Challenges and Strategies of Peer Support in Clinical Settings

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Sanism

Challenge	Our Work	Others' Work and/ or Shared Work
The real and perceived pressure to be "extra" professional or excellent in order to manage discriminatory expectations *We feel this as a pressure to*: ● Be super reliable, consistent, predictable, to keep our commitments at all costs ● Curb our feelings or passion when speaking; to be "rational" i.e. not be overly emotional or "too sensitive"; not to be or make things "difficult"; not to "make a scene" ● Be highly productive ● Not need extra support and processing time ● Have higher education ● Be able to understand and connect with everyone	Build and maintain a supportive team Intentionally undermine certain notions of professionalism that don't align with our values and uphold the ones that do Speak only about what we know Incorporate own emotions and experiences	Acknowledge the challenge and impact of sanism Include sanism in cultural humility training and other conversations about oppression Ask peer support (PS) staff about their experience Create safe space for all staff to be vulnerable, human, and open Value lived experience for staff in all roles Incorporate emotions and experiences
Exposure to trauma and oppression	Exercise choice around where and with whom we're working, e.g. whether to go to an ER, inpatient unit, who we support and/or work with, etc. Build a supportive team culture with consistent check-ins and team-building exercises	Allow choice around where and with whom peer support staff are working Provide and seek out education on the effects of trauma, sanism, and coercion Recognize and unlearn sanism

	Inform candidates about risk of trauma exposure in the interview process Have a team approach to referrals Request accommodations and support if and when needed	Provide EAP, paid medical leave, short term disability, flexible work schedule, and generous paid time off for all staff No unique paternalistic policy Hire supervisor with shared experiences Avoid saying and doing traumatizing things, e.g. not imposing disease models, avoiding coercion, etc. Provide reasonable accommodations
The expectation of being "recovered enough"	Build team culture of openness, vulnerability, and support See past *and* current experience of distress, madness, etc. as valuable sources of wisdom and connection Challenge the notion of "recovery"	Focus on ability to do the job Provide accommodations if relevant and possible Build and support agency culture of openness, vulnerability, and support See past and current experience of distress, madness, etc. as valuable sources of wisdom and connection Challenge culturally and socially dominant meanings of "recovery" Offer both full and part time employment options, and include the possibility of these shifting over time in either direction Provide EAP, paid medical leave, short term disability, flexible work schedule, and

		generous paid time off for all staff

Fear

Challenge	Our Work	Others' Work and/or Shared Work
Lack of understanding of peer support (by non-peer support staff)	Peer Support roadshow, i.e. going to different departments and locations to explain what Peer Support is and our process, etc. Practice patience and expect incomplete understanding Use the Peer Support brochure Being explicit about not being anti-everything, but pro-informed consent, non-coercive practices, transparency, etc.	Support from managers to help teams fully understand the roles of Peer Support Advocates Reach out with questions Include Peer Support in the onboarding of new staff Changing name of role from Peer Support Specialist to Peer Support Advocate
Perception of peer support as the "morality police" or fear of moral judgment from peer support staff	Assume best intentions and that folks are doing the best they can with the tools they have & what they have learned Intentionally learn about where co-workers are coming from Choose our battles Acknowledge the pressures that exist for those working within the system to not change, engage in self-reflection, etc. Nodding in disagreement Give affirmation to co-workers who may be perceiving us that way when we can	Other staff and managers modeling solicitation and reception of feedback and lack of defensiveness Engage in internal self-reflection, bring feelings to supervision, be vulnerable Create a culture of learning, growth, and development, which includes being open to feedback and accountability Move away from shaming and blaming forms of accountability overall

	Not taking on too much responsibility for this problem	Be open and transparent about feelings, including feelings of being judged Set standards for supervision that includes critical review and feedback as a way to build resiliency in receiving feedback, developing self-awareness and tolerance for difficult conversations
Lack of trust of PS	Facilitating & participating in co-reflection with clinicians and case managers Attending meetings with various staff Building relationships (including getting to know each other outside of work roles) Build on positive experiences by logging and referring back to them Engage in regular practices of self-reflection and self-awareness on our end	Keep an open line of communication with PS Initiate dialogue with PS staff Debrief and check in with folks after an experience; reflect together on what can be learned from the experience Assume best intentions Come from a place of curiosity Value doing the right thing over the easy thing Give people the support to do the right things by slowing down and having a more risk-tolerant culture
Loss of Expert Status	Embed peer support staff on teams Facilitating and participating in co-reflection Develop a philosophy of care and/or ethical guidelines that explicitly set expectations Develop competence in alternative frameworks for	Build self awareness through co-reflection, individual and group supervision Agency wide accountability to philosophy of care and approach Training

	understanding experience at all levels, starting with leadership Validate all roles as important	

Co-optation

Challenge	Our Work	Others' Work and/ or Shared Work
Tokenism of PS staff	Create a PS management position Resist speaking for all psychiatrically labelled people Ensure broad representation on agency committees, including serving as chair on several Lead trainings, offer education, resources, consulting, etc. Acknowledge that we do get tokenized, partly due to our low numbers *Include people receiving services in our advocacy efforts*	Higher level management follows leadership of PS, advocate on behalf of PS, allow autonomy in PS program design and decision-making, and demonstrate buy-in to PS Higher level management regularly solicits and truly values feedback and concerns of PS, as well as Standing Committee, people receiving services, and community members Understanding PS staff do not speak for all psychiatrically labelled people and that there are a multiplicity of perspectives and experiences in the psychiatric survivor community
Lack of funding	Not allowing financial concerns to compromise how we do the work Apply for grants	Pay PS staff competitively regardless of funding Use allocations from other programs Apply for grants in collaboration with the PS team Advocate for expanded PS funding

Lack of training	Create and implement thorough onboarding Require Intentional Peer Support Core Training, Hearing Voicing Network Facilitator Training, and Alternatives to Suicide Facilitator Training at a minimum Support team to seek out trainings to request and/or suggest	Agency financially supports access to continuing education
Lack of connection to larger movements (e.g. Psychiatric Survivor Movement, Disability Rights Movement, Neurodiversity)	Create and implement thorough onboarding Attend conferences, trainings, and other networking opportunities Collaborate with and/or engage in mutual support with local peer-run organizations Speak explicitly about our ideological connection to various movements Use the perspectives of the larger social justice movements to inform our advocacy and use personal stories as illustrations of these collective perspectives	Financially support PS staff to attend conferences, trainings, and other networking opportunities Pay for supervision and consultation from leaders in the Psychiatric Survivor Movement
Supervision by clinician	Name not being supervised by someone in a non-peer role as a standard and expectation Engage in continuous leadership development for whole team	Create a peer supervisor position Provide training to PS supervisors Higher level management follows leadership of PS, advocate on behalf of PS, allow autonomy in PS program design and decision-making, and demonstrate buy-in

Passing the buck	Clarify what PS does not do Be clear about consent with all parties involved Prioritize requests that align most directly with PS Be clear about our boundaries and limits, including only accepting self-referrals	Adequately fund community supports Everyone should have clarity of their own role and job description Understand and respect the role, job description, and guiding principles of PS
Lack of voice of PS in agency policies and practices	Ensure meaningful representation on committees and in staff meetings Build strong interpersonal relationships with co-workers in the agency	Higher level management regularly solicits and values feedback and concerns of PS Encourage and enable PS involvement at all levels of decision-making
PS uncertainty about how to be grounded in realism but also not settle for continuing harm	Normalize and make space for this uncertainty Ensure adequate individual and team supervision with space for processing these issues Develop a clear vision and articulation of values Use/develop guiding questions (such as Bonnie Burstow's Attrition Model) Stay connected to and get feedback from people working in PS in other settings	Be deeply distrubed and aware of the history and current reality of harm in helping systems so that PS aren't alone in this uncertainty

Values Conflict

Challenge	Our Work	Others' Work and/ or

		Shared Work
Documentation	Document situations only related to limits of confidentiality and/or with consent Default to practice of collaborative documentation Use documentation as a way to insert and prioritize client perspective and voice in their own record	Do not have productivity requirement Do not require PS staff to do notes with all people or in all situations Do not require PS staff to address medical necessity Do not require PS services to be on treatment plans
Attachment to and Expectation of Outcomes	Try not to have an agenda in PS relationships PS does not focus on goals, unless specifically requested by person, e.g. advocacy needs PS relationship does not need to be directly connected to treatment goals Use principles and tasks of Intentional Peer Support as primary framework	Do not require PS support to be related to treatment plan Do not require PS staff to track outcomes Shift away from documentation on progress in move from PAROO note to open narrative notes, if any notes are done
Receiving too much information about people	Practice self-referral Not being a part of the treatment team Interrupt the download of information Don't look at client charts to learn about the person	Give Peer Support staff only the info that people have asked you to share Value privacy and consent highly and acknowledge the potential impact of seeing through a clinical lens
Consent Issues	Explicitly state that our support is voluntary only Vigilantly remind people they have choice and engage in conversations about choices	Share information with folks about how they can connect with PS if they want to Value client consent highly and avoid formal or informal

	Reiterate informed consent with non-PS staff Accept self-referrals but not provider-referrals (Self-referral includes when a provider is asked by person to help in connecting them to PS) Refuse to provide services in the context of coercion Move into advocacy role if and when needed and asked	coercion
Liability and Risk	Practice robust and individualized informed consent Practice transparency Practice connection over reactivity Explore meaning and have difficult conversations Switch to advocacy role, when necessary Negotiate and do documentation and/or take action around risk together, if possible	Do not create or contribute to a culture of low risk tolerance or overblown perception of liability Do not require PS staff to assess risk, i.e. screenings or assessments to rate risk Do not exclude PS from and offer access to PS in "risky" situations Recognize that the most restrictive responses to risk increase risk Use evidence-based and promising practices in line with our philosophy of care and move away from hospitalization as the only option in response to risk
Being in but not of the system: Having a foot both in the traditional/ clinical MH system and the politicized psychiatric survivor movement	Regularly process conflicting feelings and thoughts about doing work in line with the values of the psychiatric survivor movement within the expectations and policies of the MH system	Lessen the transactional, paternalistic, prescriptive, etc. nature of services across the board (e.g. via IPS training) Don't shut down advocacy that challenges the fundamental elements of the MH system

	Explain context of how PS emerged, and be transparent with the people we support about the conflict that exists between PS values and what we have to do as employees at a DA when relevant Practice ongoing transparency and boundary-setting Have constant vigilance against the current of pathology and coercion Have a clear team vision and framework to guide us Have regular Co-Reflections and team meetings Actively stay connected to the Psychiatric Survivors Movement, Disability Rights, Hearing Voices Network, Alternatives to Suicide, and other relevant movements	Legitimize radical or transformative PS perspectives by giving them a platform in leadership spaces Support PS to stay connected to the Psychiatric Survivors Movement, Disability Rights, Hearing Voices Network, Alternatives to Suicide, and other relevant movements
Strongly held belief in Medical Model for understanding experiences	Exposure and education on alternative frameworks for understanding experiences, at all levels, including psychiatry Co-reflection and consultation	Shared and independent learning and willingness to explore alternative understanding

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