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Using Organizational Change Strategies to Guide Peer Support Technician Implementation in the VA

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Abstract

Objective—Introducing clinical interventions into existing teams can be challenging because of provider resistance and lack of understanding about the new intervention. The VA mental health system is in the process of hiring "Peer Support Technicians" or PSTs—individuals in recovery from serious mental illness hired as clinical team members. The primary purpose of this article is to demonstrate an implementation process that has potential to improve the deployment of the PSTs onto existing clinical teams within the VA.

Methods—As part of a larger randomized trial called **PE**ers **E**nhancing **R**ecovery (PEER), research staff have been collaboratively planning the deployment of PSTs with three case management teams serving those with serious mental illnesses. Clinical staff were given significant opportunity to participate in defining the PST role. PEER staff took extensive notes during planning meetings about the discussions held and decisions made about the PST role.

Results—PEER and clinical staff discussed and came to a consensus on several elements that comprise the PST job including goals for employing PSTs, desired characteristics of PSTs, job duties, training to be provided to PSTs, PST access to medical records, supervision, boundaries, confidentiality, how PSTs are to discuss their mental illness with patients, and a sick leave policy.

Conclusions—It is critical to solicit and use input from team providers and leaders when establishing PST services. This approach can be a model to implement a wide range of clinical interventions in which existing providers and teams will be asked to do something new.

Keywords

Peer support; implementation; serious mental illness; case management

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Since 2005, approximately 165 "Peer Support Technicians (PSTs)" have been hired across VA medical centers, primarily on mental health clinical teams and at day treatment centers. Chinman et al. (2008) defined VA PSTs: " …[PSTs] draw upon their lived experiences to share 'been there' empathy, insights, and skills…serve as role models, inculcate hope, engage patients in treatment, and help patients access supports [in the]community (pgs. 1315–1316)." In 2008, the VA released the *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics* (Office of Mental Health, 2008), which lists the mental health services all VA facilities must provide. It states that "all veterans with SMI [serious mental illnesses] must have access to Peer Support (pg. 28)".

A review of PST research (Chinman et al., 2006) shows that PSTs can reduce inpatient utilization, substance use, social isolation, and symptoms by role modeling community living, enhancing social networks, and improving patients' adherence to, and participation in, treatment. Additional studies have shown that PSTs can be deployed with no ill effects, yielding clinical outcomes equivalent to non-PST staff. However, other studies (reviewed in Chinman et al., 2008)—both in and outside the VA—have shown that there are significant barriers to hiring and deploying PSTs on clinical teams including uncertainty about the PST's role and unequal treatment of PSTs in the form of low wages, lack of a career path, inadequate supervision, exclusion from treatment team meetings, and restricted access to medical records. These organizational challenges could undermine the effectiveness of PSTs.

The presence of these challenges is consistent with implementation theories which suggest that, in practice, new interventions are often not implemented as intended (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Rogers, 1995; Simpson, 2002). Thus, a framework based on how care delivery organizations adopt innovative practices—e.g., the Simpson Transfer Model (STM) (Simpson, 2002)—can help support deployment of PSTs. The framework specifies four stages: *Exposure* involves introducing and training in the innovation (i.e., PSTs); *Adoption* refers to an intention to try the innovation through a leadership decision and subsequent support; *Implementation* refers to trial use of the innovation; and *Practice* refers to routine use of the innovation accompanied by local tailoring and performance feedback. Throughout the stages, outside experts (i.e., who introduce the innovation) and local practitioners collaborate to tailor the innovation to local needs. This article is a case study describing how the STM was used to deploy PSTs on three VA clinical teams as part of a randomized trial.

METHODS

Overview of the PEER study

PEER (PEers Enhancing Recovery) is a cluster randomized trial testing the impact of PSTs on patient and team level outcomes involving six MHICM (Mental Health Intensive Case Management) teams that use the Assertive Community Treatment (ACT) model (Stein & Test, 1980). MHICM teams provide intensive, flexible community support that aims to reduce psychiatric symptoms, substance abuse, psychiatric inpatient use, and costs, while improving community adjustment, quality of life, and satisfaction with services. Previous research and the VA's practice of adding PSTs to case management teams provided a compelling rationale to choose MHICM teams as the setting to examine PSTs.

Determined at random from among MHICM teams at six urban VA medical centers, three teams receive PSTs (intervention) and three teams do not receive PSTs and continue with care as usual (comparison). Of the three intervention MHICM teams, Site A's MHICM team serves 72 patients and is staffed by five nurses, three social workers, two psychologists, a patient service assistant and a quarter time psychiatrist. Site B's team serves 45 patients, and is staffed by two nurses, two social workers, and a psychologist. Site C's team serves 65 patients, and has three nurses and two social workers. Despite different professional

backgrounds, the MHICM model specifies that all staff serve as generalist “case managers” with their own caseloads.

Despite variability in staffing and patient census, the VA requires MHICM teams to have the same entry criteria, program operation, and patient characteristics (veterans must have at least 30 psychiatric inpatient days or 3 psychiatric hospital admissions in the previous year, and have a primary Axis 1 diagnosis of mental illness). Therefore, the enrolled teams are very similar in terms of caseload sizes (range of 10 to 14), % of contact made in the community (84–97%), and amount of face to face contacts per week (1.1–1.7 contacts). All teams have high ACT fidelity scores (83–91, out of 100) (Teague, Bond, Drake, 1998). Patient characteristics are similar across teams: 2/3s of patients receive VA compensation, 20% receive SSI, and 85–90% receive some form of disability payment. The average Global Assessment of Functioning score at entry ranges between 39–45, the Brief Psychiatric Rating Scale at entry ranges between 41–49. The percent of patients with a psychotic disorder and those with a co-occurring substance abuse disorder at entry is 75–90% and 10–30% respectively (Neale & Rosenheck, 2005).

Procedures

Each intervention MHICM team used a STM-based strategic planning process (described below), led by the PI (XX) and each of the three MHICM team leaders, to tailor the PST intervention to local priorities. The PSTs intervention is implemented over 12 months at Sites B and C, and for 24 months at Site A. To date, we have completed the planning process with the three teams and have hired and deployed one PST on one of the teams for about one year.

STM Stage 1: Exposure

In Stage 1, incorporation of an innovation is facilitated by cooperation with organizational units that control resources and policies. For MHICM teams, this involves gaining support from MHICM team leadership and front line staff. In 2005, MHICM team leaders at all six sites expressed interest in deploying PSTs. After randomizing teams, we made presentations at the three intervention sites’ regular MHICM team meetings and answered questions about PSTs’ potential benefits, research evidence, and typical roles. Many of the questions reflected a misunderstanding of PSTs consistent with previous stakeholder assessments on the topic (Chinman et al., 2004). For example, several staff asked whether it was common for PSTs to relapse, violate confidentiality, or inappropriately develop dual relationships. We educated the staff and helped them begin to appreciate the potential contributions of those with mental illnesses.

STM Stage 2: Adoption

In Stage 2, the three MHICM team leaders randomized to intervention formally agreed to participate in the PEER project by having PSTs join their teams as staff, funded and evaluated by PEER. Individual discussions were held with each MHICM team leader concerning the broad outline of the PST role, number of PSTs per team, and that PEER funding would support full-time PSTs for the length of the project.

STM Stage 3: Implementation

In Stage 3, PEER research staff held a formal meeting, lead by the study PI (XX), with each intervention MHICM team to tailor the PST role, foster a supportive organizational culture for incorporating PSTs, and addressing barriers to PST implementation. In these meetings (2 at Site A, 1 each at Sites B and C), a notetaker took detailed notes on the discussion (Krueger, 1998). Data analysis involved organizing the notes into summaries of participant responses to various topic areas related to the PST job definition, allowing additional categories to emerge consistent with grounded theory analysis (Strauss, Corbin, 1990). The PI reviewed these summaries and collapsed notes across intervention teams to make one document—summarized below–containing all data, sorted by topic areas.

The STM states that cultivating an on-site opinion leader helps communicate the legitimacy of a new intervention. On each team, the team leader assumed this role. These individuals were the most knowledgeable about PSTs, the most supportive (especially initially), were our points of contact, and carried the authority to make final decisions impacting PSTs.

The Site A team started 18 months ahead of the other two teams in order to pilot the deployment of PSTs (Also at Site A, because of funding, we hired one PST for two years instead of hiring two PSTs for one year). At Site A, a PST “implementation team” was formed consisting of the MHICM team leader, two senior and influential case managers, and the project PI (XX). This group met twice to tailor the PST role to their team, with the project PI serving in a facilitator role (Kitson et al, 1998; Stetler et al., 2006, Rycroft-Malone et al., 2002). In this context, facilitation refers to the use of an external change agent to enable the uptake of new practices through support and action promotion. Facilitation involved presenting to the implementation team the key variables that are important to consider when establishing a PST position. We use the term “variable” because it connotes the idea that the topic of interest could vary based on the decision of those present (e.g., whether or not to grant PSTs access to medical records).

At these implementation team meetings, each variable was discussed and a consensus was reached. A summary of decisions was sent to the Site A MHICM team leader to ensure accuracy. Minor changes were made and a final version was circulated to all MHICM team members. Prior to forming the “implementation teams” for Sites B and C, PEER project staff made presentations about PSTs and the PEER project at two annual retreats for MHICM teams that included Sites A, B, and C. The PI also made individual visits to Sites B and C to prepare MHICM staff for the tailoring work. Unlike Site A, the implementation team meeting with Sites B and C included all members of the MHICM teams. However, the same process was followed: the PI facilitated a consensus-building process and presented a summary of decisions to the team after the team leaders made minor changes to an earlier draft.

RESULTS

Key points made and decisions reached regarding PST implementation from the discussions held with the teams are summarized in Table 1.

Goals for hiring PSTs

First, all teams agreed that PSTs should be involved in all aspects of MHICM service delivery, while also offering a unique type of service. The teams felt the PSTs would embody recovery and serve as role models. Starting the discussion with the MHICM team's goals helped establish a positive atmosphere and facilitated a consensus about the reasons to hire PSTs.

Desired characteristics of PSTs

Teams discussed desirable attributes for PSTs. For example, the teams preferred individuals with some previous work experience because they were concerned about candidates' level of professionalism (e.g., being punctual, appropriate dress). Many team members wanted candidates familiar with the VA and behavioral health service delivery, including experience running peer support groups. Also, the teams agreed there was no specific type of mental illness that was more desirable, but that the individual ought to have enough experience with mental illness to be credible with patients. The teams also believed that while having some experience with substance abuse would be helpful, having at least a year of sobriety would be very important. Similarly, experience with prior hospitalizations would be helpful, but very recent hospitalizations could signal that a candidate was not ready to become a PST.

All the teams raised the issue about hiring current or former patients of the MHICM team; some as a hypothetical question; others had a patient in mind. The PI shared that most guidance documents warn against employing *current* patients (e.g., Chinman et al., 2008). However, it was agreed that while challenging, it would be possible to hire a *former* patient. All teams wanted individuals who could drive given that most MHICM services are delivered in the community. Finally, all agreed that a prevailing hiring philosophy is to find candidates who can carry out the duties of the job regardless of background.

PST job duties

Clear role definition is critical as reports show that PST roles are often unclear, leading to poor implementation (Chinman et al., 2008). The overall sentiment of all the teams was that the PST would have all the privileges and expectations as any other MHICM team member. PSTs would be expected to perform all types of case management duties including delivering medication, accompanying patients to appointments (including with the team psychiatrist), developing recovery plans, meeting with patients individually, leading and co-leading groups, using their shared experience with patients to develop strong relationships, engaging patients into services, and helping other MHICM staff. These duties are consistent with previous PST descriptions (Chinman et al., 2006). Two exceptions were raised: 1) All teams believed that PSTs should consult other MHICM staff first about what activities to perform, becoming more self-sufficient over time. 2) The PST would not have his/her own caseload. All the teams felt strongly that the PST position was too new to assign primary case management responsibility to the PSTs. Also, it was believed that being a "floater" would allow the PST the opportunity to work with multiple patients more readily. Finally, some team members said that they must be vigilant for inadvertently using the PST only for tasks disliked by other team members.

Training

The MHICM teams and the PEER staff agreed that each would provide certain training prior to and after the PSTs' deployment on the MHICM team. Prior to the PSTs' start, the PEER project would bring in the Peer-to-Peer Resource Center of the Depression and Bipolar Support Alliance. The Center provides a 30-hour training program (and a certification examination) based on training programs throughout the U.S, including the highly successful Georgia model of Medicaid-reimbursed peer specialists (Sabin & Daniels, 2003).

Also prior to their start and provided by the PEER project, PSTs would receive a two-day training in Illness Management and Recovery (IMR, Hasson-Ohayon, Roe & Kravetz, 2007) by staff from the ACT Center of Indiana. "[IMR] is a standardized curriculum-based approach designed to provide persons with severe mental illness information and skills necessary for managing their illnesses effectively and working toward achieving personal recovery goals (pg. 1461)." While the Peer-to-Peer Resource Center would focus on general PST skills, the IMR training will provide a curriculum to follow in their work with MHICM patients. Given the potential for role confusion, PEER and MHICM staff felt that it would help the PSTs to have work they could "own" in addition to general MHICM duties.

Just prior to PST deployment, it was agreed that MHICM staff would provide training in all relevant VA policies and procedures, use of the VA's electronic medical record, how to address crises, and understanding the Peer Support Technician Code of Ethics.

At the time of deployment, the PEER PI-facilitator suggested having PSTs shadow MHICM staff. MHICM teams and the PI-facilitator modified a plan developed and used successfully by the Veteran's Integrated Service Network 3 Peer Support Training and Orientation Task Force of the New Jersey VA Health Care System (Sussner, personal communication, January 20, 2009). The modified "Shadowing Plan" stated that PSTs must accompany each MHICM team member on community visits and observe their interactions. The PSTs would do this until they log at least two day's worth of visits per MHICM team member, typically one month. This plan would provide an opportunity for the PSTs to become acclimated to MHICM work, forge relationships with staff, and meet the team's patients. In fact, it is actually standard practice on many MHICM teams for new staff—of any type—to do some shadowing of existing staff.

PST access to patient medical records

All MHICM teams agreed that PSTs should document their clinical contacts in the VA's electronic medical record. All teams reported that this documentation would be important for the PSTs' accountability and communication with other MHICM staff. Also, all agreed that another team member should be a "co-signer" on the PSTs' notes. Designated co-signers are notified by email and notes cannot be accepted into the medical record until co-signed. Teams at Sites A and C designated the MHICM team leader as the co-signer on all notes; the Site B team designated the MHICM clinician with the primary administrative responsibility for the patient in question as the co-signer.

Supervision

Like training, it was agreed that supervision would be addressed by a combination of PEER, MHICM, and ACT Center of Indiana staff. PEER clinical psychologists (combination of XX and XX) would provide an hour of individual supervision weekly with each PST. Supervision would address issues of fitting into the MHICM team, professional development, and clinical activities with patients. Over the first few months of employment, PEER supervision would also address other issues including communication techniques with patients and colleagues, methods to provide support to the client, disengaging from peer support relationships, and patient self-advocacy. These topics were chosen with input from MHICM staff and are not covered in depth in the Peer-to-Peer and IMR trainings.

MHICM staff would provide an additional hour of individual supervision weekly with each PST as well as informal supervision during weekly team meetings. This supervision would focus on helping the PSTs better understand specific patients, plan future contacts with patients, and meet all the MHICM responsibilities. Sites B and C also agreed that the initial set of contacts led by the PSTs —a minimum of two weekly IMR groups and three one-on-one sessions per week—should be observed by a MHICM staff member, who would highlight and address any areas in need of immediate improvement. Finally, ACT Center of Indiana staff would provide an hour of individual supervision weekly regarding the PSTs' work using IMR, tapering to an hour monthly after 4 months.

Boundaries

This topic generated significant discussion. All teams discussed the possibility that a PST could be living with or personal friends with patients currently receiving services from the MHICM team or have him/herself received treatment from MHICM staff who would now be a colleague. While all teams agreed that supervision was the best tool to resolve these difficult issues, some general guidelines were adopted. First, PSTs are not to work outside their agreed upon hours. Second, PSTs would be encouraged to be proactive and discuss the limits of their relationship with their friends before any specific issue were to arise. Third, given that the boundaries are much "looser" in the MHICM treatment model (e.g., staff visit patients in their home), it was believed that MHICM staff would role model how to navigate awkward situations (i.e., being asked for money). Fourth, the teams did agree to never hire individuals currently receiving services from their team and that PSTs should not have romantic or sexual relationships with patients served by the team. These situations present serious conflicts of interests and were agreed to be avoided. Finally, if a former patient was hired, it was agreed that the provider would not share any information with other staff about the PST which was obtained during therapeutic sessions when the PST was a patient. In turn, the PST would not share any opinions regarding the provider's therapeutic efficacy.

Confidentiality

All the teams wanted reassurance that the PSTs would be expected to maintain patient confidentiality. The PEER PI-facilitator provided that reassurance. All agreed that violations of confidentiality would result in disciplinary action equivalent to what other staff members would receive. Related to preserving confidentiality are instances when PSTs fail to relay information learned from a patient to the rest of the team as a way of establishing a strong

relationship (Chinman et al., 2006). It was discussed that PSTs should be advised against this practice upon their hire and to be vigilant for it in supervision.

Disclosure of PSTs' mental health status

One of the primary reasons for hiring PSTs is their experience of having a mental illness and successfully recovering from it. Yet some PSTs do not want to disclose their illness or their recovery, instead preferring to have their experiences inform their work more indirectly. However, many researchers and patients alike believe that it is only by discussing these experiences openly that the benefits of peer support can be achieved (Davidson, Weingarten, Steiner et al., 1997). All three MHICM teams believed strongly in the latter view and preferred hiring individuals who would be comfortable in appropriately disclosing details about their illness and recovery. Staff did discuss that supervision should help PSTs understand the difference between disclosing for the patient's benefit (appropriate) and disclosing for their own benefit (inappropriate).

Sick leave

All staff easily agreed that PSTs should be treated like any other staff person with regard to sick leave. This meant that PSTs would be responsible for their own health like all staff and that if for any reason their health impeded their ability to do their job, they would need to leave until they sufficiently recovered.

STM Stage 4: Practice

In Stage 4, full implementation is accompanied by performance feedback. To date, we have hired one PST (at Site A), who has worked for about 14 months. The performance feedback mechanisms instituted have been monthly meetings with the MHICM team leader, weekly PEER supervision of the PST, weekly supervision with the ACT Center of Indiana staff (that tapered to monthly after four months), two annual site visits made by the ACT Center of Indiana staff regarding fidelity to the IMR model, and two site visits made by the PEER PI.

Meetings with the MHICM team leader focused on integrating the PST into routine team operations. For example, PEER staff and the MHICM team leader discussed how the PST could start groups, collaborate with other providers, and enhance their skills. Regular contact between PEER staff and the MHICM team leader has been critical as the team leaders are "on the ground", providing feedback to the PEER team about the day to day experiences of the PST.

PEER supervision has focused on a mix of administrative issues and clinical issues with patients. ACT Center of Indiana staff supervision has been assisting with the IMR group started by the PST. ACT Center of Indiana site visits involved assessing and feeding back information about the degree to which the PST was implementing the IMR model with fidelity. The IMR supervision and fidelity report highlighted areas in which the PST could improve including recruiting of patients into IMR groups, helping patients develop and achieve personal goals, getting MHICM staff to reinforce the patients' goals, and making the IMR sessions more engaging.

PEER PI site visits to Site A included the whole MHICM team and addressed several topics including the contributions made by the PST to the team, challenges in working with the PST, and strategies to overcome those challenges to improve the PST's work. In these meetings, the Site A team universally reported that the PST was contributing to the clinical care of several patients and had developed strong relationships based on a common bond of being a veteran and an individual with a serious mental illness. However, they did report certain challenges, including the need to provide more structured oversight and instructions to the PST. Both the PST and the Site A MHICM team reported that they had good relationships with each other. To date, PEER is in the process of hiring two PSTs each at Sites B and C.

CONCLUSIONS

Hiring PSTs onto clinical teams involves making decisions about issues of which the teams' staff often have strong opinions. Many implementation theories suggest that failing to incorporate the input of local stakeholders can undermine implementation of any new practice—e.g., hiring PSTs in the VA. Therefore, we believed it was critical to solicit input from team providers and leaders when establishing PST services and again in an ongoing basis throughout PST implementation. As a guide, we used an organizational change model, the Simpson Transfer Model (STM). The STM specifies the actions needed to assess the local stakeholders' needs and preferences and collaboratively develop a plan to address those needs while planning for the new practice's implementation. This article describes how we used the STM process to begin the process of establishing PST services on three MHICM teams within the VA.

To date, the three MHICM teams, given the opportunity to provide input, have been extremely supportive. Site A has offered their PST concrete support and guidance while simultaneously allowing him/her enough autonomy to forge independent relationships with patients. Sites B and C have stated that they are excited about hiring PSTs. While it is too early to draw conclusions about the success of the PSTs, these positive attitudes are promising. There are three lessons we have learned regarding the deployment of PSTs.

Facilitation and local input

The meetings between PEER and MHICM staff allowed for each group to feel like they had their input "heard". PEER staff know the PST and implementation science literature; MHICM staff are experts in the local context, including what their patients need and want and what is possible given the confines of the MHICM guidelines. This process not only helped to ensure buy-in from the MHICM staff, but it also helped the PST roles to be tailored to the sites' needs.

Sufficient planning time

Having repeated meetings between PEER and MHICM staff was advantageous. This was evidenced by nature of the questions from the first meetings to the later meetings. The earlier questions focused on basic feasibility and often reflected misunderstanding of the PST role. Later, greater understanding and acceptance of PSTs was exhibited by the teams

as they asked increasingly more detailed and specific questions about the implementation and role of the PST.

Formalized planning

Also, based on experiences with Site A, the PEER staff modified the planning process somewhat for Sites B and C to be more formalized. Instead of an informal summary, the PEER staff summarized the key decisions made in discussions between PEER and MHICM staff into a participation agreement, which specified certain responsibilities for all involved. Team leaders for Sites B and C signed that agreement. The increased clarity about these responsibilities has been welcomed by both PEER and MHICM staff.

In sum, there are many documented benefits to hiring PSTs onto existing clinical teams. However, employing PSTs is new, especially in the VA, meaning that most of the mental health workforce may be only minimally familiar with PSTs and may have no experience in establishing PST services. As with all new efforts, resistance is likely. Thus, it is important to consider the various issues mentioned above ahead of time to effectively incorporate PSTs into existing services. Using the STM and holding discussions with existing staff illuminated the attitudes and preferences of the staff, which was important to consider when implementing PSTs on existing clinical teams. We believe that this approach can be helpful to facilities who have decided to deploy PSTs and useful to engage leadership who have not been predisposed to the idea. We also believe that this approach can be a model to implement a wide range of clinical interventions in which existing providers and teams will be asked to do something new.

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Table 1

Decisions regarding PST implementation

Variable	Decision by PEER and MHICM staff
Goals for Employing PSTs	• Should be involved in all aspects of MHICM • Will provide a unique type of services with a peer relationship • Can embody recovery and serve as role models and mentors.
Desired Characteristics	
Experience Level	• Previous work experience is desirable • Knowledgeable about the VA • Experience delivering behavioral health services, especially running peer support groups
Serious Mental Illness	• Specific diagnosis not important • Enough experience with mental illness to have credibility with patients
Substance Use	• 1 year sobriety at minimum
Hospital History	• Ideally, no hospitalizations in the past year
Former MHICM Patients	• Must not be currently receiving services from MHICM • Ideally, should be some time elapsed between discharge and hire • Would require close supervision to monitor potential issues
Drivers License	• Driving is an essential part of the job
Job Duties	• Case management utilizing recovery planning tools • Adjunctive role, not a primary clinician. • Active role and duties- anything that doesn't require a license
Training	
Provided by Contractors	• Peer-to-Peer Resource Center of the Depression and Bipolar Support Alliance • Illness Management & Recovery training
Provided by MHICM staff	• Charting and documentation • Crisis recognition: responding to a client crisis • Review of all relevant VA and departmental policies and procedures • Review of Peer Support Technician Code of Ethics, signed at job start • Peer support providers' role and responsibilities
Provided by PEER Staff	• Communication techniques with consumers and colleagues • Methods to provide support to the client • Disengaging from peer support relationships • Consumer self-advocacy
Shadowing	• Will accompany and observe team members on visits for first month

Variable	Decision by PEER and MHICM staff
	• Direct observation of all initial patient contacts by the client's case manager
Access to Medical Records	• Expected to document encounters- important for team communication. • Subject to same accountability as all that access charts • Progress notes reviewed by team leader/patient's case manager
Supervision	• Includes role plays, discussion about difficult problems, issues, situations • Biweekly by Illness Management and Recovery experts • Weekly by PEER Psychologist, MHICM Team Leader, within MHICM team meeting
Boundaries	• Never engage in sexual/intimate activities with the consumers they serve. • Never accept gifts from those they serve. • Never provide their home address to those they serve. • Never enter into business arrangements with consumers they serve. • Requires close supervision to monitor "grey areas".
Confidentiality	• Training in confidentiality and appropriate use of medical records. • Subject to same accountability as other employees. • Confidentiality issues reviewed on an ongoing basis in supervision.
Disclosure of Mental Illness	• Expected to be open to sharing mental health experience • MHICM Team leader will monitor appropriateness of disclosure
Sick Leave	• No differences from standard VA policy • Must be able to do the job with standard ADA accommodations, or take sick leave

Table 2

Certification curriculum for VA Peer Support Technicians

DOMAIN	SKILLS & COMPETENCIES
Personal Self-Development	Development of personal story.
	Personal Strengths
	Managing Personal Recovery
	Facing One's Personal Fears
	Managing One's Own Self-talk and Combating Negative Self-talk.
Recovery	Components of Recovery
	Stages of Recovery
	Peer Support Role in PSR
Peer Support Principles	Being a role model
	Instilling hope
	Being an Advocate
	Principal Duties of Peer Support Staff
Cultural Competence	Understanding how roles of ethnicity, race, spirituality, gender, sexual orientation, local community and other sub-cultures may influence recovery.
Communications Skills	Effective Listening & Asking Questions Skills
	Communication styles (pass/agg/assert.), and Verbal and Nonverbal communication
	Conflict resolution skills
Group Facilitation Skills	Basic Understanding of Group Dynamics and interactions
	How to Use Support Groups
Addressing Stigma	Managing Internalized Stigma
Understanding Illness	Major Psychiatric Conditions in DSM IV
Recovery Tools	Using recovery workbooks and other self help instruments
	Problem solving, using solution focused strategies
	Telling your personal recovery story, being mindful of who you're addressing
	Knowing community resources
	Self-help Groups
	Writing Recovery Goals & Plans
	Motivating people to use their dissatisfaction with their lives as an opportunity to create the one they'd like.
	Teaching how to manage self-talk and combating negative self-talk
	Facing One's Fears
Professional Development & Workplace Skills	Ethics
	Boundary Issues and Dual Relationships
	Working effectively with professionals on an interdisciplinary team.
	Working with your supervisor

DOMAIN	SKILLS & COMPETENCIES
Managing Crisis and Emergency Situations	Early Warning Signs of Illness' Symptoms Worsening
	Crisis Prevention, Using Resources Early