Recommendations for Peer Support Fidelity on Multidisciplinary Teams

Developed by Peer Supporters in Maine

1st Edition – September 2022

ACKNOWLEDGMENTS & RESOURCES

Acknowledgments:

It has been quite a journey for us to learn the lessons outlined in this guide and practice their applications in the age of integrated peer support work. We would like to thank the following groups and individuals for their support:

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- Thank you to the Pexel & Pixabay communities for the many graphics contained in this document
- All the peer supporters doing work in Maine and elsewhere, often unrecognized and undervalued, are fighting the good fight

For further reading, please reference:

A *Handbook for Individuals Working in Peer Roles* – Sera Davidow, Erin Levesque, and the Wildflower Alliance Peer role booklet peer side (psresources.info)

The Provider's Handbook and Implementing and Developing Peer Support Roles – Lyn Legere, Sera Davidow, Western Mass Peer Network, and the Wildflower Alliance Peer Role Booklet provider side (psresources.info)

Intentional Peer Support - Peer support is about Social Change (intentionalpeersupport.org)

Hearing Voices Network - Hearing Voices Network: Welcome (hearing-voices.org)

Mad in America - Mad in America - Science, Psychiatry and Social Justice

National Associate for Rights Protection and Advocacy (NARPA) - Home | NARPA

The Icarus Project - The Icarus Project NYC (nycicarus.org)

TABLE OF CONTENTS

INTRODUCTION

This document was created by folks in peer support roles in Maine who have been working in traditional mental healthcare settings for nearly a decade. We wanted to share what we have learned from integrating peer support (specifically Intentional Peer Support) into dozens of clinical teams across the state of Maine. We have worked with a wide variety of services (including adult, youth, and children's case management; early intervention services; assertive community treatment; substance use treatment; as well as hospital and emergency department services) and have attempted to create some general recommendations based on our work with these teams.

We recognize that the structure and resources vary from agency to agency and the State of Maine's robust Certified Intentional Peer Support Training program is unique; thus, there may be components not entirely relevant to or attainable in all multidisciplinary programs. We hope that this guide invites programs to think critically about the scope and purpose of the peer support role. Lastly, we want to acknowledge that while we have extensive experience, no person or group is the authority on "peer support." We invite you to connect with experts in your area to refine these efforts continually.

We will begin with an overview of Intentional Peer Support and common examples of where integration becomes co-optation. We will then detail the areas necessary for consideration in high-fidelity peer support integration.

"Although [Intentional Peer Support] sounds like a lot of hard work (and it is), it is also fun and rewarding, simply about having good relationships that promote health in all of our relationships." ~ *Shery Mead*

INTENTIONAL PEER SUPPORT OVERVIEW

INTRODUCTION

Intentional Peer Support is a way of being in relationship with other people that focuses on honoring individual wisdom, centering the autonomy of all people involved, negotiating the confines of relationships based on everyone's feelings and needs, and discovering what it means to live the lives of our choosing. In focusing on mutual accountability on an interpersonal and communal level, Intentional Peer Support is about social change. There are four tasks and three principles.
Learn more at www.intentionalpeersupport.org

The Tasks

1. **CONNECTION:**
   - We strive to connect with one another based on our life experiences, histories, and ways of seeing the world.

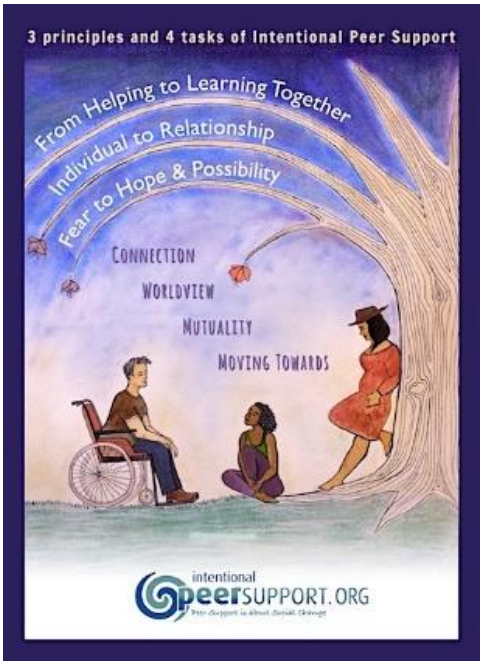
2. **WORLDVIEW:**
   - Worldview is "how we've come to know what we know." This task invites us to lead with curiosity in our interactions, striving to understand how someone's internal, familial, communal, and systemic/structural impacts affect how they see the world and move through it.

3. **MUTUALITY:**
   - Mutuality is not just about folks in the relationship sharing their own experiences vulnerably (although that's part of it) – it's about asking what everyone involved needs for that relationship to support the individuals involved and how the individuals involved can support the relationship. It involves setting vulnerability, boundary setting, and negotiation around how the relationship can work for everyone. This requires both people to step outside their own narratives and ways of being to "move" with the relationship.

4. **MOVING TOWARDS:**
   - Moving Towards references moving toward the lives we want instead of moving away from the lives we do not want. It involves thinking beyond deficit language and humanizing everyone involved regardless of life experience. We often say that even being in this peer support relationship can be a form of "moving towards."

The Principles

FROM HELPING TO LEARNING TOGETHER:
In traditional service relationships, there is a clear hierarchy of one person "helping" another. Shery Mead once said, "If you've come to [Intentional Peer Support] to help people, you are in the wrong place." IPS states that both people are considered experts on their own experiences and have something to offer the relationship; it is through this sharing of knowledge/experience and subsequent self-discovery that both people cannot just "be supported," but support one another.



FROM INDIVIDUAL TO RELATIONSHIP:
Peer support does not begin with the assumption that there is a person with a "problem" for us to solve. Instead, we assume that both individuals in a relationship have something valuable to offer one another and that relationships are invaluable human experiences for learning and growth (for both people). When the focus is widened to all individuals involved, we are humanized in a way that offers us new possibilities for seeing and navigating the world.

FROM FEAR TO HOPE AND POSSIBILITY:
When struggles are present in life, or someone is navigating those challenges in ways that might scare us, the traditional mental health system and other places in our communities may react by offering solutions and the "containment of risk." However, we acknowledge that "crisis" and risk can be powerful experiences for our growth and that exerting control over people in crisis as a means of responding to risk can restrain our growth and shut down possibilities. When we focus on what is possible in our lives and negotiate what we both need when activated or afraid, our energy shifts from containment towards creation, interpersonally and systemically.

FROM THE INTENTIONAL PEER SUPPORT WEBSITE:
"Intentional Peer Support is about the conversation. It's about how we know, how we create new "knowing" through dialogue, and about how we as human beings interrelate by beginning to practice the art of connection – with ourselves, the people in our lives, and the people on the planet we may think we have nothing in common with. For me, it is a practice that has no right or wrong. It is always in flux; much like improvisation in music. It is a process of experimentation and co-creation. It assumes that we "play" off each other and create more interesting and complex ways of understanding. *We see it as a tool for keeping the world on its toes, becoming more comfortable with less predictability as we become less reactive to fear.* In other words, it is not another practice that presumes but having the answers; instead, it aims to generate good questions." – IPS Central

COMMON ELEMENTS OF PEER SUPPORT ROLES:

- Engaging in one-on-one support (home, community, inpatient setting visits, etc.)
- Facilitating peer support groups
    - Alternatives to Suicide and Hearing Voices groups are strongly encouraged
- Phone/text/zoom support
- Going for walks, hiking, coffee shops, and other community settings
    - Avoid "office" or therapy style settings
- Connecting people to various healing/recovery communities of their choice
- Sharing of resources when requested (not jumping to problem solving!)
- Opening up new ways of seeing the world and making meaning
- Each person challenging their beliefs/ideas

COMMON EXAMPLES OF CO-OPTATION:

The following dynamics are mistakes we see teams make frequently during peer support integration. While peer support implementation efforts have some natural diversity inter-organizationally, our field generally avoids these dynamics during implementation.

If you have begun implementation or worked with peer supporters for some time, it is never too late to re-adjust, as this is a common practice in any field. We hope this section and the rest of this document offer a clear rationale for avoiding these dynamics.

ROLE BLENDING

Peer supporters are asked to take on case management, med management, or administrative responsibilities outside their role. We have even seen peer supporters being asked to do maintenance or interior decorating work. Although these examples may seem explicit, role blending can often be subtle. The separation of peer support roles from any other role on the team is crucial.

REP-PAYEES

In some instances, we have seen peer supporters tasked with rep-payee responsibilities for the folks they work with. This puts those in peer support roles in charge of others' finances. This is an incredibly unethical

TOKENIZATION

Tokenization refers to an umbrella of behaviors where a peer supporter is placed in a position of representation that is more performative than substantive. For example, an organization could hire someone in a peer support role but see it as a "checkbox" to meet regulatory requirements or appear "recovery-oriented" to the public without attempting to uphold fidelity as outlined in this document. This places the peer supporter and the field of peer support at high risk for co-optation.

Other examples of co-optation include asking peer supporters to be present during clinical discussions, requesting excessive documentation, or expecting someone to be "fully recovered" or to "role model recovery" in a peer support role. We address the problematic nature of these dynamics throughout this document.

What do we mean when we say "Mutuality?"

As referenced earlier, "mutuality" does not just mean that we have shared lived experiences. Mutuality references the idea that both individuals within a peer support relationship are responsible for supporting the relationship by "owning their part" and attempting to hear the other person fully. We often say that mutuality means "if the relationship is not working for both people, it isn't working."

MUTUALITY IS CENTERED ON NEGOTIATION

This includes everything from where to meet and what we do when we are together to what one person might need if they are afraid or hurt.

Organizations need to understand that it is a vital component of peer support work for this element to be a consistent practice. This includes peer support staff being vulnerable and setting boundaries, voicing their concerns in terms of feelings rather than organizational policy ("I can't do that because I'm trying to focus on _____" rather than "I can't do that because it's against the rules."), and openly discussing self-harm, suicide, and other situations where clinical settings may advise "assessment" and questions like 'Are you safe?', 'Do you have a plan?', etc.

If organizations attempt to place containers around the fluidity of mutuality, peer support loses its value. Mutuality's true purpose and expansive utility should be encouraged by multidisciplinary teams, acknowledging the value in its difference from standardized team processes. Peer supporters should be trusted to practice this principle with compassion, curiosity, and courage.

INTRODUCTION

A strong supervision structure is crucial to support peer supporters working on successful multidisciplinary teams and ensuring fidelity to the peer support model. We recommend two primary ongoing supervisions: regular one-on-one meetings with an Intentional Peer Support (IPS) [1] trained supervisor who is *not* embedded in the multidisciplinary treatment program paired with communication and group supervision with the program manager/lead of the multidisciplinary team.

Direct Supervision – Peer Support Supervisor

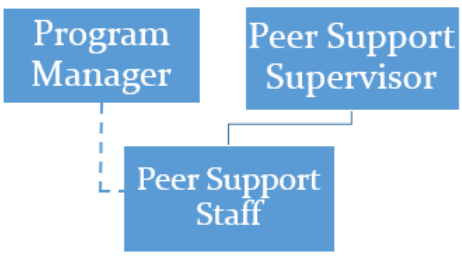
Peer support positions operate under specific models that differ from traditional clinical/provider models. Therefore, it is imperative that the peer support supervisor is trained in IPS, openly identifies with mental health/substance use/other life challenges and has experience practicing in a peer support role. Folks in these roles should also be familiar with the power dynamics often involved in navigating clinical systems (i.e., the potential for loss of power and autonomy and how to navigate these complex systems). The peer support supervisor is also keenly aware of the power dynamics in hierarchical relationships and creates space for challenging conversations without leveraging power in problematic ways.

The peer support supervisor offers education on the peer support model, strategies to navigate challenges in peer support relationships, and connection to the larger peer support team. The peer support supervisor also helps identify and resolve integration concerns and communicates about the peer support model with the multidisciplinary team, among other responsibilities.

The peer support supervisor should be aware of any desires or requests of the program manager (defined here as the leader of the multidisciplinary team) for the peer support role. This allows the peer support supervisor to cross-check these directives for fidelity and advocate as needed. Day-to-day logistics do not need peer support supervisor input (e.g., when the team shares administrative information, connects with a program participant, has impromptu meetings, etc.).

FREQUENCY: Weekly to start for the first month(s) of employment, shifting to bi-weekly or monthly over time. The frequency of supervision will correspond with the needs of the peer supporter.

Figure 1: Supervision Reporting Structure



Key Qualifications: Direct Supervisor

- Trained in peer support model
- Lived/Living Experience[2]
- Experience practicing peer support
- Anti-oppressive philosophy

[1] We use IPS throughout, as it is the foundational model in the state of Maine. This would be replaced with your model if you utilize something different. [2] This refers to openness around personal experience with mental health, substance use, or other life struggles.

Group Supervision – Peer Support Supervisor and Program Manager

The program manager has a critical oversight role in program operations, team communication, and implementation of the peer support role. This is represented by a dotted line from the peer supporter to the program manager, as shown in Figure 1. Regular meetings with the peer support supervisor, program manager, and those in peer support roles ensure that effective program functioning, the fidelity of the peer support role, and the support of the peer supporter are appropriately considered.

The peer supporter and program manager may meet 1-1 for coordination and support, but this is done thoughtfully and does not contribute to diluting the roles/values. It would be problematic if the peer supporter disclosed information about a participant in the program and the program manager took action or shared that information with the rest of the team without the person's permission.

FREQUENCY: Bi-weekly for the first month of employment, then monthly. Frequency is based on need.

Supervision Example

The example below provides one possibility for the initial integration and ongoing supervision structure. These are **minimum** expectations; more supervision can be added as needed – and is often adjusted when challenges emerge.

Initial Integration Period: Weekly 1:1 supervision; biweekly group supervision with the program manager

Ongoing*: Biweekly/Monthly 1:1 supervision; Monthly group supervision with the program manager

* The transition from "initial integration" to "ongoing" is determined by the needs of the peer supporter.

"When you start with a new model, best to set up as intended. You can always make decisions later to "tailor" it once you really understand it. I find that when people try to convince me that the new model isn't working, it is usually because they are not fully embracing it and following the guidelines."

- *Sarah Lynch, Clinical Program Manager, Portland Identification & Early Referral Program ("First Episode Psychosis" Program in Maine)*

Peer Support "Staff Meetings"

Whenever possible, we encourage *peer supporter-only* meetings, which can include those in peer support roles from different programs at the agency. This has reduced feelings of isolation and overwhelm for individuals who are the only peer supporter on their multidisciplinary team.

These meetings promote ongoing mutual support, collaboration, skill building, peer support fidelity and professional development. They may be scheduled weekly, biweekly, or monthly depending on the program's needs.

Example: We have offered biweekly "practice sessions" to try new ways of navigating challenges and a monthly group facilitator meeting. We have a monthly internal co-reflection, which various folks on our team facilitate – modeled after IPS Central's Co-reflection Process (discussed later). Lastly, we have a monthly "All-Peer Support" meeting, which includes team building, mutual support, and training offered by internal and external experts.

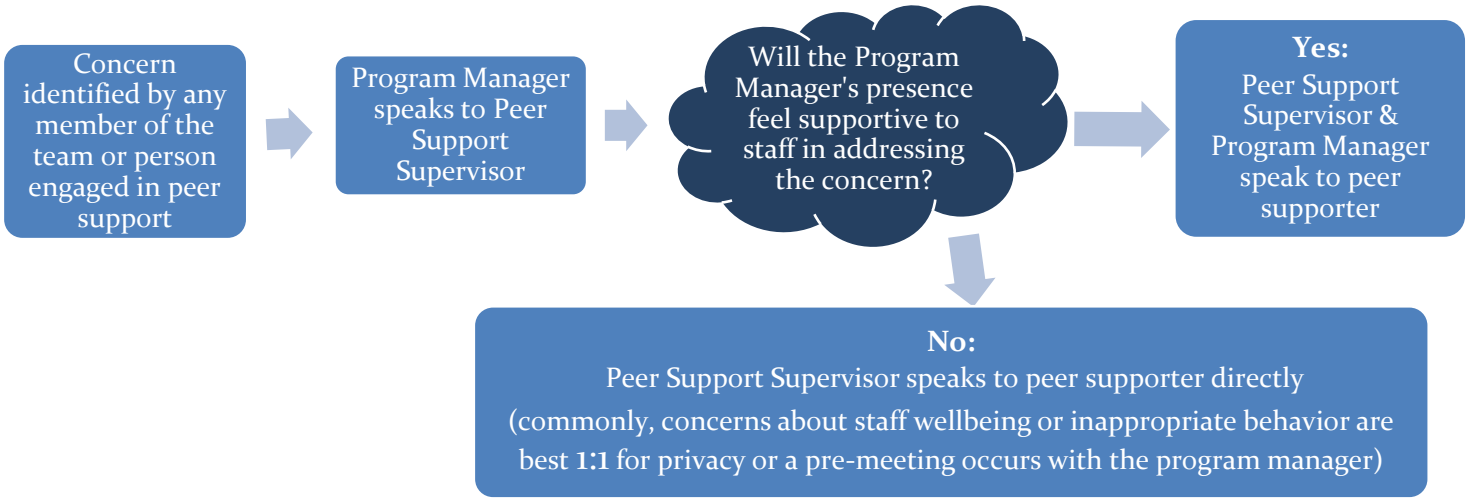
All-Peer Support Training

- Harm Reduction
- Domestic violence
- Anti-racism Topics
- De-colonization
- Deaf/hard of hearing cultures
- Advocacy Orgs
- Vicarious Trauma
- Grief/loss in support roles
- Relevant Legislation

Work Expectations

The program manager and peer support supervisor should discuss performance expectations early on, so they are clear and agreed upon by both parties.

Since the peer support supervisor is critical in maintaining fidelity to the peer support model, they will ultimately take the lead on addressing concerns. However, the program manager is an important partner in the process. Our approach is outlined below:



The peer support supervisor will take the lead for matters involving the human resources department. Practices for navigating these situations from the peer support supervisor's perspective are captured in the "Culture" section later in the manual. The program manager can be consulted where appropriate, such as gathering information when the peer supporter is accused of doing something problematic.

INTRODUCTION

It is prudent that team meetings are designed intentionally. While they provide an opportunity to support staff connection and allow team members to learn from each other's disciplines, they are often a culprit of peer support co-optation.

These meetings can create space for checking in around specific dynamics as outlined below and in the "Team Communication" section. To maintain fidelity, peer supporters are intentionally **NOT** present during the clinical discussions about specific individuals or "cases." This almost always requires teams to reorganize their team meetings.

Team Meeting Structure

Multidisciplinary teams with peer supporters **must** have a team meeting structure that maintains the fidelity of the peer support model. An effective team meeting structure allows staff to connect with one another and incorporates the peer support model/role meaningfully.

Core Elements:

- Peer Supporter is present at the beginning of the meeting
- Peer Supporter has space to ask questions and field questions
- Peer Supporter is present for discussions about logistical info (which team member sees whom [without any clinical/life details about the person], any administrative updates, office events, training, new policies, etc.)
- Offers check-ins with all team members *(see Team Building section)*
- **Those in peer support roles leave before any clinical discussion takes place**
    - It is absolutely necessary that this is **always** the case. (*see next page)*

Adding Peer Support to an Existing Team

When adding peer supporters to an existing team for the first time:

The presence of a peer supporter almost always necessitates the reconfiguration of the team meeting; this may be disruptive to typical team culture and processes. The concerns around this disruption are valid, yet the perils of not taking time for this modification are far more problematic. In our experience, those peer supporters on teams that have not made this a priority have experienced low job satisfaction, burnout, higher turnover, and inter-team turmoil. Therefore, we strongly recommend that program managers work collaboratively with the peer support supervisor to implement changes to the team meeting structure in a way that best supports all staff during the transition.

Why Peer Supporters Are Not Present in Clinical Discussions

There is power in sharing our own stories and maintaining the autonomy of how, when, and to whom we share pieces of our lives. Hopefully, this is power that we all hold outside the mental health system. If we went to a coffee shop with a friend and they knew something about us that we did not directly tell them, we would probably be pretty upset, and trust in the relationship would be impacted. Sometimes we forget about this in the clinical field, and it becomes so normalized that we stop reflecting on what an individual can internalize about themselves during the process (e.g., everyone else is the expert, we are a "case" to be solved or managed, etc.).

When we offer people the choice to share what they want as trust develops in the relationship, we reinforce the power-sharing that is so crucial to peer support work. We reinforce that people are able to make decisions for themselves and have the opportunity to create *their own narratives* about their lives, which may involve unlearning deficit narratives that can limit growth.

Additionally, hearing what other clinical staff say about someone changes how peer supporters approach the person, what they might bring up, and how they might interpret things. It makes it hard to truly meet the person without judgment and with an open mind, which limits the opportunities for co-learning and power sharing. It infringes on having an authentic, trusting, open and honest relationship, particularly when the peer supporter is asked NOT to share what was discussed.

Nothing About Us Without Us!

From the beginning, peer support has been an alternative to mainstream mental health treatment. Foundational to this are our roots in the disability justice framework of "Nothing about us without us". This communication structure with team members is crucial to practicing in alignment with those roots. **Any time a peer supporter shares personal information about someone receiving services to team members, they step away from our core principle of "nothing about us, without us."**

The history of our work has taught us that when peer supporters begin to replicate clinical practices such as talking about folks when they are not present, they lose the nature and intent of the role, and more importantly, its effectiveness in creating space for people to make new meaning in their lives.

But what about the value of the peer support voice on the team?

We acknowledge the value the peer support voice can bring to clinical discussions, particularly in offering alternative perspectives and shifting away from diagnostic/deficit language. However, we believe our priority must always be the *individual relationships* with the people with who we practice peer support. It is a form of tokenism to suggest that those in peer support roles must hold the voice of all "peer support values" and human/patient rights. Every team member has this responsibility. ***Maintaining the sacredness of the individual peer support relationship is more important than having the peer support perspective at the table during a clinical discussion about a specific person – especially when there are other ways to bring their perspective into team discussions*** (see thematic discussions section)**.**

But what if the person in services doesn't care?

Some people may be ambivalent or unconcerned about people talking about them when they are not present. This does not negate the necessity of the peer support role offering alternatives. We want to contribute to people reclaiming their voice and choice instead of contributing to the conditioning of ambivalence around folks' self-narratives. Often, when folks are in "client" roles for a long time, they internalize that they are not the expert of themselves. It is a foundational value of IPS to challenge that internalized notion, the importance of which folks are sometimes not fully consciously aware of after years of being in service and having their story written for them.

So they can never be present?

If the person in services is present for the discussion ***and*** wants the peer supporter to be there ***and*** they have discussed the peer supporter's role for the meeting (along with what is off limits to talk about), then the peer supporter may be present for the discussion. The intent in this scenario is to support the person, not the team (and is not to push an agenda). The peer supporter should redirect any questions asked of them to the program participant; we often see this dynamic arise and should strive to encourage providers to speak directly to the person.

It may be helpful to talk to other organizations with this same focus and intent. It can offer additional ways to include the peer support voice, structure clinical discussions, and strengthen communication in ways that promotes learning, community building, advocacy approaches, and fidelity.

> "Start with asking the questions: What is going well with what you have currently in place? How can this new model maintain some of these successes? What could be better? What do you hope to have this new model offer to your system? How can it help to standardize the peer support role, and support peer support staff to not get pulled into other roles? Think of supporting peer support staff in the same way that other disciplines on the team have their own training, supervision and parameters. Structure helps with consistency and helps people feel supported in their unique role."
>
> - *Sara Schmalz, Clinical Director, Behavioral Health Clinic*

INTRODUCTION

Sharing information is one of the more nuanced and, at times challenging aspect of collaborating on multidisciplinary teams. We have outlined general categories of information that we recommend sharing frequently, seldom, and never.

What Information to Share Frequently

Information that can be shared between the team and peer support <u>frequently</u>:

FREQUENT

Logistics

From Team to Peer Support:
Where the person is (location), changes (e.g., hospital), and next office visit

From Peer Support to Team:
Where, with whom, and when peer support is meeting with people

Team Logistics

Administrative information (meetings, events, special occasions, etc.).

Connections

From Team to Peer Support:
Whom the peer supporter reaches out to (new program participants or ongoing participants who have requested peer support), partnering up with another team member to see someone (to facilitate trust), coordination for peer support involvement in intake meetings (for introductions, not the whole time), alerts of any discharges/program graduates, confirmations of new contacts with individuals in the program.

From Peer Support to Team:
Status of connections made (connected, still outreaching, having a hard time reaching, need support connecting), and strategies to address any needs (partner with another team member, coordinating a shared office visit, etc.).

Safety

From Team to Peer Support:
If there is a serious concern of physical harm to the peer supporter (to suggest meeting in a public place).

From Peer Support to Team:
If there was an incident where physical safety was compromised.

What Information to Share Seldomly

Information that can be shared between the team and peer support <u>seldomly</u> <u>(and with great caution):</u>

"Crisis"

SELDOM

From Team to Peer Support:

If the team hasn't heard from the person in a considerable amount of time, if a person is having a significantly challenging time/has changed location because of challenges (e.g., crisis unit, hospital, etc.).

From Peer Support to Team:

If peer support hasn't heard from the person in a considerable amount of time.

If someone is struggling, it's okay to ask the peer supporter to reach out but **omit any other details around those struggles.**

"Give Jim a call, he's having a hard time."

EXAMPLE: Its okay for the peer supporter to know the person had police at their home, but peer supporters should avoid hearing about "why" unless it directly impacts their physical safety.

On Call:

From Team to Peer Support:

If someone has called an on-call instrument (pager, special line, etc.) looking for additional support from peer support

From Peer Support to Team:

There would be no communication from peer support to the team on this topic, as they would not hold on-call responsibilities on teams that have this resource.

What Information to Never Share

Information that is <u>never</u> to be shared between the team and peer support:

NEVER

Clinical Discussions

For Both Peer Supporters and Teams:

Clinical or treatment discussions about people in the program.

Judgments

For Both Peer Supporters and Teams:

Entering into assessments or judgments about someone and/or their decisions and behaviors.

Personal Info

For Both Peer Supporters and Teams:

Sharing a person's trauma history, diagnosis, and information about medication (including changes to meds), disclosing test results, or any other identifying or non-logistical personal details.

Peer Support Supervision is a place for those in peer support roles to share more detailed content (which has been de-identified) to improve and guide the peer support relationship. **We don't use names.**

Advocacy

Sometimes, individuals will ask peer supporters to relay information to clinical staff. Some peer supporters view this type of request, and their interest in agreeing to it, as a form of advocacy; there are caveats to this. We believe that each individual has the power to advocate for themselves, and that acting as a messenger can create a problematic power dynamic. When individuals ask peer support to relay information, we want to offer folks the opportunity to hone their own power, by:

- Discussing with the individual what they would like to express/request of the clinical staff and any barriers to doing so directly
- Helping the individual write down these thoughts to reference during that conversation
- Being present either on a phone call or in person during the conversation, but not speaking for the individual and redirecting any questions asked to the peer supporter back to the individual

We believe supporting the individual to express their concerns directly aligns with developing mutuality and shared power. However, in instances where the person is terrified or unaware of how to do this, it is sometimes OK for the peer supporter to advocate on someone's behalf *if they are present to witness it.* After this, a debrief should be conducted on what each person learned and how things could be improved.

INTRODUCTION

Documentation requires a thoughtful and intentional approach in peer support. The often definitive and deficit-based stories told in medical records have immense power. Whenever peer support is required to document, it should be done collaboratively and offer only the least possible amount of information required by state and federal regulators (typically for billing). "Nothing about us without us" is imperative to peer support fidelity, so creativity and advocacy are often important in responding to regulatory bodies requiring documentation.

Documentation Protocol

In a peer support relationship, it is necessary that both people feel confident that the information shared between them will stay between them. Peer support relationships mirror other trusting and healthy relationships – where we do not share the information entrusted to us with those outside the relationship. Many people we practice peer support with (and many of us ourselves) have had trust broken or had information that was shared in confidence used against them by service providers. Those in peer support roles will also share personal stories about their own experiences and will want to ensure their information is not shared outside the relationship. This is the relationship's "shared responsibility."

In many clinical settings, notes are required for billing or contract deliverables. Most often, the purpose of a note is to document that a meeting occurred for these purposes. **We only write notes if a regulatory entity or state grant administrator requires it**. We have successfully removed that requirement from some peer support grants by asking funders if it is possible for the information/data they need to be captured in de-identified ways, such as quantitative data that doesn't identify individuals. We've also been successful when senior leaders explained to Medicaid how adding a diagnosis or other element to our note is not aligned with our model.

Typical Note Example:

- "Met with _____ in the home (community or office or group). Talked about some challenges and hopes for the future. Planning to meet again soon."
- Talked about past experiences and how they have impacted present relationships.
- Working on building connection.
- Validated each other's recent challenges.

Language to Avoid:

- Any diagnostic or medical language (ex: "they were a little manic" or "they seemed depressed.")
- Any information about a person's mood, thoughts, or emotions – as it is more detail than necessary and is a judgment.
- Messages to team members (ex: "John wants the case manager to find transportation for next doctor's appointment." Peer support can support John in making that request directly.)

First Contact

Having early conversations about role expectations and breaking down assumptions is crucial to creating a space for learning and growing together, where the possibility of disconnection or harm is minimized. The first contact(s) is a great place for these discussions.

Confidentiality: Nearly all discussions will be entirely confidential, but the two individuals in the peer support relationship will need to discuss if there are ever circumstances where that would change. "Shared risk" is shorthand for the concept we use where the two individuals determine how the relationship can support really difficult emotional situations. These conversations are typically centered on medical emergencies, abuse, and suicide or self-harm. Conversations on these topics should be honored as sacred **and never expected to be relayed outside the relationship.** This should only occur when one person in the peer support relationship needs more support from the outside; the consequences of this should never be underestimated (police involvement, Child Protective Services, etc.), so the person needing external support should ask for that from someone who isn't going to take matters out of their hands.

Example: "When you talk about your plans to self-harm for the week, would you be willing to talk about harm reduction around cutting materials and practices to minimize the risk of hurting yourself? I know the worry is "my stuff," so I'm curious if that's a conversation you'd be willing to have?"

Sharing Information: We recommend that the peer supporter share that they will not be the middle person for information between any person receiving services and other team members. We also ask the person not to share with other team members any personal information the peer supporter has shared.

Documentation: Peer supporters should share what information is required to be documented, including specific examples as listed on the previous page. This can always be co-authored. Peer support may need to explain that the program exists because the state/contract/etc. pays for their time together, and that notes are how the funder knows that people are receiving support.

At the beginning of each peer support relationship, peer supporters explain what language will be used on a regular note. They then ask if the person is comfortable with language:

YES: Then offer that if at any point they want their notes to be different, we can talk about it. Notes can also be written together if both individuals desire. Our notes are so generic that people often don't want to add anything more.

NO: Then ask if we can talk about it and find a solution that works for both of us. This might include approving the specific wording. If still No, then the peer supporter would talk with their supervisor. Often these situations originate from an individual's trust being broken in the past, which deserves to be validated and honored.

INTRODUCTION

Thematic discussions are a process that allows all team members to offer their perspective or approach to situations encountered at work without focusing on a specific individual. They provide an opportunity for team members to better understand one another's perspectives and roles, and to build trust, collaboration, and comradery. These discussions help incorporate peer support voice into the team and help all team members grow. **It is important to create an environment that welcomes mistakes and encourages messy, challenging conversations.**

Thematic Discussion Structure

TIP: Leave time at team meetings once a month for **Thematic Discussions.**

Thematic discussions offer a reciprocal framework for the team to learn about the peer support perspective, and for those in peer support roles to learn about the team's approach, without focusing on individuals. Teams can deliberately build trust and community by intentionally making time for team members to learn from each other, particularly how their respective roles respond to challenging situations. A key element in this process is fostering an environment that welcomes uncomfortable/challenging conversations that are built on a foundation of curiosity and candor.

There are two core elements of this process:

1. De-identification
2. De-pathologizing

De-identifying the names or other identifying information about program participants is critical to the process. As mentioned in the "Multidisciplinary Team Meeting" section, the peer support role only receives information about a person from the person themselves and is only involved in discussions about them when they are present.

De-pathologizing conversations create space for all perspectives related to human experiences. They allow team members to use common language to explore a situation from a person-centered, strengths-based approach.

We have found that this specific de-pathologized and de-identified framing has the secondhand benefit of opening possibilities for the connection between clinicians and the people that they serve in a new way. In addition to improving peer support satisfaction and team cohesion, thematic discussions can enhance services and quality of care.

Normalizing Uncomfortable Conversations

Thematic Discussions offer the opportunity for each team to discover a balance of what level of detail in daily communication feels appropriate for both clinical and peer supporters. **This practice should exist within a culture that strives to embody a philosophy that *mistakes are OK to make here***. To set this tone for thematic conversations, this philosophy should be practiced in all realms of day-to-day team culture.

Below is an example of an individual conversation between a clinician and a peer supporter veering into territory that doesn't align with fidelity to the peer support model and how candor could be encouraged:

Clinician: "I'm not sure whether this is too much information to share or not. Could I try, and you let me know if I'm off the mark?"

Peer Support: "Yes."

Clinician: "I'd be really worried about this Sarah. I haven't heard from her in a week. She's gone off her meds before abruptly, and it ended poorly then. What do you think we should do?"

Peer Support: "I hear you that you're worried. I haven't heard from her either. I can keep trying to check in and let you know if we touch base. Since you welcomed the feedback, I'd prefer not to hear medication history in the future. That's the sort of thing that could impact our relationship, since I'm learning about it from you, not her."

Both peer support, and clinical staff can be apprehensive about these conversations. Those in peer support roles are rarely incentivized to challenge the status quo when too much information is shared, and clinical staff can be afraid of oversharing, so they communicate scarcely. We don't want anyone feeling like they have to walk on eggshells around other team members, hence striving for a culture of transparency where mistakes and candid feedback are normalized. This sets thematic conversations up for success, as candor can be a crucial element to fidelity and growth for everyone involved.

"If you are incorporating Intentional Peer Support onto an existing team and the process feels easy, there is probably a problem. Teams should be prepared for a period of growth and some discomfort (in a good way). Dialogue about questions should be encouraged and supported. There needs to be education throughout the service continuum that the value added is precisely in peer support roles NOT providing clinical services. This would be true even if there was a peer support staff with a PhD in Counseling Psychology. What makes it transformative is the difference."

- *Alan Bean Burpee,* Senior Director of Community-Based Programs, *Behavioral Health Clinic*

What Does This Look Like in Practice?

We have discussed why thematic discussions are important for team connection and fidelity to peer support. We have also shared the crucial elements of de-identification and de-pathologization. Here is a brief outline of what this process could look like:

1. Team decides to present a situation they might realistically encounter and be struggling with (someone struggling with intense isolation, self-harm, hearing voices, stopping medication, etc.)

2. Team vets the presentation for pathology and identifying information: peer support should support this process but not be expected to be the only voice

3. One team member facilitates discussions around the topic with a guided outline. Outline topics can include:
    - Situation
    - Team member reactions ("This brings up sadness/fear/confusion for me")
    - Clarifying questions
    - Possible ways forward in the situation
    - Ways in which the team members can support one another

4. The team does a "check out" and offers feedback about the process. A follow-up thematic conversation can be planned.

This process could either be around an actual situation or a hypothetical one. If real, de-identification becomes crucial.

Peer supporters and other team members are encouraged to speak very openly if the conversation veers into pathology or clinical assessment. This process should be highlighted by team self-awareness and self-reflection, with the entire team seeking to grow its proficiency in various situations through an IPS-influenced lens.

INTRODUCTION

As highlighted throughout this document, the balance of fostering both peer support autonomy/fidelity and team cohesion is challenging yet vital. Familiarizing one another with the various models/philosophies practiced by each time member is helpful to this process.

We recommend giving the multidisciplinary team a formal introduction to the peer support model and role and incorporating continuing education on this topic. We have practiced quarterly training for the team, and quarterly or yearly agency-wide trainings that incorporate information about all disciplines on the team.

Peer Support Trainings for Team

Training the entire multidisciplinary team in the various aspects of the peer support model is an excellent way to support peer supporters in maintaining the model's integrity in a clinical setting. It also provides a foundation for conversation and mutual learning.

To fully support the peer support role, it is essential for the team to understand the model. Carving out specific training time throughout the peer support integration process is necessary to move towards this understanding and support. This may be true for all disciplines if the entire team is new.

FREQUENCY: Quarterly (Some teams choose to do this monthly if time permits, focusing on a deeper dive of one task or specific principle or value)

Agency-Wide/Multiple-Team Large Trainings

Many teams/agencies have regular training opportunities. We recommend that space is created for learning about peer support at these trainings. If consultation groups exist in your agency for determining annual/quarterly training topics, it is best for those peer support roles to participate in these groups actively.

FREQUENCY: Quarterly or annually (or as frequently as agency/team trainings occur)

An Important Note on Peer Support Continuing Education

Best practices in peer support are constantly evolving, and it is important that both peer supporters and peer support supervisors are consistently trained in new ideas, developments, and ways of practicing the model. An organization that invests in peer support should be prepared to regularly assess these training needs from peer supporters and supervisors and account for them in the budget, just as they would with any clinical position.

INTRODUCTION

The confluence of integration factors unique to the peer support role, such as not being present during clinical conversations, offering alternatives to pathology, and only minimally documenting interactions, can make peer supporters feel disconnected from the team. Additionally, teams can feel disconnected from peer support given that their interactions with peer supporters are different from those of their clinical colleagues (e.g., many clinical roles build relationships by talking about "cases"). Intentionally structuring times for dedicated team relationship building is important for employee health and retention and for team connection.

Team Building Exercises

Building relationships with other team members is an important component of work satisfaction, particularly given the above-mentioned concern. Unfortunately, traditional team building often occurs as team members discuss specific "client" concerns and collaborate on solutions, rather than as part of a thematic discussion as outlined in a prior section.

One possibility we've seen success with is a focus on getting to know each other or getting to know how the team navigates challenging situations. Examples include:

LIFE CENTERED:

- What's important to you when you're not at work?
- Did you have a role model growing up? If so, who?
- What did you want to do for a living when you were a kid?
- Who would you have dinner with if you could?
- What's a favorite memory that has stuck with you? Why?
- What's your favorite activity to do locally and why?
- What was your worst style choice growing up?

WORK CENTERED:

- What kind of conversations would we have with someone who shares about self-harming?
- Have you incorporated any harm reduction conversations into your work this week? How?
- What is one strategy you are using (or trying) to help create balance in your work?
- What is one challenge you are experiencing at work right now?

Think about how you can incorporate time for both team rapport building and de-identifying thematic discussions amongst team members in your team meetings and training. Annual team retreats have proven successful, too.

Co-Reflection for Multidisciplinary Teams

For multidisciplinary teams with peer supporters on them, we recommend that in addition to regular training, peer supporters lead "co-reflections."

Co-reflection explores how the person in the 'support' role is contributing to and being impacted by the challenges in a peer support relationship, what it is bringing up for them, and how they are contributing to the challenges in the relationship. It is an important component of IPS work, as it fosters self-awareness and allows reflection on what the 'supporter' needs moving forward. If other multidisciplinary participants are willing to be vulnerable in this space, it can increase connection with peer supporters *and* with the folks in their services.

These gatherings focus on the tasks and principles of Intentional Peer Support and recognize there are myriad ways of making sense of the human experience in a non-pathologizing manner. It is a pre-requisite that participants come with a willingness to step outside clinical language and diagnostic categorization.

The structure of these gatherings usually involves:

1. Introduction: how is everyone feeling/coming into the space, or other check-in
2. IPS Task & Principle Discussion: What it means, why it's important, and each person's experience
3. Discussion of challenges: a focus is on opening up possibilities and perspectives around a situation

The term "co-reflection" and structure are from IPS Central.
You can learn about IPS Central's Co-reflections here:
[Co-Reflection | Intentional Peer Support]

"I have gently said to case managers and therapists that some of the people we work with have had providers for years, and probably have a sense of what and how we are going to say something before we say it. With a less traditional approach like IPS, issues and needs can be framed differently, and the conversation look so different even around the same topic. This can lead to a shift or change. This remains true even if case managers or therapists are doing what they can to mitigate power dynamics, and avoid the "medical model." The role needs to be different (intentionally.) In this way, the services and approaches can truly complement each other."

- *Sara Schmalz, Clinical Director, Behavioral Health Clinic*

INTRODUCTION

We recommend that every agency have a Peer Support "department" for peer supporters to gather regularly. These departments are divisions where there are people focused explicitly on overseeing the development of peer support in an organization, including representation of those fitting the above description of a peer support supervisor in senior leadership.

Peer support departments offer spaces for mutual support, collaboration, training, and relationship-building that are essential for sustainability. Those in peer support roles who are supervised outside of these departments often experience role blending. This leads to a sense of isolation that is not conducive to personal or professional health for the individual or an organization with peer supporters.

What Can A Peer Support Department Look Like?

PRACTICE & SUPPORT SESSIONS:

Our peer supporters meet bi-monthly to "role play" challenging situations. This practice opportunity has proven extremely helpful, as peer supporters try language and approaches to have transparent conversations around disconnection or conflict.

Similarly, we provide a monthly group facilitation support meeting to allow folks to share concerns and challenges around group facilitation.

We recommend connecting peer supporters with colleagues doing this work (even if they are working at other agencies) to gain access to this significant learning opportunity.

LEADERSHIP & PROFESSIONAL DEVELOPMENT:

Since shared power is a vital component of the work, peer support department leadership needs to facilitate a more horizontal culture with shared decision-making processes. There are various ways to glean meaningful input from direct support roles. We encourage you to seek those out and explore them with your team.

Providing opportunities for folks to gain experience with various components of leadership is critical. Some practices we have implemented include grant writing workshops, peer support supervision working groups, meeting facilitation and project management skill shares, and organizational policy sub-committees.

CO-REFLECTIONS/GROUP SUPERVISION

Peer Support Department Managers & Supervisors and agency peer supporters (inside and outside the specific team) meet at least monthly as a group to build community, navigate challenges together, and have specific training/information that enhances the work. Peer support should never be practiced in isolation.

This is available as an entire team across the agency and within specific "disciplines" of peer support (e.g., substance use, family, youth, etc.)

ANTI-OPPRESSIVE CONSCIOUSNESS EDUCATION:

A critical component of any peer support department is integrating a robust anti-oppressive curriculum. Peer supporters should be able to understand the interrelated causes and effects of racism, patriarchy, poverty, ableism, and sexism (among other oppressive systems) and apply those understandings to peer support relationships. Peer support departments can also play an essential role in manifesting anti-oppressive values in larger organizations that have not integrated this consciousness into their foundational values or treatment principles. Investment by Peer Support Department leadership in undoing systems of white supremacy is necessary.

What Do We Mean by "Shared Power"?

IN PEER SUPPORT RELATIONSHIPS

We discuss the concept of "shared power" as a fluid process of speaking to the type of power we hold, each of our feelings and challenges around any power imbalances, and negotiating how we can practice sharing power together. This often shows up as one person being paid while another person is not, one person having the "organizational credibility" of having a job title and status, or one person not being beholden to an intensive setting (inpatient, court-mandated outpatient, etc.). Imbalances in power can lead to individuals internalizing deficiency, limiting the pathways toward living a fulfilling life.

WITHIN A PEER SUPPORT DEPARTMENT

This principle should also be practiced. There is often a hierarchy in these departments that denote specific responsibilities (i.e., director, manager, supervisor, direct peer supporter, etc.) and respective levels of power and status. It is important to recognize how power imbalances can leave peer supporters feeling dissatisfied or misrepresented, and to take concrete operational steps to ensure power is shared in hierarchical structures.

"Peer support has been an essential component of the MaineMOM program as it gives my patients a safe and confidential space to explore their recovery. Having peer support on our team also makes me a better medical provider as their lived experience gives me new perspectives on how I might best support and care for my patients.

This manual should be mandatory reading for any medical team with integrated peer support. It beautifully explains both the philosophy of peer support and clarifies what the role is (and is not)."

- *Alane O'Connor, DNP, Clinical Advisor, Maternal Opioid Misuse (MOM) Initiative; Director, Perinatal Addiction Medicine*

Some ways this can be done

ESTABLISHING ANONYMOUS MECHANISMS FOR CANDID FEEDBACK.

- We consistently survey our team on supervision satisfaction (Does your supervisor treat you with respect? What could be different?), training needs, and team decisions that need to be made. These decisions run the spectrum – smaller items to department-altering decisions; the critical concept is that *all peer supporters should have multiple mechanisms for feedback that account for power imbalances in the organizational hierarchy.*

SPACE FOR FEEDBACK

- Offering peer supporters substantive places to offer feedback on treatment standards and organizational policy. In healthcare systems, it can become lost that those in peer support roles are not simply being open about lived experience but advocating for more significant change. Organizations investing in peer support must create non-performative pathways for peer supporters to influence best practices.

ENCOURAGING DISCUSSION

- Breaking peer supporters into smaller groups and encouraging discussion about satisfaction and dissatisfaction around work. Individuals with less organizational power can be intimidated to be candid with a supervisor because of possible ramifications; if a group approaches a supervisor with a concern, the group is safer from a supervisor's unchecked power than an individual might be. We offer time in our monthly staff meeting for this: breaking our team into small groups based on organizational title and having them return to a larger group to provide feedback, both positive and negative. Peer support leadership should be grounded in hearing peer supporter concerns around labor recognition and fidelity.

CREATING WORKING GROUPS/COMMITTEES

- Our team has working groups of peer supporters to decide and inform practices. For instance, developing processes around onboarding/welcoming new staff onto the team (what's working, what's needed), anti-racism (to create materials that foster anti-racism work inside and outside our organizations), website content and design (to update the language on our public facing website to align with our roles/values), developing tip sheets (addressing oppressive/racist comments, inappropriate sexual/romantic comments, first contract conversations) etc.

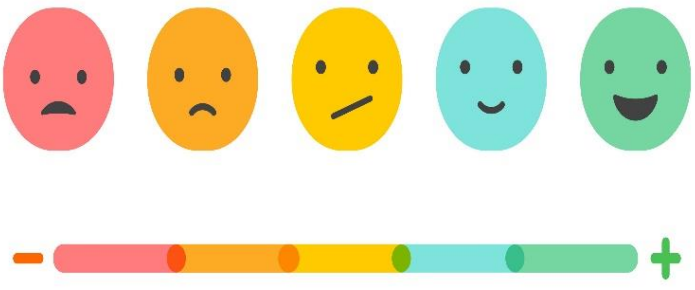
More ways this can be done

SUPERVISIONS

- Pertaining to peer support supervision, vulnerability and mutuality can be centered when performance concerns arise, rather than traditional corrective action measures. Expressing confusion or frustration with someone's actions on the job, extending curiosity as to what led them to the decisions they've made, and planning together to address both individuals' concerns should be the aim of this discussion. Corrective action processes are often ineffective because punitive measures frequently foster shame, so they should only be resorted to if someone is causing harm and IPS-influenced restorative options do not work. Mutuality means peer supporters *and* supervisors are seeking to grow together.

PAY EQUITY

- Most importantly, *pay equity*. Peer supporters are universally underpaid. A culture of shared power and respect cannot be achieved without proper compensation. Pay standards should be based on peer supporter feedback and national/state metrics around what constitutes a *comfortable* living wage. Wages set from national standards are well behind the curve and lead to peer supporters working longer hours at a second job and/or living paycheck to paycheck.



IN CONCLUSION

Many within the peer support, consumer/survivor, and ex-patient movement feel conflicted or even strongly opposed to the idea of integrating peer support roles into healthcare or other institutional systems. These sentiments suggest that we cannot possibly integrate into the systems whose oppression necessitated our birth without significant co-optation. We respect this worldview and the powerful work in our movement outside these systems. It is imperative to develop universal human rights within the mental health system for these outside-of-the-system movements to flourish.

We also recognize the current healthcare trends proliferating peer support positions and the importance of including this human rights, anti-oppressive perspective inside the mental health system. As a result, we find great merit in carefully drawing out what peer support integration can look like within that system. We have outlined several essential components of this integration: supervision, team meetings, thematic discussions, training and education, team building, documentation, sharing of information, and culture.

Based on feedback from those in peer support roles and several recent articles about co-optation, it seems clear that many settings have not integrated peer support into their healthcare systems with the same focus on upholding peer support fidelity. For that reason, we embarked on this journey to offer our experience and recommendations while acknowledging that this work will inevitably evolve past this point in time. We welcome that growth and those lessons as we seek to build community with those embarking on similar journeys.

We hope this document will serve as one guide for your practice in mental health care settings, leadership, and community building in a way that is most conducive to the origins of our work and, ultimately, to the well-being of our communities.

In solidarity,
The authors.

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Note: If you would like to use text from this document in your own products/documents; or present this information in forums outside your agency, please contact us before doing so. We also welcome feedback. *We are happy to offer consultation, support or training on integrating peer support onto multidisciplinary teams.*

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