Peer Specialists and Their Relationship with Professional Providers: Their Role in Addressing Special and Underserved Patient Populations

Historically, the largest underserved population in behavioral health has been people who abuse drugs and alcohol. Not coincidentally, that has also been the population with the most extensive use of peer self-help and peer "sponsors" in all of behavioral health. Over the last several decades when people with serious, persistent mental illnesses, especially psychosis, have wanted more than "meds only" they too have had to resort to peer services – in support groups, clubhouses, and drop-in centers. Now, as our communities are increasingly demanding that mental health take a more active role with specialized populations, like cultural subgroups and LGBTQ, and with socially disruptive populations, like homeless people and incarcerated people, we're again trying to develop peer services and providers. The definition of "peer" keeps changing as the population being focused on changes.

Some of the motivation behind this trend is monetary. Most underserved populations don't have sufficient funding to be well served by professional providers. For better or worse, peer providers are often seen as a more affordable alternative. Indeed, Alcoholic Anonymous, probably has the most political and recession proof funding anywhere in behavioral health since it's so heavily self-funded.

The other, probably more important, motivation is that it is difficult to form treatment relationships with these populations, usually an essential element of successful services. Some of the difficulty is from their side – they have often been stigmatized, rejected, excluded, and disrespected by professional providers and have learned to mistrust and avoid us. Some of it is from our side – our actions are usually reflecting larger social stigmatization, rejection, exclusion, and disrespect or our frustration with treatment ineffectualness. Most professional providers simply don't want to work with various socially undesirable populations. Our standard way of overcoming our tendency to withdraw is to cloak ourselves in professionalism – even if we don't like someone, we're professional enough to give them good care anyway. For many people, that stance just isn't enough for them to trust us and work with us. "Caring professional" seems a cruel oxymoron.

Some professional providers are "abnormal in a certain special way" so that our hearts go out to some underserved populations that "normal" society rejects. This unusual compassion and empathy is usually based on personal experiences, not professional training. For example, for years we have done dual-diagnoses integrated services trainings only to find that most mental health professionals still pull away from actively using addicts and alcoholics in frustration and dismay.

Peer providers also have a propensity to be "abnormal in a certain special way" and to be able to build trust and connectedness. This ability doesn't usually generalize to all undesirable groups, just to those their "life experiences" specifically impacted. For example, a good alcoholism sponsor is not necessarily a good peer advocate for people with schizophrenia, nor is a "voice hearers" self-help group leader necessarily good at supporting inmates when they get out of jail.

Within mental health a large, diverse, and sophisticated array of peer providers has emerged. One group, "angry advocates", has their roots in the psychiatric survivor movement and they tend to actively combat professional stigmatization and disrespect. They may work for Protection and Advocacy or Patient's Rights. This often puts them into direct conflict with professional providers.

Some of these people advocate for and/or provide entirely separate peer-provided services, and can be antagonistic to all professional services, especially involuntary treatment and medications. They tend to confront professionals with the dehumanizing and traumatizing aspects of our practice and system. That puts them into even more conflict with professionals.

Some of these people have gotten official support to directly influence professionals and transform our system, usually within the Recovery Model. Their jobs include a mandate to change the professionals they're working with. They are being asked to move from being "outside revolutionaries" attacking the system from without, to "inside reformers" working for change from within. Many don't have the personality or predilection to make this change. They also are likely to have a history of antagonistic relationships rather than collaborative ones. Usually they aren't given enough power to overcome professional resistance directly.

Another group, "collaborative coworkers", has their roots in gratitude for services they've received and a desire to give back to others, hopefully in better ways than they were treated. They tend to want to work alongside professionals assisting with existing services and supplementing them. They often ally themselves with professionals and may be criticized for "selling out" by the "angry advocates".

Some professionals will react negatively to anyone with a mental illness, or other "abnormal" life experience working alongside them. One psychiatrist told me that, "People with mental illnesses have damaged brains. Why would anyone want to be helped by a brain damaged person?" This exclusion has a long history – including of excluding homosexual psychiatrists. Standard Human Resource hiring and risk management practices have enshrined these barriers in policy. In many places writing down on an application that you have a serious mental illness will disqualify you from employment. Being on SSI makes you a worker's compensation risk. Having a felony on your record makes it so you can't do outreach in the jail. A great deal of work has had to be done to rewrite these policies to facilitate hiring peer providers.

For professional staff, resistances are usually couched in countertransference terms, or as fear of decompensations or relapses, or as wariness of having to treat a coworker. While there are real challenges when someone's condition interferes with their work, when we look at how differently these challenges are discussed than the challenges in dealing with physical illnesses in the workplace – even unpredictable neurological conditions like multiple sclerosis – it becomes clear that most of this is stigma related rather than work performance related.

Almost paradoxically, one of the most powerful aspects of working alongside peer providers is how it actively challenges the professional staff's preconceptions about the capabilities of people with mental illnesses. Nothing has transformed me more than working alongside successful, impressive colleagues who have the same conditions I've been trying to help people function with all these years. This impact is the greatest when staff knew the person when they were at their most impaired or treated them themselves, but hiring people we know intimately as our patients has significant downsides too. In my view, if the focus is on improving services it's best to hire people who were treated elsewhere, but if the focus is on transforming professional staff it's best to hire known patients.

Our system already has a large number of professional providers who have lived experiences of mental illnesses, but most of these staff are keeping their experiences hidden fearing the reactions of colleagues and patients. This need to maintain secrecy can be emotionally difficult – one person described it to me like "being a double-agent betraying other people with illnesses, while going along with disparaging discussions about what 'people like that aren't capable of doing'". (She was fired when she finally revealed that she had a Bipolar condition and was taking medications.) This secrecy also stifles them from developing any peer support strategies and services to integrate within their work.

Professionals are most likely to overcome these preconceptions when they actually see these peer providers being useful and helpful. Therefore, peer providers must be hired because they are able to do the job well and enhance our services, not as a charitable job or "therapy" for them that will end up reinforcing limited expectations. They also need to be supervised, disciplined, and even fired when they are not doing their jobs. Some peer providers do not accept the need to perform their jobs well and distort the concept of accommodation from giving people needed supports to do their job to lowering their job requirements. In my view, this attitude has damaged the peer provider movement.

Many programs have set aside jobs for "peer specialists" specifically open only to people with lived experience to insure they are included, but often with vague job requirements. Nonetheless, when peer providers are hired, they often do prove their worth and the professional staff often will welcome them, but into the lowest rungs of the treatment

hierarchy, with the low pay, disrespect and marginalization that comes with that lowly rank. They may become "go-fers" given the least desirable tasks. The professionals already at those lowest ranks, may feel their jobs and roles are directly threatened by these new peer providers and be unwelcoming and excluding. It can be hard at times for these peer providers to feel really included and valued in their teams.

Some peer providers have attempted to "climb the professional ladder" using the same strategies professional providers to – getting professional academic and skills training, creating new certifications and licenses, joining professional organizations like the International Association of Peer Supporters, and billing for their services. Unfortunately, almost paradoxically, the more they seek and attain professional acceptance the more they lose what made them special and different in the first place – and risk losing their emotional identity.

On the other hand, one of the main strategies in keeping these peer providers marginalized and excluded is to accuse them of lack of professionalism – especially a lack of ability to follow confidentiality rules, to respect "boundaries" and maintain "professional distance" - precisely the traits that are making it difficult for professional staff to engage these untrusting populations in the first place. Peer providers are more likely to use self-disclosure to build trust, tell their own stories to build hope, see people outside of the office "meeting them where they're at", motivating people and building skills by doing things alongside people instead of talking about doing things, focus on quality of life goals instead of symptom goals, and become overtly emotionally involved, sometimes even developing "real" friendships and relationships.

All of these skills are complex and need to be learned and practiced to develop. Too often developing these skills is hampered by professionals leading them towards the professional approaches that aren't working instead of learning new relationship-based skills with them. Until professionals start valuing and learning these essential relationship-based skills more than we usually do at present, peer providers are most likely to get useful training and supervision in these skills from other accomplished peer providers instead of from professional providers.

A third group of peer providers act as "relationship extenders". They tend to refrain from taking sides either advocating for patients against the professional staff or from working to get the patients to obediently "comply" with the professionals' treatment plans. Instead they focus on providing a set of relationship-based services that traditional professionalism hinders. These services may include:

Outreach and engagement

Welcoming

Building trust

Using personal experiences and stories constructively

Exposure

Building hope

Empowering

Acceptance and non-judgementalism

Helping them develop a personal narrative and identity that incorporates their experiences

Learning side-by-side by modeling

Building self-help and coping skills

Taking growth-oriented risks together

Using crisis as opportunities for growth

Mentoring

Finding meaning and blessings in suffering

Connecting to people and roles in the larger communities

Moving on from dependency on mental health services and professionals

Learning to give back to others

These relationship based functions can be integrated into a multidisciplinary team and can catalyze the motivation, hope, and energy needed to propel other treatment, rehabilitation, and case management services forwards.

Over time, the professional staff may start to realize that these relationship-based services are the core of promoting recovery and that we should all be mastering and using them. Programs may create a culture that emphasizes these values that peer providers have been emphasizing all along. For example, the program may create a "welcoming culture", a "counterculture of acceptance", "a place of belonging and usefulness", or become a "bridge to the community".

At that point the distinction between peer providers and professional providers may dissolve away. The professionals realize that they too have "lived experience" that has drawn their hearts to be working with this particular special and underserved population and is the core of their passion and effectiveness. No longer do "peer specialists" have to be working just in set aside "affirmative action" "peer specialist" jobs. Now "lived experience" that specifically help us relate to and work with the population we're serving becomes a "value-added" for every employee.

A fully developed program incorporates people with lived experience into a whole range of positions and capacities:

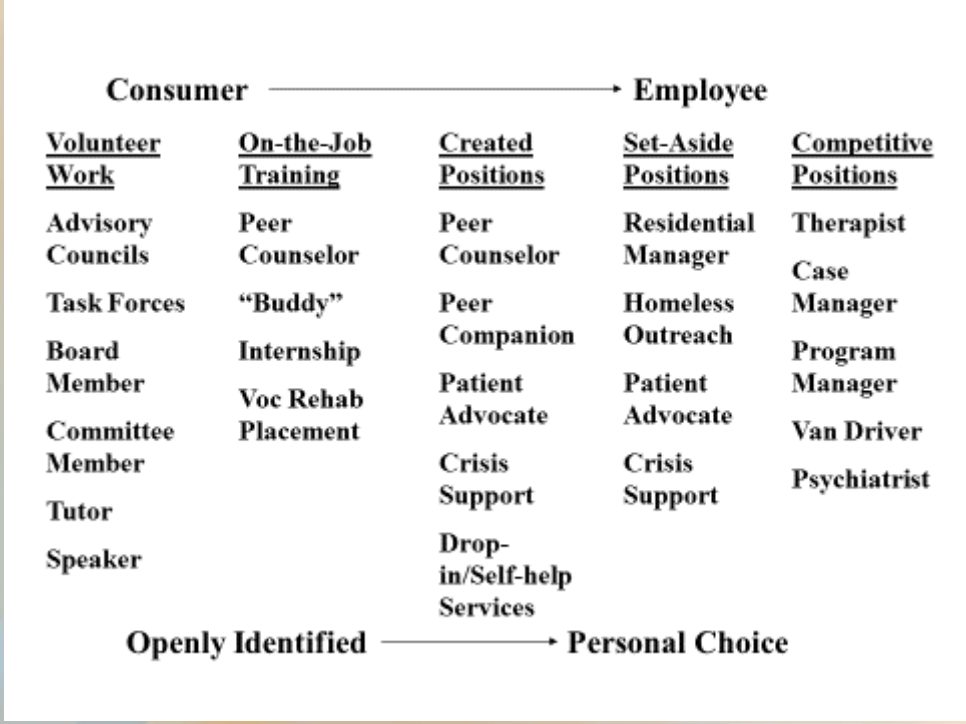

Chart adapted from Ronald Diamond, MD

The distinctions and barriers that separate and dehumanize us - between staff and patients, between sick and well, and between helper and helped - blur. We're all on journeys of recovery and we're all traveling together with our peers.