TO: Massachusetts Department of Mental Health C/O Jerome Collins
FROM: Massachusetts Peer Support community & our invested allies
RE: RFI, New Model to replace Community Based Flexible Supports, **COMMBUYS #** BD-17-1022-DMH08-8210B-16243

QUESTIONS
Section I: Integrated Team Model –

1. **What standards does DMH need to consider to safeguard and support peer roles on the Integrated Team, including job functions and supervision?**

Preamble: This collective response will focus solely on the issue of peer support as it will be implemented in the New Model. In writing this response, we recognize that the implications of the outcome of this RFR have the potential to affect ***all*** peer roles in the state. This is because:

- It is likely that whatever framework is established for peer roles in the New Model will influence how they are developed in subsequent contracts.
- It is no secret that the peer support community has struggled to find harmony within itself, and that conflicts have sometimes run high. There are many reasons for this, but one primary and driving reason is that lack of guidelines from the Massachusetts Department of Mental Health (DMH) regarding how peer roles are developed among its various service contracts has led to significant divergence between contractors in ways that have sometimes pitted peer supporters against one another.

  Peer roles have been shaped individually by organizations, and without full understanding of those roles or how to implement them in accordance with the Certified Peer Specialist (CPS) Code of Ethics or training and other core values. This has meant that, very often, peer supporters have two choices: 1) Either accept that they will need to work in a way that is inconsistent with their training and/or the integrity of peer roles or 2) Immediately begin pushing back against those that employ them. The latter option is understandably frightening because it can lead to loss of job or further sense of isolation in the workplace, and many people (understandably) choose a position that they believe will be most likely to preserve their job. However, this choice can then put them at odds with other people working in peer roles, and can lend itself to a trend of distortion of integrity that can lead us all further and further from where we truly hope to land.

Thus, we believe that guidelines from DMH (<u>if well informed</u> by the voices of people working in peer roles who have had the time, access to information, and experience to consider these issues fully) on these roles is absolutely essential to a peer workforce that is able to work collaboratively across the state. We are also well aware that the opportunity to affect the most basic expectations of contractors where peer roles and the New Model are concerned will likely not come around again for perhaps another decade, and as such, the time to act is now.

The Mistake of Integration: We would like to begin by addressing the opening statement embedded in the RFI:

"Given that the integrated team will ensure that the full complement of services are available to all individuals and that the team will continue to serve individuals as they move between settings…"

We would like to be clear that this is an assumption that we do not believe to necessarily be true. It has not been demonstrated to be accurate in practice across the state, and integration onto teams has served as a substantial barrier to integrity where peer roles are concerned. What actually contributes to access for *any* role includes (but is not limited to):

- adequate and consistent training and supervision for employees,
- adequate funding leading to the ability to hire enough well-trained, qualified employees to each role and then retain them,
- minimizing paperwork and other administrative tasks that detract from ability to focus on the human part of the job, and
- clarity about mission and priorities, so that people can focus on doing their job well.

As aforementioned, integration is a particular risk when it comes to peer roles. In fact, we have seen peer roles be most successful under the following models:

- Peer roles sub-contracted by the clinical/traditional organization out to a peer-run organization that then trains, hires and supervise those roles and supports them to go back into that organization to offer peer support
- All peer roles in an organization coordinated as a part of a 'peer team' where hiring, training, supervision, meetings (etc.) are concerned, and then each person in a peer role is assigned to particular areas or tasks within the organization that they go out and do for the bulk of their day (while still maintaining membership with that peer team)

Essentially, what we believe is generally most effective is the *opposite* of integration, at least where peer roles are concerned. However, this is not to be confused with a role that is not fully visible and accessible within each organization. That is a goal that we share with DMH, and what follows are our best recommendations at achieving that aim.

Supporting Peer Roles: Peer support is based on the idea of commonality or shared experiences. However, peer support is not simply about how each person in a relationship identifies individually, but also how they interact with and relate to one another. In that regard, it is essential to remember that true peers (in any context) do not hold power over one another, and both have the capacity to learn from and be impacted by each other (mutuality). This understanding (often lacking in environments where peer roles are employed) is essential to understanding what a peer role should look like, or how best to support it. In order to adequately support the peer role in the New Model, at a minimum, here is what must be included:

- **Ratio**: There should be a minimum of 1 FTE of peer roles per every 30 people receiving supports at a given organization. In organizations where ratios result in fewer than 5 FTEs of people working in peer roles, that organization should be required to support paid time for those employees to network, consult with and otherwise receive additional support from other peer-oriented groups (Recovery Learning Communities, etc.).

- **Payrate**: In order to attract and retain a high-quality peer support workforce (and move the system further away from the myth that peer roles are low-skill, entry level positions designed primarily for the rehab of the individual employed), the pay scale should be set with a starting point for direct peer support that reflects the abundance of life experience that they are bringing. The starting rate should be no less than $15.00 per hour (more in areas where cost of living is highest, with financial recognition given for completion of core trainings like CPS).
- **Supervision**: All organizations should offer leadership roles within the peer support framework, so that people in peer roles are supervised by people who have worked and been trained in peer support. (This also helps to create a ladder for potential job growth.) At a minimum, individuals supervising peer roles should be required to attend an approved training specifically focused on understanding and providing oversight for peer roles. Generalized training on peer roles should also be provided to all employees at the organization to help reduce the potential for a hostile work environment that can result when a role is misunderstood and an employee becomes isolated or devalued.
- **Training:** All organizations should be required to provide paid time and support for individuals in peer roles to seek outside training and networking opportunities on an ongoing basis, even if that support is more limited for other roles in the same organization. No organization in the New Model will be equipped to provide all (or even most) training or networking support internally. Most other roles provide an internal opportunity for shared learning and networking because of the sheer numbers of other people employed in those roles, and/or because the organization has many years of experience with that role. Neither is true in the case of peer roles, and this sort of training and networking is essential to developing and retaining a highly qualified peer workforce.
- **Code of Ethics**: All organizations employing peer roles under the New Model should be required to demonstrate how they will shape those roles in a way that is consistent with the Massachusetts Certified Peer Specialist Code of Ethics. We are not aware that any other professional would be asked to work in a way that is in conflict with their Code of Ethics, and it is essential that people in peer roles also not be asked to do this.
- **Core Tasks**: There has been a general lack of clarity across Massachusetts organizations about what someone working in a peer role can and can't be asked to do. In order to demonstrate clear understanding, organizations should be required to submit job descriptions that are specific to the peer role. They should also be asked to demonstrate that they understand that the following tasks are
    - **Participation in the Medication Administration Program**: Although it is reasonable that someone in a peer role may (upon request of the person receiving supports) assist with learning about different treatments, thinking through how to approach doctors with specific requests, and so on, there is never a time when someone in a peer role should be responsible for any part of the MAP program or attending a MAP class, up to and including delivering pre-packaged pills. At a minimum, this conflicts with #10, Dual Roles, CPS Code of Ethics.
    - **Participation in a Rep-Payeeship Arrangement:** Although it is reasonable that someone in a peer role may (upon request of the person supported) assist with

learning about their rights, think through steps they may want to take to become more independent with their money, learn skills like bill paying, etc., at no time should someone working in a peer role be responsible for anything related to a rep-payeeship arrangement, up to and including delivering related daily funds. At a minimum, this conflicts with #10, Dual Roles, CPS Code of Ethics.

- **Routine Notes:** Although it is reasonable that someone in a peer role may take their own notes for the purpose of memory, scheduling, etc. (just as someone receiving services might also do), at no time should someone in a peer role be responsible for writing routine notes about someone, especially notes that would go in a paper or electronic file or otherwise become a part of a permanent record. At a minimum, this conflicts with #7, Respect for Privacy, CPS Code of Ethics.
- **Completing Treatment Plans or Assessments:** Although it is reasonable that someone in a peer role (upon request of the person receiving services) might support someone to think through what they want to put on their treatment plan, or even attend a treatment planning meeting with that person, at no time should someone in a peer role be responsible for leading this process or participating in any way that is not guided and initiated by the person receiving supports. At a minimum, this conflicts with #10, Dual Roles, CPS Code of Ethics.
- **Reading Files or Notes:** Although it is reasonable to share with someone in a peer role if there has been a recent incident of violence or other notable issue with immediate implications (just like one might with any other human being in proximity), at no point should a person in a peer role be expected to routinely read files or notes on a person or otherwise receive information about them. At a minimum, this conflicts with #7, Respect for Privacy, CPS Code of Ethics
- **Attendance at Meetings:** Although it is reasonable (and even desirable) for individuals in peer roles to be included in best practice, advisory, quality management, and policy setting meetings (etc.,), at no time should people in peer roles be expected to attend meetings where individuals receiving services are routinely discussed when they are not also present and/or have requested the presence of that peer supporter. At a minimum, this conflicts with #10, Dual Roles, CPS Code of Ethics.

Participation in any of these tasks represents a violation of the CPS Code of Ethics and a disconnect with the overall mission and values of peer roles. Participation in these activities causes serious mission drift, and dramatically reduces the efficacy of the people attempting to provide this support. Participation in these activities are also precisely what leads to peer roles being less available or inaccessible to people receiving services (because they are being pulled into other tasks that take them away from people, and/or because they no longer even look like peer roles, etc.).

What we are seeking is in line with national peer specialist guidelines (see: na4ps.files.wordpress.com/2012/09/nationalguidelines1.pdf), and consistent with what research tells us lead to the best outcomes (see http://www.psresources.info/the-evidence and local

outcomes from Advocates). We do not make these requests frivolously or without deep consideration based on research and many years of first-hand experience among us.

We thank you for your time and consideration.

On behalf of the Massachusetts peer support community by the 134 undersigned individuals (**please note**: Some individuals were not permitted by their workplaces to list their agency affiliation) and 9 organizations,

Signatures omitted for privacy of signors