support techniques and their effectiveness, and provide trainings if necessary. This gives administrators a better understanding of the proper application and supervision of PSSs. The PN keeps up to date on trainings and new developments concerning peer support work, as well as delivers direct services to higher-risk clients who are in more complex situations.

The Roles of the Peer Navigator and Other Staff in MISSION

What is MISSION?

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) is a time limited, yet flexible, wraparound service intervention for individuals who have experienced homelessness, hospitalization, and/or incarceration, and whose ability to return to independent community living is further complicated by a co-occurring mental health and substance use disorders (COD). The key service components of MISSION include: Critical Time Intervention (CTI) case management, Dual Recovery Therapy (DRT), Peer Support, Trauma-Informed Care, and Vocational and Educational Support. Because our work involves both individuals who are homeless as well as those who may be involved in the criminal justice system, we have also integrated Rapid Re-housing Support and a Risk, Needs, Responsivity framework to be used based on the setting. For in-depth information on the essential elements of MISSION please visit www.missionmodel.org.

What Role do Peer Navigators have in MISSION?

Peer navigators (PNs) are a relatively new addition to the MISSION program. MISSION PNs are certified peer specialists who have greater experience and more advanced training in peer support recovery than MISSION peer support specialists (PSSs). They play a very valuable role in MISSION by providing guidance and assistance to PSSs, meeting with organizational administrators, providing direct care for high-risk clients, and collaborating with case managers (CMs; see Figure 1).

MISSION Peer Navigator Responsibilities

- Helping PSSs and clients to discover and navigate peer and other recovery related resources
- Supporting PSSs with complex cases
- Facilitating regular meetings with PSSs to support each other, and share ideas and resources
- Supporting PSSs in their unique roles and struggles
- Creating and updating peer roles within MISSION
- Keeping up to date on new peer developments and trainings
- Conducting trainings on peer support techniques for new PSSs and administrative staff

Figure 1. MISSION Peer Navigator Responsibilities

Who are the other MISSION Staff Members and What are Their Roles?

Each MISSION team consists of a case manager and a peer support specialist, who together are responsible for delivery of the MISSION service components to program clients. There is also a MISSION clinical supervisor (CS), who oversees and supports the work of the CM/PSS team. It is

important for the PN to understand that he/she is working jointly with the PSS/CM team and the CS, and to be aware of the specific responsibilities of these team members. Table 2 is a brief outline of the key responsibilities of the PSS, CM, and CS.

Table 2. MISSION Team Member Responsibilities

MISSION PSS Responsibilities
• Providing support based on personal experience and expertise • Delivering 11 Peer-Led Sessions (see Appendix D) • Assisting with the MISSION Participant Workbook • Providing support based on personal experience and expertise • Assisting with recreational planning and modeling healthy living • Accompanying clients to self-help group meetings and other recovery services
MISSION CM Responsibilities
• Introducing clients to the MISSION program • Developing treatment and discharge plans • Delivering 13 structured Dual Recovery Therapy (DRT) sessions (see Appendix D) • Communicating with Clinical Service Providers • Managing clinical crises • Assisting with benefits and entitlements
MISSION CS Responsibilities
• Diagnostic assessment • Identification, prioritization, and management of high-risk cases • Clinical coordination • Supervision of the CM/PSS team
MISSION CM/PSS Team Responsibilities
• Attending meetings at residential facilities • Linking clients to community services/supports • Assisting clients to secure/maintain housing and employment • Monitoring symptoms and discussing relapse prevention, coping skills, and problem-solving strategies • Transportation assistance • Support during crises • Helping clients advocate for themselves and ensure two-way communication with providers

PEER NAVIGATOR DO'S AND DON'TS

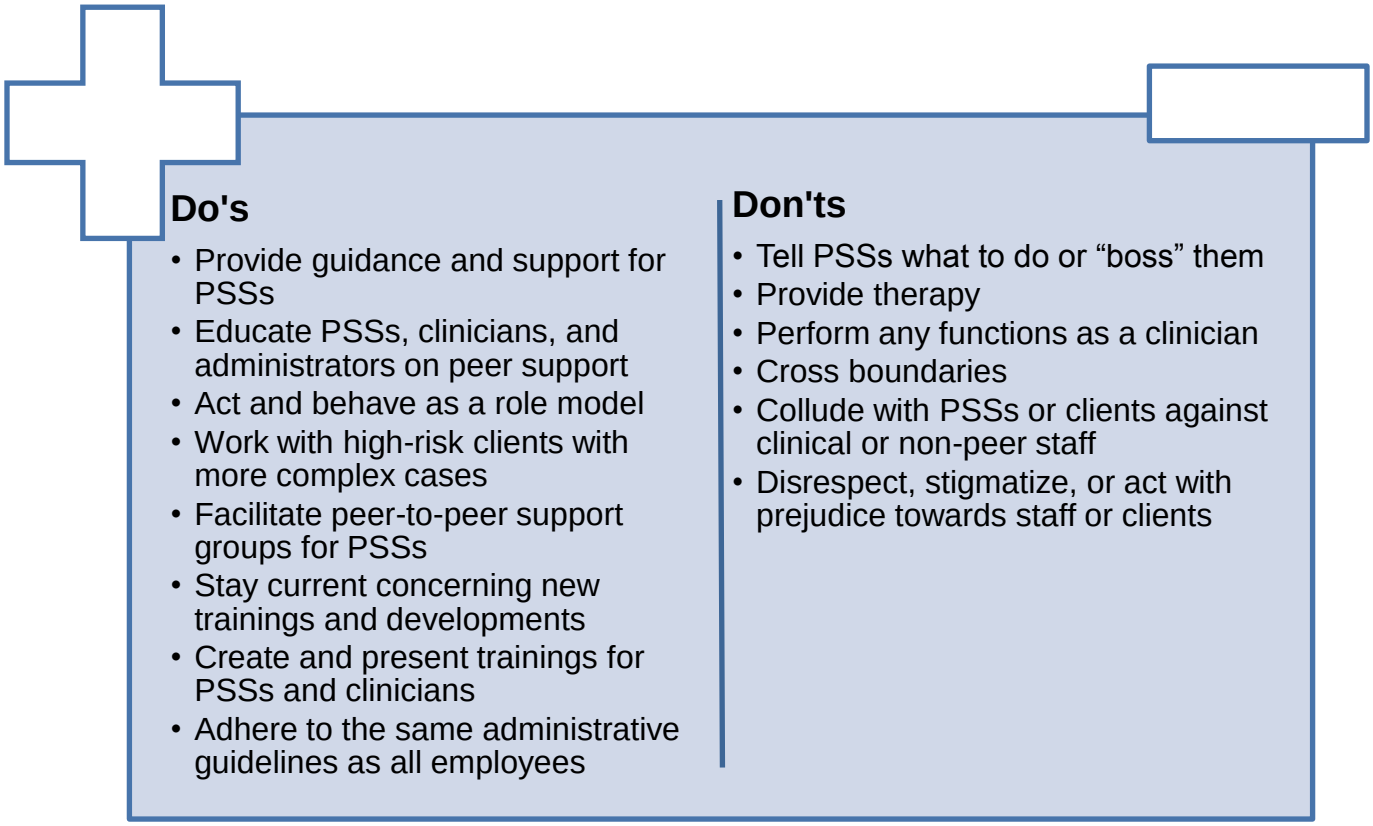

Figure 2. Do's and Don'ts of the Peer Navigator Role

THE ROLE OF PEER NAVIGATORS IN THE SUPERVISION OF PEER SUPPORT SPECIALISTS

PSSs are a fairly new addition to many organizations. Unlike the majority of health care disciplines that operate in a hierarchical manner, PSSs work on the basis of mutuality and equanimity. Within a peer support framework, power differentials between peer specialists must be avoided if they are to be effective in their work. This can bring up questions about who should supervise the PSS and how supervision should be accomplished.

Supervision provided by the Clinical Supervisor

Standard supervision with a clinical supervisor can be tricky. Clinical supervisors are likely to have traditional healthcare backgrounds, and be more accustomed to supervising in authoritative or directive manner. Problems may arise if the CS and PSS have different expectations about the supervisory relationship. Therefore, it is suggested that CSs become knowledgeable about peer support philosophy, and that adjustments to standard supervising techniques are considered. Clinical supervisors are encouraged to form a sense of mutuality and be open and curious with their PSS supervisees at the outset of their work together. Asking PSSs for their thoughts and encouraging their input is a great way to form a healthy and successful supervisory climate.

Supervision provided by the Peer Navigator

If PNs are employed in the organization they can supervise PSSs. This type of supervision has had positive results at many agencies. However, potential issues can arise around administrative matters. For example, there may be pushback if a power differential is created, which could be damaging to the peer working relationship. This can be resolved if, before initiating supervision, it is discussed and agreed that administrative matters would be handled in a separate additional supervisory session with the PN. Another method is to have two supervisors - the PN for clinical matters and a non-peer supervisor for administrative matters. These two approaches are more time consuming but can be extremely effective.

It is important for supervisors and peers to remember that PSSs, like all employees, must adhere to organizational policies. They are responsible for showing up on time, keeping appointments, completing documentation, and so on. It is essential that PSSs are held accountable for following the same administrative policies as everyone else in the agency. Supervisors should be careful not to coddle PSSs, as they are not fragile people who need extra attention and protection. Treating them this way could lead to PSSs not living up to their full potential and to possible dissention in the department because of preferential treatment. The PSS should always be treated as an equal member of the team with a unique role.

PEER NAVIGATOR TIPS FOR EFFECTIVELY SHARING RECOVERY STORIES

Sharing recovery stories in an effective way is one of peers' greatest, most important tools. A recovery story is defined by the Transformation Center of Massachusetts as an approach to "Sharing our lived experience in an intentional way to benefit others and inspire hope about recovery" (http://transformation-center.org/). When sharing your story it's important to be aware of the difference between a recovery story and an illness story.

A **recovery story** is a recounting of where we were, where we are now, and how we got there. We spend a short amount of time talking about our past in order to connect to listeners, and then spend the majority of time focusing on where we are now and how we got here. Our overall attitude should be realistic and positive, positive, and more positive!

An **illness story** is one that is centered on the past, and involves telling "war stories", trying to "one up" another speaker, and talking excessively about medications, hospitalizations, and other negative, graphic details. An illness story does not inspire people to move forward and can potentially be harmful. Therefore, we should always be watchful when sharing our story that it does not inadvertently turn from a recovery story into an illness story.

It's essential when sharing your story to have a good understanding of your audience as well as the purpose of sharing:

- Are you sharing at a support group?
- Are you speaking to administrators?
- How large is your audience ten people? A hundred people?
- Is your goal to help others? Or,
- To inform professionals? Or,
- To advocate for political change?

Keeping these factors in mind will help you to share your story in a manner that best meets the needs of your specific audience. It's helpful to know the amount of time you are allotted to speak, so that you can plan how much time to spend on each section of your story.

It is also critical to always consider the potential risk to yourself of sharing your story before you share it. For example, think ahead about whether there could be any negative repercussions to you from disclosing specific personal information to a given audience. Telling your recovery story repeatedly provides great practice for every PSS. Once you have gotten to know it well, you can use "snippets" (i.e., pieces) of your story to educate and support the people you serve, which you will probably find yourself doing quite often.

Remember – The goal of sharing your story is to help instill hope, model resiliency, and show people that recovery is real and can be attained!

COMMON CHALLENGES FACED BY PEERS AND HOW TO ADDRESS THEM

Lack of Role Clarity

When people in an organization do not understand the unique role of PSSs, PSSs may be underutilized, and cannot fully perform their role. PSSs are hired with the best of intentions, however there may be a lack of clarity about their roles. As a result, PSSs may be relegated to driving, beverage getting, or other grunt work. While some of these tasks may be performed by PSSs from time to time, PSSs possess the life experience, skills, and training to provide an array of very essential services to clients. Prior to hiring PSSs, it would benefit the organization to become familiar with peer support philosophies/methods and the role of PSSs through training provided by a PN or an experienced PSS. This will help to ensure that PSSs are given the opportunity to perform the full range of responsibilities associated with the PSS role once they are employed.

Stigmatization

Stigmatization is a very frustrating challenge that does occasionally surface. Some individuals in the organization may be unintentionally biased against people in recovery - not being able to see past the addiction or mental health diagnosis. For instance, peer specialists may be unfairly scrutinized when taking sick time, requesting reasonable accommodations, or treated as fragile people who need extra attention and protection rather than as equal team members. While this is typically unintentional, it can cause a split between team members and a breakdown in communication within an organization, which can have a damaging effect on office culture and the clients being served. Stigma should be openly discussed and addressed by the team.

Philosophical Differences between Peer Support and the 12-Step Model

While all PSSs have been trained in the peer support model, some may also have a 12-step background. Training in peer support involves learning to meet individuals “where they’re at” and to use “harm reduction” (see Appendix F for a definition) in order to decrease the negative consequences associated with substance use. Conversely, the 12-step model usually embraces the “abstinence only” position. The differences in these two philosophies should be discussed and guidelines should be developed to ensure consistency in service delivery. For example, how staff should manage a situation in which a person shows up intoxicated to an individual or group meeting should be clarified.

Maintaining the Use of Non-Clinical Language

One of PSSs’ most important tools is language. When doing our job, it is essential that we use every day, non-clinical language, keeping the client first. It is also essential to use this language during our interactions with other team members. This includes during team meetings as well as more informal conversations. It is easy to fall into using the language that those around us may use. If we unwittingly adopt the language and philosophy of the clinical setting it can create a power differential and potentially hurt our relationships with the clients we are serving.

Peer Background and Hiring Policies
Peers have “lived experience” and as a result may have previous contacts with the criminal justice system, large gaps in their work histories, and/or received services from the agencies they are applying to for PSS positions. Hard and fast rules about not hiring those with criminal records, spotty work histories, or individuals who have previously been clients, may not make the best sense when it comes to hiring PSSs and adjustments to such rules should be considered. It is sometimes having these “negatives” that make the best peers.

Keeping the Relationship Peer and Information Sharing
PSSs have a unique relationship with the people they serve. It is based on trust and mutual transparency. If the client shares information with the PSS that the PSS feels is important to share with the CM, he/she should ask the client for permission to share it unless it is information that they are mandated to share. Asking for permission to share it and abiding by the client’s wishes is essential and very helpful to the peer relationship. Not abiding by this could damage the relationship and keep the client from forming trust in future relationships.

In some organizations PSSs might be asked by staff to get information about the client that they are not privy to or to get the client to do things such as talk in groups or take his/her medications; that is not our job and goes against the Code of Ethics of Peer Support Specialists. Organizations may have their own specific policy around staff communications. When there is a conflict between an organization policy and Peer Code of Ethics, PSSs make known their commitment to their Code of Ethics and take steps to resolve the conflict.

Boundaries Issues
The peer-client relationship can be very close, with both parties sharing intimate information. It is easy for boundaries to get confused and for people to get too close. When this happens the supporting relationship can become a dependent relationship. The goal of peer support is to assist the person served to become more independent over time, with success coming when they do not need to work with us any longer. PSSs should be careful about giving out their cell phone number, email address, home address, or any other personal information. This will help create healthy boundaries and give both parties personal space.

Abrupt Termination of Services
If your organization is working within a Critical Time Intervention (time-limited) framework and a client is not ready to graduate from services it can be problematic to end services abruptly after the predetermined amount of time has ended. It would be wise to address this possibility as a team and to develop guidelines early on that are aligned with your agency.

Self-Determination and Choice: Working with Clients on a "Bender"

There may be instances in which clients are putting themselves in risky situations and do not have their own best interest at heart. We see this critical issue occasionally faced by peer support specialists (PSSs) in their work with clients with active substance use and mental health issues. Because of the complexity of the decision regarding when PSSs might need to push the boundaries of self-determination and choice when working with clients with mental health and/or substance use issues, we put together a group of senior peer support specialists and peer navigators for a roundtable discussion on this issue. The group included a diverse group of participants who have different roles and approaches in the recovery field, and have familiarity with 12-step and case management approaches (see addendum).

We grappled with the question of how PSSs can best approach their work with clients who are in danger of losing their housing vouchers, or other similar negative consequences, because they are using substances aggressively or are on a "bender." When this occurs, some form of intervention may be necessary because clients are putting themselves in serious harm's way and the reasonable judgment needed for positive choices is compromised.

Can the PSS be involved in an intervention when the client is avoiding or refusing peer support services given that client self-determination and choice are central tenants of the peer support philosophy?

The first item roundtable participants requested was a working definition of "mandated peer support" and what it would look like. The consensus was that "mandated" peer support services should be provided only when the client does not possess the capacity to make logical choices and is at risk of serious negative consequences as a result. Further, decisions about intervening are always made with the best interest of the client as a human being in mind. It was then brought to the attention of the attendees that participation in MISSION is voluntary and that MISSION services are not forced or mandated.

After much discussion, it was agreed upon that the most effective way to proactively deal with the issue of "mandated" peer support services was to draft a written agreement with clients during or shortly after their enrollment in MISSION. This agreement should be created in tandem with the client, PSS, and CM, and should clearly state that the client agrees to accept more direct support and help from the MISSION PSS/CM team during times of crisis and impaired decision making. The written agreement should be clear and easy to understand.

There are several benefits to using this type of written agreement with clients, in addition to the primary goal of decreasing harmful consequences to clients during a crisis. Among them is that developing an agreement demonstrates to clients the MISSION team's strong commitment to them during future possible crises at the outset of the relationship. The use of this agreement sends the message to clients that the MISSION PSS/CM team understands that a crisis can happen and are confident that it can be worked through and resolved. The use of this agreement also prevents confusion and misunderstanding during a crisis as the circumstances warranting more PSS help, and

the interventions that the team will engage in are clearly documented, and can be referred back to at any time.

There can be very rare occasions that despite having signed the agreement, the client avoids or refuses PSS services at the time of a crisis. In this case, the client can continue to obtain MISSION services from his/her CM. The CM should review the crisis agreement with the client and remind him/her that peer support services are available at any time. The CM should also convey the expectation to the client that as he/she re-stabilizes, PSS services will resume. The PSS should try to maintain some open line of communication with the client, if possible, and remind the client that he/she is being thought of and is always welcome to re-engage. Included on the following page is a Sample Crisis Agreement.

SAMPLE CRISIS AGREEMENT

I agree to accept directive help and support from my MISSION team if I am in crisis and do not have the capacity to make logical choices due to the aggressive use of substances and/or an exacerbation of my mental health symptoms.

My MISSION team and I have worked together to identify and create the following list of high-risk behaviors that puts this agreement into effect. These behaviors are:

_____

_____

_____

_____

My MISSION team and I have discussed and agreed upon the following MISSION PSS and CM interventions to help reduce the negative impact of the crisis and keep me safe. The agreed upon MISSION PSS and CM interventions are:

_____

_____

_____

_____

When the crisis remits and I am making logical choices my MISSION team will no longer use this agreement. The following signs or behaviors indicate that my MISSION team can stop using this agreement.

_____

_____

_____

_____

I agree that the MISSION team may institute this contract if I am actively engaging in the high-risk behaviors identified above.

_____ _____

Client Date

_____ _____

Case Manager Date

_____ _____

Peer Support Specialist Date

INTEGRATING PEER NAVIGATORS INTO YOUR MISSION PROGRAM

Peer navigators (PNs) are a recent addition to the MISSION Program. Whenever a new position or component is added to a clinical treatment program it is a good idea to think ahead and to develop a "road map" for best integrating it into the program. The Simpson Transfer Model provides a simple guide for how this can effectively be accomplished. The model has four stages of action (see Figure 3), which can be used as a guide when adding PNs to a MISSION program.

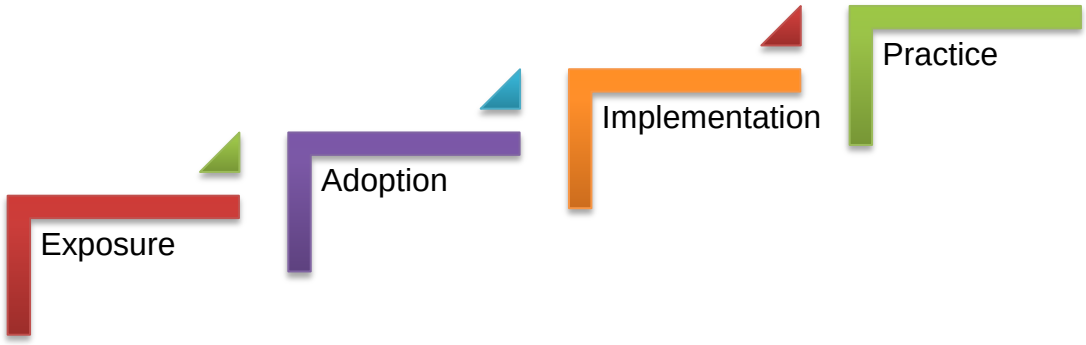

Figure 3. Simpson Transfer Model for New Component Integration

Here are important tips for each for these stages:

Stage 1: Exposure Tips

Identify an enthusiastic individual who can champion for the PN position and find new roles for the PN in the organization. Ideally, he/she has time allotted in his/her work schedule for these duties. The champion is encouraged to develop a 3 - 4 person team, to help provide formal and informal presentations to stakeholders. A PowerPoint on Advanced Peer Support Techniques for Peer Specialists was created for use during these presentations.

Stage 2: Adoption Tips

Once decided that a PN will be part of your MISSION program, several steps can be taken to ensure that the PN gets off to a great start.

1. Identify areas where needs exist or desired results are lacking, and determine how the PN can help fill these gaps and contribute to the overall goals of the program.
2. Offer to help write a brief statement of the contributions the PN(s) will make to the specific outcomes for MISSION clients.
3. Have individual discussions with administrators and stakeholders to discuss issues, such as the number of PSSs the PN(s) will supervise, how the supervision of each PSS may be shared between the clinical supervisor and PN, and who will supervise the PN(s).

Stage 3: Implementation Tips

In order to effectively implement the PN position, the creation of a local implementation team is recommended. The team typically consists of the program leader and 2 or 3 experienced staff. The team has many functions, which include: overseeing the hiring of the PN(s); meeting with staff to tailor the PN role to the specific program; reviewing documentation (e.g., official job description and posting); meeting with the organization's Human Resources Department to clarify questions; and ensuring that the hiring committee includes a representative(s) from each program (see Appendix A and B). Finally, once hiring is complete, it is essential to ensure that PNs are well orientated to the facility/organization and to the MISSION program, and that training and supervision are in place.

Stage 4: Practice Tips

Once the PN is hired, it is essential to have a system in place to monitor and give feedback to support performance. This system should include regular supervision and the tracking of documentation adherence and continuing education hours. PNs should be encouraged to obtain additional relevant certifications and leadership trainings (see Appendix C). Additionally, encouraging PNs to serve on committees and participate in other organizational events will increase their visibility and reinforce their value to the agency.

References

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Simpson, D. D. (2004). A conceptual framework for drug treatment process and outcomes. *Journal of Substance Abuse Treatment, 27*(2), 99–121. doi: 10.1016/j.jsat.2004.06.001

Appendix A: *MISSION PEER NAVIGATOR SAMPLE JOB DESCRIPTION*[1]

POSITION: MISSION Peer Navigator
GRADE:
REQUISITION:
DAYS/HOURS: Monday – Friday, 8:00-4:30pm
REPORTS TO: Community Support Program Supervisor
DEPARTMENT: Scattered Site Housing

LOCATION: 1 Maple Street, Boston, MA 1234 Scattered Site Housing/Various Boston Neighborhoods and Surrounding Cities

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SUMMARY OF POSITION:
MISSION provides comprehensive, intensive case management support to chronically homeless individuals with histories of substance use and mental health disorders using the Housing First model promoting long-term stability in housing and the end of homelessness in Boston.
The MISSION peer navigator works as part of an intensive case management team, serving individuals with active co-occurring substance use and mental health disorders. MISSION uses a harm-reduction, trauma-informed approach to working with clients, including the utilization of Stages of Change Theory, Critical Time Intervention (CTI), and Motivational Interviewing (MI) techniques, and the MISSION Model of clinical case management. The peer navigator provides guidance and support to peer support specialists (PSS) as the PSSs assist chronically homeless individuals with co-occurring mental health and substance use disorders, to identify and access housing, recovery support services, mainstream benefits, social services, and community-based resources. The peer navigator engages, educates, and supports the PSSs to provide culturally relevant support, drawing upon his or her own lived experience of homelessness and recovery from substance use and/or mental health disorders. The peer navigator also serves as an educator and consultant on peer support to administrative staff.

The MISSION peer navigator will perform four core functions:

1. Supervise peer support specialists,
2. Assist leadership team with strategic planning and systems brokering across agencies,
3. Help streamline Medicaid application processes, and
4. Deliver services for more complex cases

QUALIFICATIONS:
The person in this position must have a clear commitment to the population we serve, and be able to work as part of a team. The individual must have a previous history of homelessness; previous participation in mental health and substance use service systems as a recipient of service; must also

[1] This sample MISSION peer navigator job description based upon version developed by the Pine Street Inn, Boston, MA.

have a willingness to convey this experience; must hold certification through a recognized Certified Peer Specialist Program or Recovery Coach Academy; and have two or more years working as a peer specialist with individuals experiencing homelessness.

EDUCATION/TRAINING:

REQUIRED:

- High School Diploma or equivalent
- Peer certification through a recognized Certified Peer Specialist Program or Recovery Coach Academy
- Strong verbal and written communication skills
- Computer proficiency in Microsoft Office Products

PREFERRED:

- Bi-lingual – Spanish/English
- A valid driver's license in good standing

KNOWLEDGE/EXPERIENCE:

REQUIRED:

- Two or more years working as a peer specialist with individuals experiencing homelessness
- Prior experience conducting housing searches for vulnerable populations
- Experience facilitating peer support groups
- Understanding of wellness and recovery principles
- Knowledge of self-advocacy, self-help, and empowerment programs
- Thorough knowledge of the types and availability of public and private community-based resources and programs serving individuals experiencing both homelessness and co-occurring disorders
- Ability to establish, build, and maintain working relationships and links to the community
- Ability to set limits fairly and consistently while maintaining appropriate boundaries
- Ability to interact effectively and establish rapport with diverse groups of people of different ethnic, cultural, and/or socio-economic backgrounds
- Experience working as part of a team

PREFERRED:

- Experience working with chronically homeless individuals in Housing First and/or SAMHSA funded programs
- Knowledge of government benefits systems and local area service providers
- Experience with Homeless Management Information System (HMIS)
- Experience with Critical Time Intervention and Trauma-Informed Care

PHYSICAL ABILITIES/SKILLS:

REQUIRED:

- Ability to access different building locations and program sites via vehicle, public transit, and by foot, in varied weather conditions, including climbing several flights of stairs and lifting up to 50 pounds
- Ability to sit for long periods of time and use a computer, calculator, fax, copier, and other office equipment
- Ability to communicate professionally both verbally and in writing, and to successfully represent organization in various forums

MENTAL ABILITIES/SKILLS:

- Ability to juggle many competing demands and to prioritize work efficiently and effectively
- Ability to take initiative, plan, and work independently
- Interpersonal skills, patience, persistence, tolerance, ability to engage and develop rapport with a wide range of personalities
- Highly developed professional ethics, adherence to the Massachusetts Certified Peer Specialist Code of Ethics, and maintenance of appropriate boundaries
- Ability to contribute to the overall integration and success of the program as a team player, accept and offer guidance as appropriate, participate in PSS activities and trainings as requested, and promote organizational integration based on its mission, vision, and values

ESSENTIAL FUNCTIONS INCLUDE BUT ARE NOT LIMITED TO:

- Meet regularly with the peer support specialists, both individually and as a group, to train, support, and guide their work.
- Deliver Training Workshops with the clinical case manager that will be incorporated into statewide trainings on ending homelessness.
- Participate in relevant inter-agency task forces or advisory board meetings as directed.
- Support the clinical case manager and peer support specialist(s) to assist clients in successfully meeting the goals of the client-centered, strengths-based, individual service plans (ISP).
- Responsible for the coordination of outreach and engagement efforts to establish referral systems and resources.
- Support the development of self-advocacy skills and other strategies that promote recovery to clients served through education and the modeling of healthy lifestyle skills.
- Provide strengths-based interventions with clients experiencing psychiatric distress or other acute crises.
- Develop individually based crisis intervention plans with each client in order to reduce the number of hospitalizations and/or police responses.
- Intervene directly and/or cooperate with team efforts around crisis stabilization for clients.
- Maintain accurate written records and documentation in accordance with program standards including, but not limited to, ISPs, client charts, incident reports, detailed case notes and referrals, and third party billing, when applicable. Enter HMIS data as needed.

- Assists clients in completing medical, financial, and other forms of documentation that are necessary for housing services, MassHealth, primary health care access, and other social services, such as DMH and social security.
- Provide advocacy and brokerage services with community agencies and other resources, with the goal of supporting each client's personal growth, independence, and housing stability.
- Demonstrate initiative in exploring existing and potential resources for clients through the development of positive working relationships with service providers in the Greater Boston community.
- Actively participate in referrals and aftercare/discharge planning to and from treatment programs when appropriate.
- Attend regularly scheduled administrative, supervisory, and staff meetings, as well as in-house and external case conferences, and other meetings as needed.
- Participate in required and recommended trainings to enhance skills, and be vigilant about trainings and workshops that may benefit PSSs.
- Follow all Medicaid regulations and performance specifications, and submit documentation for covered MISSION services.
- Serves as a mentor to promote hope, resiliency, and empowerment.

SUPERVISION TO BE RECEIVED:
The MISSION peer navigator will meet regularly with the community support program supervisor.

INTERNAL CANDIDATES
IF INTERESTED IN APPLYING FOR THIS POSITION, PLEASE SUBMIT A PROMOTION/TRANSFER APPLICATION TO THE HUMAN RESOURCES DEPARTMENT WITHIN 10 DAYS OF POSTING.

This agency is an Equal Opportunity/Affirmative Action Employer.

Appendix B: *PEER NAVIGATOR SAMPLE JOB ADVERTISEMENT*

Overview

MISSION provides comprehensive, intensive case management support to chronically homeless individuals with histories of substance use and mental health issues using the Housing First model, promoting long-term stability in housing in the pursuit to end homelessness.

The MISSION peer navigator is a certified peer specialist or recovery coach who works as part of an intensive case management team that serves primarily homeless individuals with co-occurring mental health and substance use disorders. The peer navigator provides guidance and support to peer support specialists (PSS), as the PSSs assist chronically homeless individuals with co-occurring mental health and substance use disorders to identify and access housing, recovery support services, mainstream benefits, social services, and community resources. The peer navigator engages, educates, and supports the PSSs to provide culturally relevant support, drawing upon his or her own lived experience of homelessness and recovery from substance use and/or mental health disorders. The peer navigator also serves as an educator and consultant on peer support.

Responsibilities:

- Meet regularly with the peer support specialists, both individually and as a group, to train, support, and guide their work.
- Participate in relevant inter-agency task forces or advisory board meetings as directed.
- Support the clinical case manager and peer support specialist to assist clients in successfully meeting the goals of the client-centered, strengths-based, individual service plans (ISP).
- Provide support and services to a small caseload of high-risk clients with more complex cases.
- Maintain accurate written records and documentation in accordance with program standards.
- Attend regularly scheduled administrative, supervisory, and staff meetings, as well as in-house and external case conferences, and other meetings as needed.
- Participate in required and recommended trainings to enhance skills, and be vigilant about trainings and workshops that may benefit PSSs.
- Follow all regulations and performance specifications as required by Medicaid. Submit monthly billing documentation to billing department.
- Deliver Training Workshops to peer support specialists and clinical case managers explaining peer support techniques and how they work, to help further knowledge for PSSs, and assist agencies in proper integration of PSSs.
- Be familiar with resources and community agencies that will help support clients' personal growth, independence, and housing stability.

Qualifications

- High School Diploma or equivalent
- Peer certification through a recognized Certified Peer Specialist Program or Recovery Coach Academy

- Strong verbal and written communication skills
- Computer proficiency in Microsoft Office Products
- Ability to work cohesively as part of a team
- Two or more years working as a certified peer specialist, with experience working with homeless individuals
- Prior experience conducting housing searches for vulnerable populations
- Experience facilitating peer support groups
- Thorough knowledge of public and private community-based resources and programs serving individuals experiencing both homelessness and co-occurring disorders
- Ability to establish, build, and maintain working relationships and links to the community
- Ability to set limits fairly and consistently while maintaining appropriate boundaries
- Ability to interact effectively and establish rapport with diverse groups of people of different ethnic, cultural, and/or socio-economic backgrounds

Appendix C: *SUGGESTED TRAININGS FOR PNs AND PSSs*

Certified Peer Specialist Training
A training for peer specialists and people who have struggled with mental health, substance use, trauma, and other issues. This training teaches people a unique set of skills, tools, and approaches to work with others in the same or similar situations, to help them discover their own path to recovery. The training teaches skills such as effective listening, cultural awareness, using one's recovery story as a tool, how to advocate for change, and much more. Peer Specialist Certification is given upon completion of this rigorous training and the passing of a written and oral exam.

Recovery Coach Training
This training is very similar to the certified peer specialist training but is directed at people who have only substance use issues. One does not have to be in recovery to participate this training.

WRAP (Wellness Recovery Action Plan)
This is a peer-run training to help people design their own Wellness Toolkit. It is in notebook form that participants can refer back to at any time. It contains a daily maintenance plan; a list of friends or supports; a record of triggers and early warning signs; and a crisis plan. The crisis plan is especially helpful as once created it can be given, with permission, to important others who can help implement it if a crisis arises.

WHAM (Whole Health Action Management)
This is a peer-run training designed to teach skills to better address individuals' whole health (i.e., physical, mental, and spiritual) using a strength-based approach. In this training, instruction is provided on ten domains for whole health. These are:

1. Stress Management
2. Healthy Eating
3. Physical Activity
4. Restful Sleep
5. Service to Others
6. Support Network
7. Optimism Based on Positive Expectations
8. Cognitive Skills to Avoid Negative Thinking
9. Spiritual Beliefs and Practices
10. A Sense of Meaning and Purpose

In this training, participants set goals in one or more of these domains and use various supports to help attain them including weekly peer support groups and one-to-one peer support.

Leadership Academies
This consists of retreats, usually of several days duration, which teach participants to effectively advocate and facilitate services as well as other leadership skills.

Peer Group Facilitation Trainings
These are trainings that focus on the ins and outs to facilitating a peer support group.

Trauma-Informed Care
This is an approach that emphasizes physical, psychological, and emotional safety for the provider and the person served under the assumption that they have experienced some form of trauma. Within this approach, the individual is made to feel safe and the risk of re-traumatization is greatly reduced. This approach helps people rebuild their sense of safety, control, and empowerment.

Motivational Interviewing (MI)
A non-judgmental, non-confrontational, goal oriented approach to help one explore their ambivalence, and elicit and increase motivation for change. MI is person driven and uses four general processes.

1. Engaging- getting the person to talk and think.
2. Focus- narrowing the process down to what the person wants to change.
3. Evoking- eliciting motivation to change by increasing the person's confidence, awareness, and readiness.
4. Planning- developing a succinct set of practical steps to achieve his/her goal.

There are also additional available webinars and resources accessible at:

- https://inaops.org/free-webinar-series/- International Association of Peer Supporters
- http://www.samhsa.gov/- Substance Abuse and Mental Health Services Administration
- http://www.nyaprs.org/- New York Association of Psychiatric Rehabilitation Services
- http://motivationalinterviewing.org/- Motivational Interviewing

Appendix D: *STRUCTURED DRT SESSION TOPICS AND PEER-LED TOPICS*

13 DRT Session Topics, Led by Case Manager
1. Onset of Problems
2. Life Problem Areas Affected by the Individual's Co-occurring Disorder
3. Motivation, Confidence, and Readiness for Change
4. Developing a Personal Recovery Plan
5. Decisional Balance
6. Communication Skills Development
7. Twelve-Step Orientation and Recollections
8. Anger Management
9. Relapse Prevention
10. Interpersonal Relationships
11. Changing Unhealthy Thinking Patterns
12. Changing Irrational Beliefs
13. Activity Scheduling

11 Peer-led Session Topics, Led by Peer Support Specialist
1. Willingness
2. Self-acceptance and respect
3. Gratitude
4. Humility
5. Dealing with frustration
6. Handling painful situations
7. Significance of honesty
8. Courage
9. Patience
10. Medicine maintenance
11. Making a good thing last

Appendix E: ACRONYMS

Acronym	Phrase
ADL	Activities of Daily Living
CM	Case Manager
COD	Co-occurring Disorder
CPS	Certified Peer Specialist
CS	Clinical Supervisor
CTI	Critical Time Intervention
DMH	Department of Mental Health
DRT	Dual Recovery Therapy
HMIS	Homeless Management Information System
ISP	Individual Service Plans
MI	Motivational Interviewing
MISSION	Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking
PN	Peer Navigator
PSS	Peer Support Specialist
SAMHSA	Substance Abuse and Mental Health Service Administration
WHAM	Whole Health Action Management
WRAP	Wellness Recovery Action Plan

Appendix F: GLOSSARY

ADLs- An acronym for activities of daily living, such as shaving, showering, budgeting, and grocery shopping.

Bias- Unintentional or intentional preference, sometimes discriminatory.

Certified Peer Specialists (CPS)- People in recovery from substance use and/or mental health issues who have completed a rigorous training and passed a test certifying them in the state in which they took it. In this training they are taught a unique set of skills and tools which they use to support others who are in the same, or similar, situations.

Community integration- Working with individuals to comfortably introduce, or reintroduce, them into the community, or communities, of their choice.

Consumer advocate- A person dedicated to protecting and promoting the rights of others.

Co-occurring disorders (COD)- The existence of both mental health and substance use disorders.

CPS Code of Ethics- A written set of principles to help guide CPSs in the various roles in which they function. This is signed by CPSs and they are expected to adhere to these guidelines to the best of their ability when supporting others and with their colleagues.

Culturally relevant- Anything that is meaningful about an environment a person needs or wants to explore.

Harm Reduction Theory- An approach which uses practical strategies and ideas to reduce the negative consequences associated with risky behaviors. Some examples are needle exchanges, methadone or SUBOXONE programs, and condoms/dental dam availability. Organizations that institute this theory do not demand full abstinence, but rather meet people where they are at with the goal of reducing harm. You can find more information at http://harmreduction.org/about-us/principles-of-harm-reduction/

Homeless Management Information System (HMIS)- An information technology system used to collect data on the provision of housing and services to homeless individuals and families and persons at-risk of homelessness.

Housing First- A human services approach that provides homeless individuals with housing first and then addresses underlying issues. This is in contrast to other programs where individuals have to address issues and take other steps before getting housing. Housing First is guided by the premise that housing is a basic human right.

Lived experience- In recovery terminology, this refers to one's history in the recovery system.

Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking (MISSION)- A wraparound service intervention designed to meet the needs of those experiencing homelessness and co-occurring disorders.

Motivational Interviewing (MI)- A goal-oriented, client-centered approach that utilizes the Stages of Change Theory to help clients explore their ambivalence by strategically using skills such as asking open-ended questions, active listening, and reflecting. There is more information at http://motivationalinterviewing.org/.

Non-linear- Not a straight path.

Recovery Coach- A person who promotes recovery by removing barriers and obstacles to recovery, and serves as a personal guide and mentor for people seeking or already in recovery.

Resiliency- The ability to bounce back or recover.

Self-determination- A person's right to make their own decisions.

Stages of Change Theory- A model of behavior change which assesses an individual's readiness to act on new healthier behavior. There are five stages of change in this theory; Precontemplation, Contemplation, Preparation, Action, and Maintenance. When working within this model, MISSION team members are cognizant of which stage of change the client they are working with is in, and adjust their intervention strategies accordingly. A helpful website for more information is http://www.aafp.org

Stigmatization- Generic negative labeling of a group of people based on an assumed characteristic or trait.

Strengths-based- A practice that emphasizes a person's strengths rather than their deficiencies.

Substance Abuse and Mental Health Services Administration (SAMHSA)- The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance use and mental health on America's communities.

Transparent- Honest and open, non-secretive.

Trauma-Informed Approach- A model that maintains that providers should presume going in to every relationship that there may have been some form of trauma (e.g., use, neglect, loss, etc.) in the person's life and then act accordingly when meeting with them. Some examples are letting the person choose where to sit, leaving the door open during meetings, not coming up behind someone, not

hugging, and not touching without permission. You can find more information at http://www.samhsa.gov/nctic.

ADDENDUM

MISSION Peer Support Roundtable

March 17th, 2017

MISSION PSSs have raised the difficult question of how they can assist clients who are engaging in risky, potentially very harmful behavior and are refusing/avoiding peer support services, given that client self-determination and choice are essential ingredients of peer support. Because of the complexity of the decision regarding when PSSs might need to push the boundaries of self-determination and choice when working with clients in this situation, we invited a group of senior peer support specialists and peer support navigators for a roundtable discussion on the issue. Included were a diverse group of participants with different roles and approaches in the recovery field and familiarity with 12-step and case management approaches, who shared ideas and developed recommendations. The MISSION Peer Support Roundtable participants and minutes are presented below. We would like to express our thanks and gratitude to the participants for their thoughtful and insightful contributions.

Meeting Discussion

What happens when a client does not want peer support, but is not in the right frame of mind to make that decision?

List of Participants (Alphabetical)

Ian Farquhar, Clinical Research Assistant
Department of Psychiatry, University of Massachusetts Medical School

Jennifer Harter, Psychologist
Department of Psychiatry, University of Massachusetts Medical School

Jack Lynch, Addiction Specialist

Ryan O'Brian, Case Manager
East Boston Rehab and Health

Allen Ryba, Peer Specialist/Recovery Coach
Massachusetts General Hospital

David Smelson, Vice Chair of Clinical Research
Department of Psychiatry, University of Massachusetts Medical School

Paul Styzcko, Certified Peer Specialist Director
Boston Resource Center

Max Trojano, Clinical Research Assistant
Department of Psychiatry, University of Massachusetts Medical School

Robert Walker, External Consumer Engagement Liaison
Massachusetts Department of Mental Health

Charles Weinstein, Certified Peer Specialist Recovery Coach Program Manager
Partners Healthcare

Jocylyn Wender-Shubow, Coordinator
Department of Mental Health, Shattuck Hospital

Corey Williams, Case Manager
AdCare Criminal Justice Services

Roundtable Minutes

1. Introductions
    - David Smelson
        - Working to enhance peer support within MISSION
        - Peer support interventions sometimes enter a gray-area when clients do not want peers around
    - Allen Ryba
        - What happens when a client is on a “bender,” and denies peer support? Can peers still intervene?

2. Overarching question of the meeting
    - If client is about to lose voucher (or other item/service), can peer support be required?
        - Influence (Coercion) vs. choice
        - Losing a housing voucher (or other item/service) would be extremely detrimental to client, and would cause setback in recovery
        - If someone does not want to see program staff, do you continue to try to see them? Where do you draw the line?

3. What services does a client initially receive in MISSION?
    - Necessary to understand what the client is receiving before advising on interventions
        - MISSION is housing-first model that provides wrap-around services in a time-limited manner
            - Case managers and peer support specialists work together to provide care
            - Provide Dual-Recovery Therapy (DRT) sessions, and peer-led sessions
            - Provide community linkages for employment, healthcare, etc.

4. Do we have a working definition of “forced peer support?”
    - Mandated services with the best interest of the client in mind
        - Used only when client is not in a capacity to make logical choices (i.e., on a “bender”)
        - “We will work with you, but you must agree to peer support services.”

5. Can other resources be used first?
    - Perhaps peer support specialists should serve as a last resort?
        - Forced peer support is not truly peer support
            - If peer support is forced, client-peer relationship may become compromised
            - Peer support specialists should never do anything to break the client’s trust
            - Peer support specialists should never be put in an authoritative position

6. Counterargument: Peer support specialist most likely has a “special” relationship with client, and client may be more likely to accept services from peer support specialist, as opposed to a case manager or clinician
    - Reality is that peer support specialists are put in positions where they must use force/coercion more often than not
    - Peer support specialists may have more rapport with client than other clinicians, even though other clinicians may represent more appropriate interventions

7. Is it possible to bring the relationship back to normal after forced peer support?
    - In the end, the client must “want” to engage with the peer support specialist. Using force is essentially meaningless if the client will not openly converse with the peer support specialist
    - No consensus reached on this question

8. Housing-first model says you cannot intervene if a client does not want to be seen; yet MISSION promotes intervention. How do we reconcile this difference?
    - At some point, when someone is on the brink, you have to worry about them as a human regardless of what the official relationship is (i.e., model design, contract, etc.)
    - Peer support specialists should simply inform clients of their situation: “You will lose housing if you continue on like this,” but not use force

9. When do intervention attempts stop? To what extent do we press the client to allow intervention?
    - As long as they are not using force, there is nothing wrong with continued attempts to intervene

10. Need plan of action before crisis situation arises
    - Peer support specialist and client should have premeditated plan before crises arise

11. Model/contractual issues
    - Client signs contract before MISSION services are delivered

    - Contract ensures that client must accept services, regardless of the circumstances, so forced peer support in a time of crisis is circumvented because the client has already agreed
    - MISSION-Criminal Justice programs (i.e., MISSION model adapted for wrap-around services in specialty courts) have judicial consequences if contract is not upheld by the client
- Clarification: Not all MISSION programs involve jail diversion/court-ordered services
    - Client signs contract in all MISSION programs, but they are not necessarily court-ordered
- Peer support services should not be included in any of the contracts
    - Again, forced peer support is ineffective
    - Useful engagement must be of client's own volition
    - It would be better if MISSION was introduced in the following way:
        - Client must agree to meeting with case manager in order to receive MISSION. Additionally, the client will be told that a peer support specialist is available as a resource
    - Does this approach undermine the status of the peer support specialist?
        - No, this makes the peer more attractive to clients
        - Peer support specialists are now valued and respected in the field; this may not have been the case when MISSION was first developed (Hence, the idea to make case management and peer support required)
        - Speaking from experience, if I were a client and someone offered me the option to voluntary speak with a peer support specialist, I would be more compelled to do so than if the peer support specialist was forced upon me
    - If peer support was optional, we could then enhance the MISSION orientation to educate the client about the value of peer support
        - Give definition of peer support
        - Include more structured activates
        - Draft a crisis plan between provider and client

12. Conclusions: Potential solutions
    - Complete crisis agreement before services are delivered
    - Establish a clinical hierarchy
        - Some individual should be higher above the peer support specialist to intervene when necessary
        - Potential model
            - Have peer navigator or peer manager above the peer support specialist
    - Possibility of making peer support services a voluntary resource