Key 1: Documentation Standards

Peer specialist's work must be consistent with their role and the principles of recovery in everything they do, including documentation. Because of this, documentation completed by peer specialists may look different than documentation completed by clinical staff.

Peer Specialists are not trained clinically and therefore can not diagnose, treat or give professional advice. Instead, peer specialists share their lived experience and use language based on common experiences. Motivation through hope and inspiration will be reflected in the language. Instead of doing tasks for the person or providing necessities, the peer specialist will support the person in learning the skills and finding the resources to accomplish tasks and meet basic needs.

Peer specialists will focus on the person by working in the context of their identified recovery plan and goals. The person's words and personal recovery goals will drive the work completed with the peer specialist. Peer specialists will approach their position as a role model, versus an expert authority, so that the person served can start to view themselves as the expert on their own experience. This will help the person understand there are many pathways to recovery and recovery is possible for them.

Peer specialist services must be voluntary for them to be effective. Therefore, a record of a recommendation for peer services to the person served and an agreement to the services should be reflected in documentation.

To meet the Agency for Health Care Administration's requirements, service documentation must contain all of the following:[1]

- Recipient's name.
- Date the service was rendered.
- Start and end times.
- Identification of the setting in which the service was rendered.
- Identification of the specific problem for which the service is being provided.
- Identification of the service rendered. (Peer Specialist's intervention with the member)
- Updates regarding the (recipient's response toward the intervention) and progress toward meeting treatment-related goals and objectives addressed during the provision of a service.
- Dated signature of the individual who rendered the service.
- Printed or stamped name identifying the signature of the individual who rendered the service and the credentials (e.g., licensed clinical social worker) or functional title (e.g., treating practitioner).

One of biggest challenges for a Peer Specialist will be to remain strengths-based when indentifying and addressing specific problems. Peer specialists should never focus on what is wrong with the person. Addressing the problem as a challenge or barrier towards the person achieving personal recovery goals and discovering healthy coping skills will help peer specialists provide interventions consistent with the peer role.

Ideally all goals in an individual's treatment plan will be developed by the person and written in the person's own words. However, there may be times when the goals of the treatment team are not consistent with the person's priorities. For example, medication adherence may be the treatment team's goal to achieve the person's goal of recovery. However, if the medication has an undesirable side effect that negatively affects the person's life, medication adherence may not be a priority. In this case, an intervention consistent with the peer role would include teaching self-advocacy skills and working on shared decision making tools. While all work done by the Peer Specialist must correspond with the treatment or service plan, goal progress should be focused on the goals defined by the person.

WRAP, Wellness Recovery Action Plan, is an evidence based approach that should be reflected in documentation as an intervention. Other examples of problems, interventions, and progress towards goals that are consistent with the peer role include:

Specific problem	Intervention consistent with the peer role	Progress toward meeting treatment-related goals and objectives
Sara lacks a support system. She does not have contact with her family.	Sara and I discussed the qualities she wants in a supporter. We talked about whether the member's of her family had these qualities. She identified that her sister does. We weighed the pros and cons of reconnecting with her sister.	Goal: "Have support besides staff at the Center". Progress: Sara decided she wants to meet with her sister but is still nervous. At our next meeting we will role play possible scenarios for her meeting with the sister.
Sara is on food stamps and reports she can not buy healthy foods because it is too expensive.	Sara and I met at the downtown farmer's market. We walked through the market and I taught her how find the best deal and how to look for quality in fruits and vegetables.	Goal: "Lose weight". Progress: Sara became comfortable with a new resource to get healthy food at a discounted price. She reported, "I am going to come here every week".
Sara reports she is not taking her medication as prescribed because she can not remember to take it.	Sara and I talked about what she is like when she is feeling well. She identified that she is not doing everything on her daily maintenance plan, which included "taking my antipsychotic". I helped her set a reminder on her phone and create an hour by hour schedule based on her daily maintenance plan.	Goal: "Complete everything on my daily maintanence plan everyday." Progress: Sara set an automatic reminder on her phone to look at her daily maintanence plan every morning. She created a daily schedule to help her remember to take her medication.

Documentation must also be individualized, demonstrate a recovery and resiliency focus, and have a support or treatment benefit to the member.[2] For consistency with the peer role and the principles of recovery, documentation should reflect the following standards:

- Tells exactly what happened and does not predict, judge or offer personal opinion.
- Does not use clinical language.
- Uses the person's own words.
- Is person-centered and includes the person's goals.
- Offers support instead of unsolicited advice or directives.
- Demonstrates collaboration with the person served.
- Uses empowering, hopeful language that is strengths based.

Examples Using Documentation Standards

Documentation Standard	Example of Documentation Consistent with the peer role	Example of Documentation NOT consistent with the peer role
The documentation tells exactly what happened and does not predict, judge or offer personal opinion.	Sara's hair and clothing appeared dirty.	Sara is either depressed or psychotic because she isn't taking care of herself.
The documentation does not use clinical language.	Sara reported she is struggling to keep up with housework because she is hearing voices.	Sara is decompensating and hallucinating.
The documentation uses the person's own words.	Sara reported, "I've been smoking pot to make the voices be nice."	Sara is using drugs to cope.
The documentation is person-centered and includes the person's goals.	We discussed the goal she had made to regain custody of her children and how smoking marijuana could be a barrier to reaching her goal.	I reminded Sara of the treatment goal the program had set for her to abstain from smoking marijuana.
The documentation offers support instead of unsolicited advice or directives.	I explored with Sara the events in her life that are triggering her to smoke marijuana.	I told Sara to stop smoking marijuana and exercise instead.
The documentation demonstrates collaboration with the person served.	We discussed adding a wellness tool to her trigger action plan. Sara decided she wanted to try journaling.	I told her that exercise works for me when I am symptomatic. Sara agreed to exercise.
The documentation uses empowering, hopeful language that is strengths based.	We talked about past similar struggles and how her determination helped her overcome them. I reminded her of the new tools she had and how far she had come.	Sara is getting worse. She is too stubborn to do what she needs to do to get better.

[1] Agency for Health Care Administration. (2014). Community Behavioral Health Services Coverage and Limitations Handbook.
[2] Agency for Health Care Administration. (2014). Managed Medical Assistance Program: Attachment II.