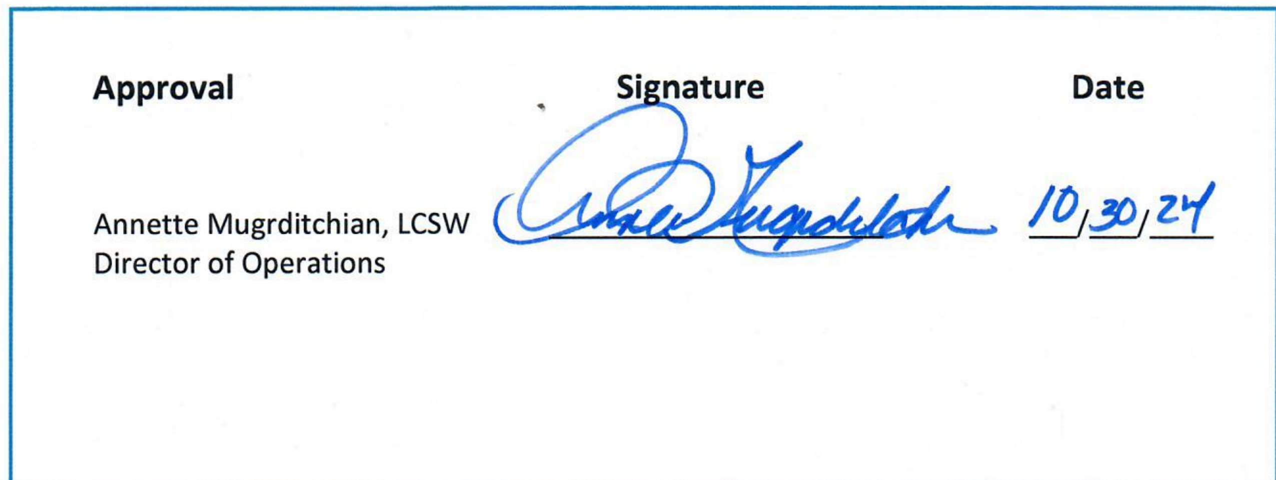
Behavioral Health Services (BHS)

Supervision of Peers Practice Guideline

Fall 2024



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Introduction

Purpose

Peer supervision is a collaborative relationship between two professionals; one having a greater degree of specific knowledge and skill helping the other with the goal of enhancing professional competence and evidence informed practice to benefit care to the individuals and families being served. Supervision is a distinct professional competency that requires specialized training and knowledge. This Practice Guideline is intended to provide a framework to inform peers and peer supervisors, as well as to differentiate the scope of a Peer Supervisor's role versus a Clinical Supervisor's role.

Intended Audience

Those in supervisory roles of peers who provide services to individuals and families served within HCA's County or county-contracted behavioral health and substance use disorder programs are the primary audience for these guidelines.

Definition of Terms

A **Peer** (used interchangeably with "supervisee") is a professional who provides services based on shared understanding, respect, and mutual empowerment between clients in similar situations. Peers provide a wide range of services including, but not limited to, advocacy, rehabilitation services, substance abuse counseling, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting and more. Peers may be volunteers or staff who may require supervision to perform activities related to planning, developing, and evaluating behavioral health services and support for individuals and groups and to provide liaison between clients and service providers.

Peer Supervision is a professional and collaborative activity between a supervisor and supervisee in which the supervisor provides guidance and support to the supervisee to promote competent and ethical delivery of services. Peer Supervision differs from Clinical Supervision in that clinical supervision is targeted to those who are in the role of a clinician, psychiatrist, or psychologist. In addition, it differs from that of Clinical Supervision in that peers do not operate under the supervisor's clinical license.

Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential.[1]

Resilience is "the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress, such as family and relationship problems, serious health problems or workplace and financial stressors. It means 'bouncing back' from difficult experiences."[2]

Peer Supervisor is a departmentally designated staff member meeting the educational and professional requirements who monitors, evaluates, mentors, collaborates, and develops specific competencies of peers under supervision.

Trauma can refer to a single event, multiple events, or a set of circumstances experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being.[3,4]

Trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations.[3,4]

Background

Development of Guideline

This Practice Guideline was developed by the Behavioral Health Services (BHS) Practice Guidelines Workgroup, which is a committee of clinicians, peers, supervisors, psychiatrists, and BHS managers who represent all BHS areas [i.e., Adult and Older Adult (AOA), Children and Youth Services (CYS)]. The Practice Guidelines Workgroup was developed to create and standardize clinical practice guidelines within BHS. The Guideline was developed based on a review of the literature and other popular research sources (e.g., internet websites) in the field.

Selection of Evidence

Existing practice guidelines developed by state and national associations were used as resources in the development of this Practice Guideline. Journal articles referencing established guidelines were also included. All resources used were published in the early 2000s to the present.

Documentation of Need

With the growth of the peer workforce in behavioral health and the recent passing of Senate Bill 803, there is a growing need for standardization in how peers are trained[5] and supervised.[6] In 2007, for example, the Centers for Medicare and Medicaid Services stipulated for *each* state to impose their own training and certification requirements.[6,7] Although the Substance Abuse and Mental Health Services Administration (SAMHSA)[8] has since developed nationally identified core competencies pertinent to peer support, each behavioral health system is expected to develop guidelines specific to their context and workforce. Developing clear peer supervision guidelines aims to meet this need within the BHS system of care.

Given the unique roles peers hold within behavioral health services, it is important to offer distinct guidelines from traditional clinical supervision to supervisors on how to support peer workers. Specifically, peer workers are part of the paradigm shift in behavioral health that recognizes the importance of "recovery-oriented" care, where the goal is to maintain long-term recovery past the acute crisis[9] by empowering and actively involving peers' lived experiences into the recovery process. By contrast, traditional mental health aims to treat and control mental health symptoms[9]. This point is compounded by the fact that supervision of peers is often provided by licensed professionals trained within a mental health model and who may be less familiar with the recovery-model that peers operate within. This may result in role conflict and ambiguity among peers, clinicians, supervisors, and clients.[10,11] It is therefore imperative to offer peer-specific guidelines that are distinct from clinical supervision and consistent with the principles of recovery for clinical supervisors.

Moreover, having the necessary systemic infrastructure in place for peer workers (i.e., trained and supervised well) will ensure clients and families receive the most effective "evidence-based mental health model of care." [7] In fact, the benefits to clients of receiving effective peer supports are well documented in the literature. Several studies have demonstrated improvements in client feelings of empowerment, self-esteem, and confidence[12]. Randomized control trials have shown peer services to be cost-effective by way of shortening enrollment length and reducing re-enrollment rates.[13,14,15] In addition to client benefits, peer workers themselves can experience notable benefits in their own recovery, such as improved self-esteem, confidence, and decreased self-stigmatization in their own recovery.[16] The added benefit of integrating effective peer services is heavily dependent on the quality of supervision and guidance offered to the peer workforce.

Justification

Overall, research suggests that inclusion of well-trained and supported peer workers result in multiple benefits for clients, peer workers, and organizations.[6,17] Although there is a widespread agreement on the importance to uphold to a peer-specific supervisory standard, there is a paucity of formal guidance in place in our system of care. The Peer Supervision Practice Guidelines are a resource applicable BHS-wide for supervisors overseeing peer worker services.

Consistency with Policies, Regulations, Laws, and Professional Standards

Practice Guidelines are expected to meet the following requirements: be based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field; consider the needs of the individuals and families served across BHS; be adopted in consultation with contracting health care professionals; and be reviewed and updated periodically as appropriate. A Guideline differs from a Professional Standard, which is mandatory and, thus, may be accompanied by an enforcement mechanism. A Guideline is not mandatory, definitive, or exhaustive. This Practice Guideline is intended to be aspirational, with the intent to facilitate continued development of professional practices and to promote high quality services. This set of guidelines may not apply to every professional or clinical situation within the scope of the Guideline. As a result, the Guideline is not intended to take precedence over professional judgment. These guidelines are meant to provide consistency with other HCA policies, the Office of Compliance, and any state or federal regulations to which HCA is already adhering. Federal and State laws supersede these Guidelines.

Guideline

Guideline Statement

This Practice Guideline highlights recommendations drawn from established practice guidelines from state and national associations. Its primary purpose is to educate professional staff and to identify well-supported practices to help guide the provision of high-quality services. These Guidelines are designed to educate about desirable professional practices, to suggest or recommend specific professional and personal behavior, and to guide performance. Applications for the use of this Practice Guideline are outlined and include the following common elements of peer supervision: supervisor competence, supervisory relationship, professionalism, logistics, and ethical considerations/confidentiality.

Applications

Qualifications for Supervisors of Peers

In accordance with existing State of California qualification guidelines,[23] BHS expects those in a supervisory role of peers to meet the following requirements:

Option 1

- Have a Medi-Cal Peer Support Specialist Certification; and
- Have two (2) years of experience working in the behavioral health system; and
- Have completed an approved supervisory training.

Option 2

- Be a non-peer behavioral health professional, including registered or certified substance use disorder counselor; and
- Have worked in the behavioral health system for a minimum of two (2) years; and
- Have completed an approved supervisory training.

Option 3

- Have a high school diploma or general equivalency degree (GED); and
- Have four (4) years of behavioral health direct service experience, which may include peer services; and
- And have completed an approved supervisory training.

Functions of the Supervisor

A common way to categorize supervisors' various responsibilities is to align them under the headings of *Administrative, Educative, or Supportive.*[18,19] Each department within BHS is unique and may have a supervisor fill one or multiple of these supervisory tasks:

Administrative supervision focuses on effective implementation of a program's policies and procedures as well as management of the peer's performance. This could include the peer's quality of work, their workload, being a liaison to administrative operations (i.e., payroll and human resources), effective use of program resources (including time management), program model fidelity, and record keeping.

Educative supervision focuses on professional development of peers through training, modeling, and provision of structured learning experiences. Educative supervision may include providing appropriate opportunities to reflect on peer practice, focusing on knowledge, skills, and attitudes, providing individualized support and learning, and providing avenues for peers to develop professionally.

Supportive supervision focuses on the morale and job satisfaction of the peer and can include providing feedback on their work, discussing personal reactions to work, providing validation and encouragement as appropriate, promoting self-care practices, and advocating for the important roles that peers can play in a behavioral health system. Supportive supervision focuses on encouraging a peer to perform their job to the best of their capabilities.

Determining Supervision Format

The frequency and duration of the supervision should be established before the supervision process starts. In addition to regularly scheduled peer supervision, supervisors should be accessible and provide timely response to peer supervision requests from the supervisee (e.g., crisis situations, consultations on child or elder/dependent adult abuse reporting). The supervisor should discuss coverage plans with the supervisee for occasions when the supervisor is absent or otherwise unavailable. Each program may offer different formats depending on their program, needs, and staffing.[19]

- Individual Supervision
    - Individual supervision has several advantages, including the ability to provide exclusive attention to a peer; peers often experience this format as safer, and it provides greater confidentiality. Additionally, individual supervision may afford opportunities for shadowing[20] where either a supervisor observes a peer during a meeting with a client or vice versa. This effective form of supervision allows for in vivo learning that is more objective and often leads to a quicker pace of learning. Disadvantages of this format are that dependence upon a supervisor could form, peers are only exposed to one perspective in supervision, and the opportunities to learn from colleagues may be limited.

- Group Supervision
    - The advantages of group supervision include shared information and greater exposure to different perspectives, cohesiveness among peers and reduced isolation, and more efficiency in supervision for supervisors overseeing multiple peers. Group supervision can also be a supportive avenue for peers to develop their confidence within a safe, supportive, and structured setting.[21] Disadvantages of group supervision for supervisors to be aware of include that peers may feel unsafe or uncomfortable working and sharing in a group, and peers may find it difficult to have their specific needs addressed. Supervisors must also be able to balance the group to ensure that each member is getting relatively equal time.[22]
- Co-supervision
    - This format of supervision involves more than one supervisor and can be utilized when an organization does not have supervisors who are peers themselves.[22] For example, peers may benefit from a second supervisor who has more expertise with peer work where the other supervisor may provide more administrative supervision. Advantages to co-supervision include that peers benefit from the guidance and support from multiple supervisors and that they can develop their competencies with a supervisor skilled in the competencies of peers. Disadvantages or special considerations with this format may be that some agencies lack the resources to offer co-supervision and supervisors need to be aligned with their communication and expectations for peers which may take additional time.

In an effort to ensure that all established guidelines are being met, supervisors should establish a written agreement, with the supervisee at the onset of the supervisory relationship. Examples of supervision agreements are provided in the Quick Guide. It is recommended that a Supervision Agreement include:

- Responsibilities and expectations of both parties and of the program
- Programmatic goals
- Supervision structure, including frequency and duration
- Limits of supervision responsibility
- Learning objectives
- Measurable goals that are mutually agreed upon
- Specific guidelines to evaluate the supervisee's performance
- Setting a timeframe with objectives that will trigger the need to evaluate progress and possibly set new goals, responsibilities, and expectations

The recommended best practice is weekly 1-on-1 individual supervision, and no less than once a month. For group supervision, it is recommended that the peer follow the frequency that has been established by the program and service area and prioritize attendance.

Fundamentals of Peer Supervision

This section focuses on some of the fundamentals of supervision that are generally more unique to those who supervise peers. In an effort to stay up-to-date and engaged in high-quality supervision, supervisors should participate in training and stay abreast of the latest research on peer work and recovery[18]. Supervisors are also encouraged to participate in regular consultation with other Peer Supervisors to discuss and problem-solve issues that arise during peer supervision and to continue to develop their skill set in facilitating peer supervision.

In accordance with the State of California's requirements for supervisors of certified peer support specialists,[23] this workgroup recommends that all supervisors of peers complete the required training for supervisors within 60 days of beginning to supervise a peer staff. In addition, it is highly recommended that all supervisors also complete the training "Recovery Practices for OC HCA Leaders," offered annually through Behavioral Health Training Services.

Understand Peer Roles and Practices

Supervisors should understand the variety of roles and practices that peers can engage in at their program. Some examples of roles and practices for peers include providing rehabilitative services, community outreach, mentoring, and resource coordination. To best support peers in their roles and practices, it is critical that supervisors understand the core competencies set forth by SAMHSA.[18]

Supervisors Have a Recovery Orientation and Model Recovery-oriented Practices[18]

Peers serve a unique role in a behavioral health system in that they utilize their experience and knowledge of personal recovery to assist others in a supportive manner. This method of service delivery has been found to help reduce many of the common barriers to accessing and adhering to treatment for individuals including stigma, a lack of trust or distrust of medical and behavioral health professionals. It has been also found to help reduce the perception that professionals may not understand their personal experience and a dissatisfaction with the general approach of the medical model where one presents with symptoms and professionals address those symptoms.[24] According to SAMHSA, the Recovery Model is based on the understanding that recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential.[25] The recovery process is a personal one and characterized by continual growth that may involve setbacks, when resilience becomes a highlighted component of individualized recovery. Additionally, a recovery orientation encourages supports and services to be flexible as what works for one person may be very different than for another and actively address diversity in service delivery while seeking to reduce disparities in healthcare access and outcomes.[25]

Since effective peer work is hinged upon authenticity and integrity, supervisors of peers should model recovery-oriented practices for peers, including demonstrating belief in peers' ability to grow and develop professionally with individualized goals, framing challenges, or setbacks as opportunities for growth, providing structured learning opportunities that are strengths-based, and advocating for recovery values.

Further, supervisors can model taking a holistic view of a person, viewing them beyond their diagnosis and/or addiction and demonstrating respect for and a belief in the value of each individual. Supervisors can also authentically support peers by assisting them to address issues of poverty, trauma, and discrimination, as peers would be expected to do with their clients. Teaching should be based on an understanding of what the peer is already capable of, including their strengths and goals, and then instructing them on the skills they need to successfully execute their work tasks. Evaluation of performance should be done in collaboration with peers.

While self-care is an essential practice for any provider in a behavioral health system, peers are asked to engage in their work with clients in an even more personal manner, sharing their personal recovery experiences to motivate others to engage in recovery. Although peers should not be considered more "fragile," their wellness and success can be encouraged not just by a supervisor stating the importance of self-care, but actually modeling it for their supervisees.[20] This could look like a supervisor setting healthy boundaries with their time, demonstrating ways that they leave their work at the office, sharing rituals that they utilize for "taking the day off" when they return home, setting time aside for reflection or debriefing, or structuring mindfulness-based activities in their day. If peers are expected to model recovery for their clients, then it is incumbent on supervisors to model the same for those whom they supervise. Supervisors should also monitor and teach peers to monitor compassion fatigue. One useful self-assessment tool that individuals or teams can use to assess and track the positive and negative effects of providing help to others is the ProQOL.[18]

Trauma-informed Supervision (See OC HCA TIC Practice Guideline for Trauma-Informed Care Workplace and Practice)

As consumers of behavioral health services, it is not uncommon for peers to have had some experience of trauma in their past. As such, supervisors should maintain a trauma-informed approach when working with peers that is based on SAMHSA's 4 Rs[26] and the principles of safety, choice, collaboration, trustworthiness, and empowerment.[27] The 4 Rs state that a trauma-informed approach:

- Realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma in individuals and families served, staff, and others involved with the system of care
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices
- Resists re-traumatization

A trauma-informed workplace prioritizes development of trusting relationships and addresses behavior with positive and compassionate approach. Supervisors will likely find that an ongoing, inquiry-based process allows for teamwork, coordination, creativity, and sharing of responsibility. A trauma-informed approach to supervision focuses on strengths and previous experiences of resiliency that can be applied to the present and future.

Intensify Support During Times of Vulnerability[20] – Transitioning into new roles, experiencing significant changes in one's life, or experiencing anniversaries of traumatic events are often periods of increased vulnerability. While the supervisory relationship should never be considered a therapeutic one, supervisors may also encourage supervisees to recognize times of potential vulnerability that they may need to intensify their engagement in their recovery, their support, and consider seeking additional supervision or consultation around.

Strengths-based Supervision

Strengths-based supervision is a collaborative process between the peer and the supervisor that enables the delivery of high-quality services and supports that build upon the peer's strengths and assets.[18]

Supervisors should actively seek to discover and highlight the peers' strengths and competencies, even if they do not appear immediately relevant to their current work assignment. Previous successes, no matter how seemingly trivial, may be a source of self-efficacy and pride to build upon and can foster greater creativity and resiliency when approaching future challenges. By learning a peer's strengths and previous successes, the supervisor can save time avoiding duplicative learning, and instead work with peers to continue working on new goals collaboratively. Focusing on strengths does not mean that problems are not addressed. Rather, strengths-based supervision frames issues as learning opportunities.

Support the Development of the Unique Knowledge and Skills Needed for Peer Support Practices[18]

Supervisors are responsible for providing and/or linking peers to a supportive educational environment(s) to enhance skills to provide services to individuals with needs that may be unfamiliar to them, to increase the success and performance of their work. [18] Supervisors should not assume that someone with lived experience in recovery will automatically understand and endorse recovery-oriented approaches[20] or have knowledge of specific clinical language.

Supervisors can also support peers by helping to hold them accountable for upholding recovery values. Peers may require additional coaching to ensure that their approaches are recovery-oriented.[20] Peers should promote multiple pathways to recovery and monitor and address any frustrations that they may have when a client may pursue a path different from their own. Additionally, peers may have personal experiences of engaging in a hierarchical, provider-driven treatment where their recovery goals or actions were determined predominantly by the provider. Supervisors can support peers in clarifying and amplifying the client-driven approach in their role as mentor to the client.

Developing a Recovery Narrative

One of the central tools that peers use to inspire individuals to engage in recovery, to reduce negative stereotypes and attitudes, and to encourage healing and empowerment is to present and share their personal stories of hope and recovery.[18,20] Furthermore, sharing a story of recovery can foster trust between the peer and the client.[28] Peers with experience in this area may have a well-honed version of their recovery story that strikes an effective balance between over-sharing details and under-utilizing their personal

experience. Supervisors who engage their supervisees in developing and practicing delivery of their recovery stories will ensure that the peer feels supported and effective in delivering their story. Because of the personal nature of this process, supervisors should take great care to develop rapport with their supervisees, set very clear expectations, and make the process predictable. Practicing one's story can help peers adapt to various circumstances and ensure that they are involving the client in the conversation versus talking at them[29] – while a detail may feel important to a peer, or that it is something that they have particular pride about, information that is shared with the client should always be shared for the client's benefit and be relatable to that client.

In general, recovery stories should highlight the following:[29]

- Change is possible (stories focus on transformation and not tragedy), strengths used in recovery, promotion of health and overall wellness, overcoming barriers (share steps taken to make change attainable), and support from others that the peer used. Peers may also be encouraged to describe maintenance efforts that they do to remain on their path of recovery.
- Recovery stories should be practiced in supervision to ensure that they promote the idea of multiple paths to recovery, and not just the one that the peer embarked on. Peers should avoid setting unreasonably high expectations and should be mindful not to set expectations too low.[26]

Ethical and Boundary Considerations

Provide a welcoming space in supervision to address ethical and boundary issues.[18] Since peers likely do not have a professional license where there is an obligation to obtain legal and ethical training (e.g., psychologist, social worker, marriage and family therapist, professional clinical counselor), it is important to ensure that they too have a solid understanding of professional ethics and boundaries. While staff should always adhere to their agency's policies and code of conduct, supervisors should consider providing ample time and space to discuss and navigate potential ethical and boundary issues.

Supervisors should ensure that they are trained and skilled in building trust and maintaining boundaries.[20]A successful supervisory relationship is shaped by a supervisor's willingness to be "open, appropriately transparent, and attentive to the peer's ideas, concerns, and needs." Creating a space where verbal and nonverbal communication demonstrates respect, value, and care for what a supervisee shares or is experiencing should be emphasized early on as well as throughout the course of supervision. Based upon a foundation of trust, the scope of supervision should be clearly outlined as a safe venue for supervisees to "receive support, perform honest introspection, candidly share difficulties, and expose vulnerabilities." Peer staff may have little to no experience with formal supervision, highlighting the importance of setting peers up for success in supervision, which may include training on how to prepare for supervision, how to use the time effectively (i.e., creating an agenda for supervision), how to give and receive feedback, clarifying roles, and pointing out the benefits of supervision. To reinforce the principles and expectations of supervision for both the supervisor and supervisee, a supervision agreement could be created collaboratively at the

beginning of a supervisory relationship that also takes into account the agency's policies and procedures related to supervision.

While supervision is supportive in nature, it needs to be clear for both the supervisor and supervisee that supervision is not treatment. Since peers may have transitioned from being recipients of treatment within the behavioral health system in which they are now working, it is even more important to ensure that the scope of supervision be clear and that supervisors are skilled at managing the gray areas that may present themselves during supervision. Setting and clarifying boundaries within the supervisory relationship should be a clear and intentional process led by the supervisor early on. During the course of supervision, if a personal issue arises, supervisors may consider the following question to help guide their response, "Does this impact service delivery?" When a personal issue appears to impede upon job performance, supervisors should make the peer aware of the potential issue and its impact. Circumstances like this may be a good opportunity for supervisors to model straightforward but supportive communication that is solution-focused and strengths-based. Additionally, a supervisor, may collaborate with the peer to identify resources that can be helpful, such as an employee assistance program. Supervisors are never to provide psychotherapy, counseling, or recovery support to a supervisee.[20]

Supervisors also serve as a model of professionalism and exemplary behavior. They are considered to be role models and should be mindful of their role and status as a supervisor. As supervisees develop professionally, they look to their supervisors for standards of how to act with peers, superiors, and individuals and families they serve. Supervisors should strive to model characteristics and interpersonal skills that are essential to the profession such as collaboration, objectivity, honesty, respectful interactions, straightforward communication, and openness to feedback.

Similar to licensed providers, peers must also not engage in dual relationships with those whom they provide services to. While many agencies have policies related to dual relationships, supervisors can support peers by providing additional training and open discussions around how to recognize potential dual relationships and how to appropriately avoid them.

Supervisors should strive to be objective when handling any situations that may arise. All conflicts should be addressed in an open, honest, and explicit manner as soon as possible. Approaching conflict in this way promotes prompt conflict resolution and can aid in minimizing the impact on the supervisory relationship.

When a peer has more than one supervisor (e.g., one for individual and one for group supervision, or one administrative supervisor and one peer supervisor) consistency in directives and expectations should be maintained, as well as when providing feedback to the supervisee. Supervisors should determine a procedure ahead of time for conferring regularly and ensuring that feedback and directives are given uniformly and predictably to a peer.

It is recommended that supervisors be knowledgeable of and refer to the Medi-Cal Code of Ethics for Peer Support Specialists in California[30], established by the California Department of Health Care Services in 2021.

These values and ethical standards were developed in order to promote a consistent message for those who are providing, receiving, and supervising services from a peer support specialist.

Evaluation, Feedback, and Affirmations[20]

In maintaining fidelity to a recovery model, supervisors should collaborate with supervisees to assess strengths and areas of growth. The method of how and when evaluations will occur should be clear and defined early in the supervision process. Supervisors may find that providing feedback can be a good opportunity for peers to reflect on what it is like when they deliver feedback to their clients as yet another point of growth and development. As such, feedback provided to supervisees should be strength-based and include affirmations, in which the supervisor expresses a genuine and positive acknowledgment of a specific accomplishment or attribute. These affirmations contribute to increasing motivation for professional development. Strength-based affirmations are different from general praise in that they are specific to a work task or peer attributed.

Examples of affirmations that are aimed to increase a peer's recognition of their strengths include, "I like the way you welcome people and help them feel comfortable here," or "The recovery plan you developed with your client showed that you really understand how to do person-centered treatment planning."[18] Feedback differs in that it provides peers input on what they may need to develop to enhance their performance or service delivery.[18] Feedback that is framed as a learning opportunity increases the likelihood that it will strengthen the peer's ability to be reflective of their performance and build upon their skills and experiences. For supervisors, it can be helpful to think of challenges, issues, or areas of growth related to peer work as a reflection of the need for more training in a particular area. Approaching feedback and supervision in this way reduces defensiveness associated with receiving feedback and focuses the feedback on development and solutions, as well as clarifying the responsibilities of supervisors or agencies to provide ample training. SAMHSA also states that characteristics of good feedback include being specific, objective, timely, individualized, genuine, and actionable.[18]

To create greater structure with these processes, supervisors and agencies should consider utilizing assessment and self-assessment tools in supervision that both supervisors and supervisees can complete and use to monitor progress and areas of growth.

Other Considerations for Peer Supervisors

Train Peers How to Demonstrate Their Value to Staff and Clients[18]

It can be helpful for peers to develop ways to demonstrate their value and role with those seeking behavioral health services with the support of their supervisor, especially since the role of a peer may be new to many behavioral health programs and to individuals and families served. Doing this in an intentional manner may help to reduce some of the hesitancy that many experience with accessing behavioral health services. A potentially effective way to develop this is to have peers practice developing this with their colleagues, where this could have the added benefit of demonstrating the value of their role to their colleagues as well

as to help their colleagues speak to their clients about peer services. While peers may have differing roles between programs, supervisors can support peers in highlighting some of the important commonalities, including that peers help to reduce stigma, are recovery and strength-focused, motivate hesitant clients by virtue of sharing their recovery experience, and that by virtue of their recovery they are able to provide essential behavioral health services to others in their community. Supervisors should also advocate for the integration of peers in the workplace[18] by educating others on their teams about the role of peers and their practices, by creating opportunities for peers to interact with others on the team, including assisting in assessment and treatment planning, and by working with leadership to ensure that peer roles are supported and do not include tasks outside of or below their scope (i.e., filing).

Specific Populations

If a supervisee is working with a specific population, the supervisor should ensure that they also have specialized knowledge in the communities and/or specialty areas the supervisee is serving.

Supervision Documentation

Supervisors are expected to maintain documentation in line with their agency's policies, which covers topics discussed in supervision, ongoing concerns (and ways they were addressed by the supervisor), training provided, and attendance and participation in supervision.

References

1. Stamm, B. (2010). The concise manual for the professional quality of life scale.
2. American Psychological Association (n.d.). Resilience. Retrieved December 12, 2023, from https://www.apa.org/topics/resilience/
3. Protocol, A. T. I. (2014). Trauma-informed care in behavioral health services. *Rockville, USA: Substance Abuse and Mental Health Services Administration*.
4. US Department of Health and Human Services. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach.
5. Training for Medi-Cal Peer Support Specialists (n.d.). Retrieved December 12, 2023, from https://www.capeercertification.org/training-for-medi-cal-peer-support-specialist/
6. Myrick, K., & Del Vecchio, P. (2016). Peer support services in the behavioral healthcare workforce: State of the field. *Psychiatric Rehabilitation Journal*, *39*(3), 197.
7. Centers for Medicare & Medicaid Services (2007). CMS State Medicaid Implementation of consumer providers into mental health intensive Directors Letter: Using Peer Support Services Under Medicaid. Retrieved December 12, 2023, from https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf
8. Substance Abuse and Mental Health Services Administration. (2015). Core competencies for peer workers in behavioral health services. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf.
9. Chapman, S. A., Blash, L. K., Mayer, K., & Spetz, J. (2018). Emerging roles for peer providers in mental health and substance use disorders. *American Journal of Preventive Medicine*, *54*(6), S267-S274.
10. Moran, G. S., Russinova, Z., Gidugu, V., & Gagne, C. (2013). Challenges experienced by paid peer providers in mental health recovery: A qualitative study. *Community Mental Health Journal*, *49*, 281-291.
11. Alberta, A. J., Ploski, R. R., & Carlson, S. L. (2012). Addressing challenges to providing peer-based recovery support. *The Journal of Behavioral Health Services & Research*, *39*(4), 481-491.
12. Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatric Services*, *65*(4), 429-441.
13. Chinman, M., Oberman, R. S., Hanusa, B. H., Cohen, A. N., Salyers, M. P., Twamley, E. W., & Young, A. S. (2015). A cluster randomized trial of adding peer specialists to intensive case management teams in the Veterans Health Administration. *The journal of behavioral health services & research*, *42*, 109-121.
14. Cook, J. A., Copeland, M. E., Jonikas, J. A., Hamilton, M. M., Razzano, L. A., Grey, D. D., ... & Boyd, S. (2012). Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning. *Schizophrenia Bulletin*, *38*(4), 881-891.

15. Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, *20*(4), 392-411.
16. Repper, J., Aldridge, B., Gilfoyle, S., Gillard, S., Perkins, R., & Rennison, J. (2013). *Peer support workers: Theory and practice*. London: Centre for Mental Health.
17. Trachtenberg, M., Parsonage, M., Shepherd, G., & Boardman, J. (2013). Peer support in mental health care: is it good value for money? Centre for Mental Health. https://eprints.lse.ac.uk/60793/1/Trachtenberg_etal_Report-Peer-support-in-mental-health-care-is-it-good-value-for-money_2013.pdf
18. Chinman, M., Young, A. S., Hassell, J., & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. *The Journal of Behavioral Health Services & Research*, *33*(2), 176-195.
19. Substance Abuse and Mental Health Services Administration (US) (2023) *Chapter 5-supervision of Peer Specialists, Incorporating Peer Support Into Substance Use Disorder Treatment Services [Internet]*. Available at: https://www.ncbi.nlm.nih.gov/books/NBK596264/ (Accessed: 09 September 2024).
20. Supervision of Peer Workers. (n.d.). Retrieved April 1, 2020, from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/guidelines-peer-supervision-4-ppt-cp5.pdf
21. O'Keeffe, M., & James, F. (2014). Facilitated group supervision: Harnessing the power of peers. *Journal of Paediatrics and Child Health*, *50*(12), 944-948.
22. Burden, E., Sarage, L., & Rose, H. (2018). Supervision of Peer Practice: The Challenges and Opportunities for Organizations with Peer Recovery Support Services Programs. Peer Recovery Center of Excellence. https://peerrecoverynow.org/wp-content/uploads/Supervision-of-Peer-Practice-Challenges-and-Opportunities_final-.pdf
23. California Mental Health Services Authority. Supervision of Peer Workers Training. (n.d.) Retrieved November 21, 2023, from https://www.capeercertification.org/supervisor-training/.
24. Kadushin, A., & Harkness, D. (2014). *Supervision in Social Work, 5e*. Columbia University Press.
25. Philadelphia Department of Behavioral Health and Intellectual Disabilities Services and Achara Consulting Inc. (2023, October 11). Peer Support Toolkit. DBHIDS. https://dbhids.org/about/organization/planning-innovation/community-affairs/peer-culture-and-community-inclusion-unit/peer-support-toolkit/
26. Substance Abuse and Mental Health Service Administration (2023). Practical Guide for Implementing a Trauma-Informed Approach. https://store.samhsa.gov/product/practical-guide-implementing-trauma-informed-approach/pep23-06-05-005
27. Substance Abuse and Mental Health Service Administration (2014). TIP 57: Trauma-Informed Care in Behavioral Health Services. https://store.samhsa.gov/sites/default/files/sma14-4816.pdf. https://store.samhsa.gov/sites/default/files/sma14-4816_litreview.pdf
28. Substance Abuse and Mental Health Service Administration (2016). Share Your Story: A how-to guide for digital storytelling. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/samhsa-storytelling-guide.pdf

29. Parker, M., & Uraine, M. (n.d.). Making Effective use of Your Recovery Story in peer Support Relationships. New England MIRECC Peer Education Center. https://mirecc.va.gov/MIRECC/visn1/docs/products/Making_Effective_Use_of_Your_Recovery_Story_Presentation.pdf
30. California Department of Health Care Services. Medi-Cal Code of Ethics for Peer Support Specialists in California (2001). Retrieved December 6, 2023 from https://www.dhcs.ca.gov/Documents/CSD_BL/MediCal-Code-of-Ethics-for-Peer-Support-Specialists-in-California.pdf.

Quick Guide

Resources

OC Health Care Agency Behavioral Health Services - Tools & Resources for Supervisors (with guidelines):

- Supervisor Self-Assessment Tool: Leading & Coaching Strengths Appraisal
- Professional Resilience Employee Plan and Resilience Performance Wheel

California Mental Health Services Authority (CalMHSA):

- Medi-Cal Peer Support Specialist Code of Ethics
- Supervision of Peer Workers Training and Qualifications

Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov

- Supervision of Peer Workers
- Supervisors of Peer Workers Self-Assessment
- A How-to Guide for Developing a Recovery Narrative
- Core Competencies for Peer Workers in Behavioral Health Services

Supervision Contract:

- (Sample) Supervision Agreement (ca.gov)

Philadelphia Department of Behavioral Health and Intellectual Disability Services: Peer Support Toolkit

U.S. Department of Veterans Affairs: Making Effective Use of Your Recovery Story

Society for Psychotherapy: Supervisor Competency Self-Assessment

Common Elements of Peer Supervision

Peer Roles and Practices	Recovery Orientation	Trauma-informed and Strengths-based Supervision	Recovery Narrative	Ethical Considerations
Supervisors should be very familiar with the important and unique roles that peers have and advocate for peers to only practice within their role and scope **Engage in up-to-date and ongoing training, including the State required training for Supervisors of Peers and HCA's Recovery Practices for OC HCA Leaders** Participate in regular consultation with other peer supervisors	Supervisors believe in, practice, and model recovery practices with peers in supervision **Support peers in reaching their full potential** Engage in supervision with authenticity and integrity **Maintain flexibility and appropriately individualize supervision to each peer based on their goals, skills, and areas of growth** Maintain collaboration and inclusion as much as possible **Hold peers accountable to their recovery practices**	Base supervision on a foundation of safety, choice, collaboration, trustworthiness, and empowerment **Peers may have a history of trauma, and supervisors should realize the widespread impact of trauma and resist re-traumatization** Intensify support during times of vulnerability or significant change **Actively seek to discover and highlight peers' strengths and competencies** Be deliberate and intentional in establishing a clear format for how and when feedback and evaluations will be provided **Provide affirmations for growth toward skills and professional development** Provide feedback that is specific, objective, timely, individualized, and actionable	Collaborate with supervisees to develop and practice their recovery narrative to be used as an effective tool to reduce stigma and increase motivation to access care **Stories should highlight that change is possible and focus on transformation and not tragedy** Recovery narratives can demonstrate promotion of health and overall wellness, overcoming barriers, and support from others	Provide a welcoming space in supervision to discuss and address ethical and boundary issues **Supervisors must have a solid understanding and training in building trust and maintaining boundaries** Establish the scope, expectations, and limitations of supervision in general and for supervision meetings early on **Supervisors should ensure that supervision is never treatment** Ensure consistency with other supervisors who supervise peers **Review dual relationships with peers and make certain to monitor and clarify potential boundary issues for supervisees** Supervisors should be knowledgeable of the Medi-Cal Peer Support Specialist Code of Ethics