REPORT / TEXAS PEER TRAININGS: CURRICULA COMPARISON

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Curricula Comparison: Certified Peer Specialist and Peer Recovery Coach Trainings

Submitted to Texas Health and Human Services Commission (HHSC)

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Background

The passage of House Bill 1486 directed development of a new peer support Medicaid benefit and defining training requirements for peer specialists who provide services to persons with mental health conditions or services to persons with substance use conditions under the new benefit. The Peer Support Stakeholder Workgroup was required by H.B. 1486 to provide input into establishing training, certification, and supervision requirements for peer specialists; defining peer support scope of services; and contributing to the development of rules defining these requirements. For the new Medicaid benefit, a peer specialist is identified as either providing peer support services to persons with mental health conditions or substance use conditions. Presently, mental health peer specialists and substance use peer recovery coaches in the behavioral health systems use different processes and overseeing entities for training and certification. Through contract with HHSC, TIEMH observed the trainings and reviewed the training curricula for both groups of peers to identify areas of commonality for an introductory peer training that serves both groups and to identify where differences existed that should remain in the individual curriculum and training programs.

TIEMH Contract Statement of Work (SOW): Compare and make recommendations on different models of establishing, supporting and maintaining a peer workforce.

SOW Operationalization: Compare and contrast the Certified Peer Specialist (CPS) Training curriculum to the Peer Recovery Coach (PRC) Training curriculum. In particular, note where the content is similar and could result in a training that applies to all peer provider types and where the content is specialized to a mental health or SUD recovery specialization.

Most important first impression after review: The values, ethics, and guiding principles of CPSs and PRCs differ between the curricula. Additionally, the way they are presented in the training manuals sometimes differs from the way they are presented by the training facilitators. Although there are some similarities as well, peer specialists and recovery coaches will need to reach an agreement on whether to:

1) adopt a subset of shared values, ethics, and guiding principles to develop an introductory “peer provider” curriculum that applies to both professions while maintaining other distinct sets of values, ethics, and guiding principles for specialized MH or SUD trainings;
2) adopt a single set of values, ethics, and guiding principles shared by both professions; or
3) not adopt any shared values, ethics, or guiding principles and exclude any content dependent on these from a combined training.

Informational Note: The CPS curriculum was revised in 2017 while the PRC curriculum was revised circa 2015.

Introduction

The primary challenge with identifying content from the two curricula that could form a basic core training for both groups lies in selecting content that aligns with the different values and ethics of CPSs and PRCs. Differences in core values and ethical standards affect the way that the two provider types deliver services. These differences should be dialogued by peers before deciding on content for a shared training. Via Hope's statement on the CPS core values highlights the importance of the values to the everyday interactions that the workforce has with people in services:

> *[The] shared core values are the foundation of our work. They are what define us as a unique profession in the mental health and recovery field. They guide our language, our decision-making, and our interactions every day. (CPS trainer's manual, p. 47)*

This statement reflects the importance that should be placed on guiding principles in the training and credentialing process that trains a workforce *how* to provide services. When evaluating whether content can be delivered effectively to both provider types in a combined training, analysis should extend beyond word choice and explore deeper conceptual semantics. Just because constructs are similar in name, does not indicate that they have the same meaning or application in practice. These considerations will require further dialogue among CPS and PRCs. 2

Even when there is overlap between CPS values/key concepts and PRC values, the meaning and application may still differ in important ways that affect practice. For example, the PRC curriculum presents **Autonomy and Choice** as a value, similar to the concept of **Self-Determination**, a key construct foundational to CPS work. While the PRC curriculum emphasizes the voluntary, but dichotomous, nature of recovery, it also teaches that it is only once the recoveree has made the decision to recover that the PRC can advocate for them and their success. *Only the recoveree can choose to take the recovery path* (PRC training manual, p. 21). This differs somewhat from the notion of self-determination taught by the CPS curriculum, which emphasizes that individuals have the right to set their own paths to recovery by deciding what is best for themselves. In this sense, recovery is not a binary choice that has either been made or hasn't, but rather represents a practically infinite array of choices for how a person decides to live their life, even if that means not abstaining from substance use, not taking their medication, or not engaging in services. In such cases, a CPS would still be bound by the profession's code of ethics to offer support to that person: *The primary responsibility of Certified Peer Specialists is to help individuals achieve their own needs, wants, and goals. Certified Peer Specialists will be guided by the principle of self-determination for all* (CPS Code of Ethics, 2017).

See CPS Core Values and Code of Ethics
See PRC Core Values (Appendix A) and the TCBAP PRS application packet (2015, pp. 9-10) or the Rhode Island Peer Recovery Specialist Certification IC&RC Exam Study Guide Ethical Guidelines (p. 21).

Differences in ethics or a Code of Ethics could be expected between these two workforces because ethics are the *principles of conduct governing a group*, and these two groups are working with different populations that might have different needs. As the CPS training acknowledges, "[CPS] ethics are grounded in [our] shared core values," which guide the daily work of a CPS. It follows that any training content which is related to the delivery of services will be rooted in the Code of Ethics adopted by that profession.

One major challenge to understanding how ethics will impact the work of the two professions differently is the lack of a clearly defined Texas Code of Ethics or Ethical Guidelines for PRCs in the training curriculum. While ethical considerations are explored in the training (from William White [2007] and "four basic concepts of ethics"), and a list of Ethical Guidelines for Peer Recovery Specialists is adopted by IC&RC (located in the Rhode Island Study Guide linked on the TCBAP website) and in the TCBAP PRS application packet, there is no clearly defined Texas Code of Ethics presented in the PRC training. Because of this, the ethical guidelines for PRC conduct are ultimately decided by the organization where the PRC is employed, but do not appear to be defined by the Texas workforce, which is different from the CPS.

In addition to being used to identify absolute boundaries not to be crossed, any nuances in the approach to service provision or in how to respond to challenging situations, will depend on analysis of the language used in the workforce's guiding ethical principles. This complexity dictates that a fully integrated training for both professions may be impractical, however, there may be specific areas of training content which are more general and applicable across the work of both professions. The lack of a formal Texas Code of Ethics for PRCs may hinder decision-making about what content should be considered for a combined training and what content does not seem to extend to both types of trainees.

Curricula Comparison

The following tables present comparisons between the two trainings in the domains of: 1) structure, 2) process, 3) content, and 4) training learning objectives. The tables are not meant to be exhaustive comparisons of every detail of both trainings, but instead focus on key points that may be the most helpful in considering the development of a combined core training. Trainers and developers should be invited to provide suggestions on what other content would be helpful for review.

These comparisons are based on the trainer's manuals, training PowerPoint slides, observation of trainings, trainer knowledge, and sometimes review of websites to supplement understanding when information was not clear. Where differences in the training as delivered by the facilitator and differences in the trainer's manual emerged, a note is provided in the tables "conversation" column. When comparing the CPS and the PRC training to determine what content is similar, it is important to attend the PRC training as the curriculum is not fully laid out in the facilitator manual and dependent on the skill of the trainer in explaining some content and linking content across days and modules.

Table 1. Comparison of structural components of CPS and PRC trainings

STRUCTURE	Recovery Coach Training	Peer Specialist Training	Conversation
Facilitation	Number of trainers required is not specified in the training manual	(P.19) Co-facilitated by a minimum of 2 trainers (3 trainers listed in guidance)	PRC trainer reported that the training is best facilitated by two co-trainers
Trainees	(Day 1, p.2) 4 to 20 per training	(P. 19) Up to 24 per training	PRC trainer also indicated that 4 per training is too little to effectively conduct the activities
Length	5 days, 46-hr training (6 of these hours spent on reading articles and homework outside of class time)	5.5-days, 43-hr training (with pre-reading not included in the total hours-see below)	
Pre-training	280 pages of essay/monograph reading (estimated 6 hours to complete)	47-page pre-training workbook	Some certification exam items are covered in the CPS pre-training workbook so that reading is required. We have not seen the PRC exam, so are not sure if some certification exam items are taken from the PRC pre-reading
Modules/Units	Four to five units per day. Unclear how long each unit lasts. Specific activities sometimes have recommended time guidelines	About four to five 60-90 minute modules per day, occasionally a 30 or 45-minute module	
Curriculum-Trainer	125 pages per 5 day training (~25 pages/day)	330 pages per 5.5 days of training (~60 pages/day)	
Calendar/Table of Contents	Agendas for each individual day, broken down by "unit," included at beginning of each day (e.g., Day 2, p. 2 and Day 2 agenda in ppt)	(p.2) Includes calendar displaying schedule for each day on one page at beginning of manual. Days broken down by module. Also includes table of contents for entire training (p.11-16)	
References	William White is the primary reference (see reference pages at end of each Day)	References are varied (Trainee Workbook p. 127)	

Note: Table 1 only compares the content of the trainings. The process of sitting for the exam and gaining certification are very different and not included here.

Table 2. Comparison of process elements of CPS and PRC trainings

PROCESS	Recovery Coach Training	Peer Specialist Training	Conversation
Introduction/Story	(Day 1, p.7) Share recovery status using slide as a guide (name, from, recovery status is, motivation for being a part, favorite word)	(p. 28) Personalized introductions but instructed to avoid discussion of recovery status or diagnosis. Developing and sharing your recovery story occurs on day four	The PRC training facilitator explored introductions to a greater depth than the trainer's manual instructs.
Homework/Review	Emphasis on homework completion and informal quizzes as a platform for discussion; review prior topics as they fit in current modules; recall concepts and acronyms from prior modules	Review topics from previous units/days at the beginning of the next module; bring prior material into the current modules	
Content delivery	PowerPoint, supplementary handouts, group discussions, and smaller group activities as teaching methods	Liberating Structures, PowerPoint, group discussions, role play, and presentations as teaching methods. Trainers are often asked to model for the trainees to illustrate certain concepts, such as sharing recovery stories	PRC trainer modeled concepts but this was not included in the facilitator manual.
Division of time for activities and discussion	Large chunks of time to complete tasks or do specific activities (E.g., Day 2, p.3: "Engage the group in a 45-minute discussion about the answers," "Give trainees 15 minutes to discuss the Roberto case study homework that was assigned on day one,**"** etc).	Guiding questions to help structure the time that trainees spend in group activities and discussions. (E.g. p. 57, "We will take three minutes for you to discuss with your group the question on the slide that corresponds to your group number."	
Community Culture/Creating the learning environment	(Day 1, p. 8) PRC working agreements ask trainees to "come up with a list" and emphasizes *safety* of the learning environment.	(p.31) CPS community culture agreements use interactive/evocative methods to create strategies for working together to emphasize respect for self and respect for others during the training.	Both post their agreements on the wall. PRC trainer reviews or comes back to the agreements as necessary. CPS trainer revisits daily throughout the week.
Progression of specific lesson	Each unit starts with a specifically-defined purpose, then progresses to individual topics.	Starts with goals, objectives, and a summary of main ideas, then delves into the main "presentation" for each module	
Self-Care	Unit 1 in Day 5 (Day 5, p. 3)	Most days have 1-2 "refresher" activities designed to take focus away from heavy topics, help trainees practice self-care. (e.g., p.57: "What am I proud of?")	
Practicing Skills	(Day 2, p.15) Motivational interviewing practice time for trainees comes at the end of descriptions of MI skills.	(p.91-95) Includes an hour-long module on listening to trainer's recovery story, preparing trainee's own story, sharing that story, and	There are other activities in both trainings but these focused on practicing skills.

PROCESS	Recovery Coach Training	Peer Specialist Training	Conversation
	(Day 5, p.10) Trainees have two exercises (about 5-10 minutes each) in Day 5 to practice recovery messaging, and to debrief on this task.	debriefing with other trainees about the process. (p. 63) Includes activity where trainees practice rewording clinical language to reduce stigma around mental health issues. (p.116-117) Includes activity where trainees practice validation, active listening, "being with" others. (p. 171, 179) Includes exercise to practice recovery dialogues, recovery snippets. (p. 198, 203, 204) Includes exercise where trainees "fuel dissatisfaction," (similar to motivational interviewing, but emphasized that it is not about setting goals or solving a particular problem).	

Table 3. Comparison of themes and content of CPS and PRC trainings

CONTENT	Recovery Coach Training	Peer Specialist Training	Conversation
Core Values and Code of Ethics	(Day 1, page 14) 10 Guiding Principles and Core Values of Recovery – SAMHSA. At the end of Day 1, PRC appropriate and not appropriate roles are listed. The title of this part of the unit is: “The Recovery Coach Duties (Ethics).” (Day 2, Unit 5, p. 19) Ethics. Basic concepts of ethics are presented (iatrogenic, fiduciary, boundary management, multi-party vulnerability) and dilemmas are discussed. At end of Day 3, awareness of trauma in those in recovery is focus of a discussion of PRC ethics. (Day 5, p. 20-21) SAMSHA guiding principles of recovery. Lists 18 different core values in the last unit of Day 5 including keeping promises, serving as an example, expressing humility, acting with discretion and respecting recoveree privacy, being tolerant, making use of self-awareness, having a recovery-first outlook, among others. Curriculum is not thematically linked by these values.	(values: p.48/49, ethics: p.51/52) Code of Ethics specifically for peers as well as Core Values (includes SAMHSA recovery concepts such as mutuality, authenticity, self-determination, respect, etc.). Code of ethics and core values are used throughout the training to explain certain peer roles and reasons for approaching peer work in a certain way.	The PRC curriculum does not have a discreet Code of Ethics for Texas, although several different sources for ethical content are drawn from in the training content (e.g., William White [2007] and “four basic concepts”). In our review of the TCBAP and IC&RC websites, we found a study guide that contained a set of Ethical Guidelines, however, those were not presented in the training and have not been adopted by Texas. The study guide also presented core values that differ from those presented in the training. To prepare an introduction training for all peer providers, it would be helpful for peers to decide together which subset of shared values and ethics this training should be based on, if any.
Model of Recovery	(Day 1, p. 15) William White’s 4 stages (initiation, stabilization, maintenance, enhanced quality of life). Focus on the concept of recovery capital (internal and external resources that help sustain recovery) as a theme throughout the curriculum	(p.74) 5-stage model (impact of a diagnosis, life is limited, change is possible, commitment to change, action for change. Recovery capital is not a focus.	The initiation stage does not fit with the CPS concept of self-determination. However, as presented by the PRC trainer, the initiation task of “stay clean and sober no matter what” differs from the many pathways approach.
Motivational Interviewing	(Day 2, p.4-15) Explicitly uses the stages of change (pre-contemplation, contemplation, etc.) and MI strategies (decisional balance,	No explicit Motivational Interviewing concepts in the CPS Training.	

CONTENT	Recovery Coach Training	Peer Specialist Training	Conversation
	open-ended questions, double-sided reflections, etc.)		
Active Listening	(Day 2, p.4-15) Lists Motivational Interviewing concepts (engagement, appropriate body language, affirming, reflection, double-sided reflection, reframing, clarifying, summarizing, etc.) to explain what active listening is.	(p.115-130) Includes module called, "The art of holding space," which incorporates listening exercises so that trainees can learn how to listen well and barriers to active listening.	
Ways of Working	(day 2, p.4-15) Uses Motivational Interview training as a substantial portion of Day 2	(p.115-124) Active listening/holding space, (p. 197-207) Fueling the power of dissatisfaction, (p.209-217) PICBBA (Problem, Impact, Cost, Benefit, Brainstorm, Action)	
Assessment/Recovery Planning	(Day 3, p.5-9) Recovery Planning is a substantial part of Day Three of PRC. Specific goals and timelines for someone in recovery, discusses the long-term nature of having a recovery coach due to the nature of substance use recovery as a long-term process, and gives suggestions/advice to the person in recovery.	CPS Training does not include assessment/recovery planning.	Assessment is not a task that a CPS would perform but many CPS work with individuals on goal discovery or self-advocacy for their planning. Advice-giving would also not be delivered by a CPS (PICBBA or "snippets" might be used instead).
Recovery Capital	(Day 3, p.3-4, and pre-training article, "Enabling or Engaging: The Role of Recovery Support Services in Addiction Recovery" by Davidson, et al.) Referenced numerous times throughout the training.	There is no equivalent concept in the CPS training.	
Recovery Identities	(Day 4, p.15) How one identifies, or does not identify, with recovery: positive (recovery is important part of identity), negative (person feels negatively toward identification w/being in recovery, sense of shame), and neutral (no particular identity with respect to recovery)	No CPS version of this topic	
Recovery Relationships	(Day 4, p.16) How one identifies, or does not identify, with recovery: positive (recovery is important part of identity), negative (person feels negatively toward identification w/being in recovery, sense of	No CPS version of this topic	

CONTENT	Recovery Coach Training	Peer Specialist Training	Conversation
	shame), and neutral (no particular identity with respect to recovery)		
Recovery Stories	(Day 5, p.5-10) Takes format of "recovery messaging" rather than a "story." Format is: who I am/how I'm in recovery, what recovery means to me, what recovery has done for me, and why I'm speaking about recovery	(p. 169-179) Includes concept of "snippets" of recovery story, brief pieces of a story used at an appropriate moment to foster hope and build relationship	
Trauma	(Day 3, p. 17-20). Addresses psychological, situational, and childhood trauma. Situational and childhood traumas are not defined clearly, examples not used	(p. 99-113) Outlines the ACES study. Addresses various kinds of abuse (emotional, physical, and sexual), neglect, stalking, domestic violence, historical trauma, bullying, natural disasters, forced displacement, system-induced trauma, witnessing violence. Includes idea that mental health issues can be a normal response to an abnormal situation	
Social identity/cultural diversity	(Day 4, p. 3-12) Idea of cultural competence, discussion of how privilege creates power dynamics between people	(p.233-249) Social identities (race, gender, sexuality, etc.) versus "personal identities" (e.g. musician, older brother, etc.), the need to allow for discomfort in discussions of how our identities differ from those of others	
History of the Peer Movement	(Day 1, p.17) General overview of evolution of classification of substance use disorders and shift to current recovery orientation of services and recovery oriented systems of care	(p.35-43) Discusses many specific people, organizations, and their individual contributions to peer movement. Includes idea that history of peer movement informs current peer work	The two recovery movements and histories of peers as providers have evolved differently and impact values and ways of working with people
Stigma and Labels	(Day 4, p.21-24) Contains topics including "The Power of Labels" and "Stigmas and Label," however, discussion of language not linked to PRC core values or ethics	(p. 57-68) Module on using person-first and human-experience language, rather than stigmatizing language, reinforces core value of mutuality	
Language	The language is different in each curriculum, for example, "recoveree" versus "the person."		It could be useful for peers to decide on what is common ground.

Table 4. Learning objectives of CPS and PRC trainings

<table>
<tr><th>Recovery Coach Training</th><th>Peer Specialist Training</th></tr>
<tr><td>Learning Objectives:
1. Fulfill personal growth through enhancing recovery capital;
2. Gain an expanded knowledge of the recovery coach role;
3. Identify and develop skills necessary to be effective as a recovery coach; and
4. Understand one's own recovery capital and how to share lived experience.
5. It is important for trainees to understand that certification does not guarantee a job as a coach.</td><td>At the end of this training, it is envisioned that participants will be able to:
1. Understand the history of the recovery movement;
2. Understand the role of individuals in recovery in a recovery oriented system;
3. Understand the values and ethics of the Certified Peer Specialist profession in Texas;
4. Understand the variety of roles and tasks that a peer specialist maybe asked to perform within their scope of work;
5. Develop the skills necessary to provide effective peer support services in both individual and group settings; and
6. Understand that the certification training is only the beginning of a professional development process that will continue during the course of their initial and subsequent certifications.</td></tr>
</table>

Summary and considerations presented to the 1486 Workgroup

Certain topics lend themselves to a combined basic training because the content and delivery does not change depending upon the *core values of either CPSs or PRCs*. However, it may be useful for peer specialists to jointly develop a shared code of ethics and values to guide an introductory training.

Based on review of the current curricula, topics that could be considered for a combined introductory training include:

- History of the SUD and MH recovery movements and the peer movements. This could include information on how the movements differ as well as where they are similar. The history of the movements plays out in values and approaches to the work
- Co-occurring disorders (which can be a place of joint understanding and discussion)
- Language (person-first, human-experience, how it can stigmatize)
- Cultural awareness/competence, issues of power and privilege in peer work
- Trauma/Trauma-informed approaches
- Self-care
- How the state mental health and substance use system works
- Peer roles in the behavioral health and other health systems
- *Shared values, ethics, and guiding principles – if PRCs and CPSs choose to develop a subset that applies across both professions for a joint training, or if they choose to adopt a single set of values, ethics, and guiding principles; e.g., both groups reference SAMHSA's 10 guiding principles.*

Based on our review, certain training topics are distinct and do not lend themselves to being included in a combined, basic training. We based this on 1) incongruence between content and core values of each workforce, or 2) focus of content is specifically on either substance use-related or mental health-related issues. Based on review, the topics which could require further conversation or do not appear to lend themselves to a combined introductory training include:

- Manualized interventions (such as Mental Health First Aid) – Reference to or teaching aspects of such interventions would not lend themselves to a combined training because the delivery of any intervention will be highly dependent on the workforce's values, ethical standards, and areas of focus.
- Crisis Management – Approaches to crisis management vary depending on the workforce's values, ethical standards, and areas of focus as well as the organization in which they work. We recommend offering Crisis Management interventions and techniques, delivered from a peer perspective, as a standalone training.
- William White's Stages of Recovery – These stages were designed with substance use specific issues in mind.
- Recovery Identities (3 types) – The identities were designed with substance use specific issues in mind.
- Recovery Relationships (3 types) – The model was designed with substance use specific issues in mind.
- The Smoking Cessation content in the PRC training would benefit from a revision to fit the peer model of service delivery. We suggest not including the content in either a core PRC or CPS training. Smoking cessation is a Medicaid billable service, and might be delivered as a stand-alone training if the content was changed to a peer-based delivery model, the peer had been a tobacco user, and the individual attending had voluntarily selected to attend a peer-led cessation group.
- Topics that rely heavily on the use of scenarios, case studies, or vignettes to reinforce a concept or demonstrate appropriate use of a skill. The subject matter of these learning tools should be aligned with the specific population being served by CPSs and PRCs (i.e., either mental health focused or substance use focused).

- Topics related to content or resources that are either specifically substance use focused or specifically mental health focused (e.g., job roles, Medication Assisted Treatment/Moderation Based/Abstinence Based, TRI, ATTC, UNITE, etc).
- Assessment of Recovery Capital (ARC) – conducting assessments is not a service that a CPS would deliver but we also understand that the intent of completing the ARC is to provide feedback on the level of recovery support (capital) a person has in their lives, similar to the "getting ready" section of the "Getting in the Driver's Seat" guide that is used by some CPS for working on goal discovery and self-advocacy. We include the ARC for further peer discussion.
- Values, ethics, and guiding principles – if peers and recovery coaches do not agree to adopt any shared subset of values, ethics, and guiding principles.

Considerations for the **structure** of a combined training include:

- Decide on a minimum and maximum number of trainees.
- Decide on the requirements for co-facilitation of the training (and number of co-facilitators).
- Assign topics as either "units" or "modules" with specific instructions and guidelines for timing of content delivery.
- Choose a room for the training that closely matches the number of participants.

Considerations for the **process** of a combined training include:

- Include community-building warm-up exercises before lessons.
- Time specific activities and lessons to ensure that appropriate weight is given to topics.

Recommendations from the 1486 Workgroup

On June 21, 2018, at a meeting of the 1486 Stakeholder Workgroup, TIEMH facilitated a group discussion for the purpose of building consensus regarding the topics which would serve as the most informative, cross-professional content for an introductory or orientation training that targets both individuals seeking certification as Certified Peer Specialists and Peer Recovery Coaches.

Feedback was collected from the group via a two-step process to review each potential introductory/orientation topic: 1) small group discussion (3-4 in each group), followed by 2) small group report out to the whole committee. Participants on conference call provided feedback during the report outs. Approximately 18 minutes were used for each round of topic discussion. Because the two Codes of Ethics for CPS and PRCs are similar but may be expressed differently in their work, discussion groups were asked to keep this in mind as they determined which topics would be suited for an introductory / orientation peer training, including any high-level notes or caveats for each topic.

Overall, the workgroup was supportive of inclusion of the entire collection of eight potential training topics presented and agreed that this smaller curriculum group would work on the curriculum content, reporting back to the larger 1486 workgroup throughout the development process for feedback and approvals.

The following is a summary of the workgroup's response to each of the topics.

History of the movements:

- Emphasis on the terms "recovery" and "pathway" having different meanings for SUD & MH. History section is an opportunity to define these terms together, and agree on them
- Need to be aware of the differences in distinct history and language of both movements, but also the shared purposes
- Keep the section brief and high-level, but do explain histories of ***both*** sides
- Include and explain concept of many pathways to recovery

- Explain what “person-centered” means

Co-occurring conditions:

- Emphasis on underlying trauma at root of both MH and SUD. Include ACES study
- View of co-occurring disorders depends on which door you walk into (“surrender” linked to SUD, “empowerment” linked to MH)
- Issue of changing language (“challenges” rather than “disorders”)
- Peers can increase access to services, potentially reduce healthcare costs

Language:

- Non-stigmatizing language (experiential/person-first) can shift systems toward recovery orientation, while disorder/illness-focused language can do the opposite
- Use of language is extremely important to an introductory training because it can show peers how to distinguish between labeling people and describing their recovery
- Nevertheless, times when “disorder” language is necessary → health insurance, payment
- Concept of being “strengths-based” is important

Cultural Humility:

- Should not be extremely in-depth in the joint training, will be more detailed in specific SUD/MH trainings
- Should be connected to advocacy and social justice aspects of the Recovery Movement
- Important to discuss issues of power and privilege, the need to acknowledge power differential in helping relationships
- Importance of being non-judgmental

Trauma:

- Crucial that peers understand what *trauma-responsive care* is, not just trauma-informed → need to know how to respond
- This training may be first time peers hear about these concepts
- Peer must have awareness of their own trauma, can create difficulties in work if they don’t
- Shared in both MH and SUD
- This section can include what peers need to know to be able to recognize if a workplace is trauma-informed or not

Self-Care:

- This section should be less didactic, more experiential
- Topic should be interspersed throughout the training, not just in one place
- Sub-topics should include: recognizing compassion fatigue, secondary trauma, healthy boundaries, role-modeling self-care
- Connection between trauma on-the-job and self-care should be explored
- Should be addressed in both joint and specialized trainings

State Behavioral Health System:

- How do potential peers fit into a larger system
- Discuss not only state, but how services get funded beyond state
- Advocacy

Peer Roles in Systems:

- This section can help prepare peers for the experience of working in an organization that may not be fully recovery-oriented; expect to face pushback
- Convey idea that recovery-oriented systems need peers, but merely having peers doesn’t make the system recovery-oriented
- Explore what a job description for a peer might look like; differences between MH and SUD peer jobs
- Need to encourage integrity of the peer role, and the challenges this may pose in an organizational setting

- Understanding how a peer's role is different from, yet complements, other work in their organization
- How to effectively advocate in organizations, and how to communicate with clinical staff

After the meeting, TIEMH took the workgroup's inclusion recommendations and located the content in the respective curricula. Table 5 provides page numbers in the respective curricula that correspond to the shared topics.

Table 5. Content topic page numbers from PRC and CPS manuals

Content Topic	CPS Trainer Manual	CPS Trainee Manual	PRC Trainer Manual	PRC Trainee Manual
History of the Movement	pp. 35-43	pp. 15-19	Day One: p. 17	Day One: p. 15
Co-occurring Disorders	Topic not included in curriculum/manual	Topic not included in curriculum/manual	Day Four: p. 17-21	Day Four: p. 19-24
Language	pp. 57-68	pp. 27-30	Day Four: p. 22-24	Day Four: p. 24-28
Cultural Humility	pp. 233-249	pp. 93-98	Day Four: p. 3-16	Day Four: p. 2-17
Trauma	pp. 99-113	pp. 43-48	Day Three: p. 17-20	Day Three: p. 20-23
Self-care	p. 31, 185-186	p. 75-77	Day Five: p. 3-4	Day Five: p. 2-3
State BH System	pp. 301-312	pp. 121-126	Topic not included in curriculum/manual	Topic not included in curriculum/manual
Peer Roles in Systems	p. 39 (History of peer work and its implications for peer work/roles today) p. 254-299 (Modules 17, 18 and 19: Ethics and Boundaries, Change Agent, and Power, Conflict, & Integrity)	p. 103-120 (modules 17, 18, 19: Ethics and Boundaries, Change Agent, and Power, Conflict, & Integrity)	Day One: p. 16-22 (Roles, where peers work, job description, differences from other staff) Day Three: p. 10 (resource broker) Day Five: p. 20-21 (Ethics and Legal issues include topics related to peer roles)	Day One: p. 16-23 (Roles, where peers work, possible job description, differentiation from other staff) Day Three: p.12, 14 (PRC as resource broker) Day Five: p. 39 (Ethical conduct related to peer roles)

At the end of the discussion, the workgroup determined that this information would be used by a subgroup of workgroup members to create the introductory peer curriculum. The workgroup also determined that based on the topics discussed, the training might be 8 to 16 hours in length (depending on outcomes of the group's work) and to be most effective, should be delivered in person. At the time of the meeting, the workgroup discussed keeping the content of an introductory training at a high level, while also providing enough detail about the peer

role so that an individual who completes the training gains a clear understanding of what peer work is and is not. This would prepare future peer providers to make an informed decision about whether to apply for the respective intensive peer specialist or recovery coach training and certification programs.

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Appendix A. Peer Recovery Coach Core Values

Appendix A, Peer Recovery Coach Core Values

18 Core Recovery Values and Ethical Conduct

- **Gratitude** for Service-Carry hope to individuals, families and communities
- **Recovery**- All service hinges on personal recovery
- **Use of Self**- -Know thyself. Be the face of recovery. Tell your story. Know when to use your story.
- **Capability**- Improve yourself. Give your best.
- **Honesty**- Tell the truth. Separate fact from opinion. When wrong, admit it.
- **Authenticity of Voice**- Accurately represent your recovery experience and the role from which you are speaking.

Excerpted from Ethical Guidelines for the Delivery of Peer-based Recovery Support Services (White, 2007)

18 Core Recovery Values

- **Credibility**- Walk what you talk.
- **Fidelity**-Keep your promises
- **Humility**- Work within the limitations of your experience and role.
- **Loyalty**- Don't give up. Offer multiple choices.
- **Hope**- Offer self and others as living proof. Focus on the positive- strengths, assets, and possibilities, rather than problems and pathology.
- **Dignity and Respect**- Express compassion. Accept imperfection. Honor each person's potential.

18 Core Recovery Values

- **Tolerance**- "The Roads to recovery are many," (Wilson, 1944). Learn about diverse pathways and styles of recovery.
- **Autonomy and Choice**- Recovery is voluntary. It must be chosen. Enhance choices and choice-making.
- **Discretion**- Respect privacy. Don't gossip.
- **Protection**- Do no harm. Do not exploit. Project yourself. Protect others. Avoid conflicts of interest.
- **Advocacy**- Challenge injustice. Be a voice for the voiceless. Empower others to speak.
- **Stewardship**- Use resources wisely.