Supervising Peer Specialists: How supervision can help peer specialists remain peer when working on clinical teams

Highlights & Key Concepts

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Summary Ideas:

Peer support is a disruptive innovation and sets into motion a culture shift in clinical programs.

- Peer specialists are the evidence that recovery is real.
- Peer specialists blur the boundaries between health and sickness.
- These culture shifts can result in some common reactions from clinical staff: cognitive dissonance, role conflict and/or questioning their status.

How resistance to culture shifts shows up on a clinical team:

- Microaggressions
- Assimilation of peer specialists into clinical culture
- Peer specialist becomes an outsider. Is not treated as an equal on the team. Often leads to folks leaving the agency.

Supervisor Tips: Beware of drifting from your supervisor role to a therapist role.

- Validate peer specialist
- Focus on coaching the team through the growing pains of the culture shift rather than focusing on policing compliance.
- Speak privately with "repeat offenders"

Meetings, roles and differences in approach:

- Sometimes teams get impatient with a non-clinical perspective.
- The peer specialist is not "off topic" if, during a clinical meeting, they are sharing how a situation looks or is understood from a participant's point of view.
- Actively invite and make room in the meeting for peer specialists to speak up.
- Peer specialists deepen a clinical formulation into a more holistic story of a resilient human being.

Recognizing "drift" (e.g., when peers think, speak, document and act like clinicians):

- Peer specialist is in a "fixer" role in relation to the peer
- Peer specialist is trying to "motivate" and therefore is not working side-by-side with peer
- Using a scare tactic which is power-over, instead of reaching across
- Trying to achieve "compliance" with an intervention
- Working on a goal that may not be the peer's goal
- Using clinical language such as "patient" and "noncompliance"

Supervisor Tips: to counter clinical "drift" by peers:

- Role model person-first language for the whole team
- Encourage collaborative documentation
- Review documentation, reinforce good descriptive examples that avoid drift into clinical language.

Diversify use of peer support tools.

- Peer specialists do not prescribe wellness tools
- Peer specialists are skilled in using many tools
- Recovery-oriented tools complement each other. They don't compete.

Questions & Responses:

Q1 ***On your website, it states, "For over 30 years Pat has been a thought leader and disruptive innovator in the field of behavioral health recovery." What do these terms mean to you?***

A1 Mental health services have a long way to go in terms of becoming truly compassionate places where individuals who are experiencing vulnerability and their own distress can get the supports, grounded in their dignity, to build the life that they want to build. In other words, I'm not satisfied with the way things currently are. I don't want things to change, change has been happening all along, right? I want to see progress.

What I'm interested in doing is disrupting current practices in such a way that we actually transform them into a kinder, gentler and more effective human service. I want to see the "human" put back into the human services. Lecturing and carrying a message of hope is very important to inspire the hearts of our varied and very wide workforce around the world. And that's important to be literally inspired. But at the same time, what I've learned over all these long, hard years is that the transfer from training to practice is actually pretty abysmal. Eventually what I came to in my work was okay, since training isn't even nearly enough of what we need to disrupt and transform the system, I'm going to build tools. I'm going to build tools that embody the principles of recovery, and in and through using these tools, we will find ourselves and our practice transformed. My company, Pat Deegan and Associates, we are builders of tools—we build Common Ground software that's used to help make shared decision-making a reality. We have created the hearing distressing voices simulation which is used all over the world and has been translated into several different languages.

Q2 ***What are the most common themes peer specialists have shared with you about their experience with supervision?***

A2 Well, of course, peer specialists are a rapidly growing workforce not only here in the United States, but also around the world. And it's interesting having an international perspective and more global perspective, because I hear the same things here in the United States, as I might hear if I go to Switzerland, or Israel, or South Korea, if peer specialists are working in clinical settings, whether that be a hospital and ACT team, a rehab program, and they're being supervised by a non-peer, someone who has a clinical background and does not have their own lived experience of recovery, or I should say is not out about having their own experience. And then very often there's a mismatch: people are complaining because my supervisor doesn't understand what I do is different from what the case managers do. We find these frankly unhelpful scenarios where peer specialists are running to get coffee and they're driving vans and they're filing but they're not doing peer work. And if they are, in some cases, doing junior social worker, junior case manager kinds of duties. We need to close that gap in training in terms of what a peer specialist does. Supervisors really struggle with that. Hopefully we're going to make some progress there.

Q3 ***How have you seen equity, diversity and inclusion impacting the role of peer specialists and supervision in behavioral health?***

A3 I think certainly in many places around the United States there's a heightened sensibility, a heightened awareness, and to some degree, a heightened receptivity to hearing about issues of systemic oppression and all sorts of inequities. I think we're learning the language about that. And we're starting to open our ears. And by us, I mean, white people who are in dominant positions, and

	being willing to at least hear voices that very often don't get to the table. That said, there is a long road ahead of us, we have barely scratched the surface, I think, and we have a lot to learn. Being humble about that and being willing to really explore and, in some way, celebrate the intersectionality of our differences. Very often finding certain kinds of common ground can be very, very powerful. Peer specialists who have not only experienced the kind of oppression, microaggression, etc., the systemic factors that can work against us by being a person with a mental health diagnosis, we also see that can be just totally compounded by being gay or transgender or being a person of color.
Q4	***How do recovery community organizations operate as true "peer-led" organizations when we have to work under licensed clinicians (e.g., state requirements)?***
A4	There are a lot of misguided regulations that are intent on making sure that peer support doesn't go off the rails. It does reflect the lack of trust in the profession of peer support. And I think that in time, we will, like other associations, develop our own self-monitoring. I don't think we're there yet. I don't think that being a paid professional is antithetical to peer support, although I do agree that peer support has always and will always be an informal thing that people do when they reach across with compassion to love another person—that will never be regulated.
Q5	***What should a peer do when people make assumptions about peers, and even worse, engage in microaggressions towards peers? How can we help teams understand these microaggressions and do better?***
A5	It's not up to the peer specialist on a team to be the educator and the trainer for the team on these issues. With a good trusting supervisory relationship, peer specialists will hear a message from you, that you welcome them to speak about things that just don't feel quite right: e.g., comments that they found off-putting or hurtful or devaluing of them. Here are some tips. Number one, validate the peer specialist. Those of us who have been psychiatrically labeled are particularly prone to being told that we're exaggerating, we're making it up, we're not seeing reality. The next thing that needs to happen, I think is that, as supervisors, we need to begin focusing on the team, introduce the construct of microaggression and start talking openly about the culture shift. Hopefully we can do that before the peer specialist joins the team. But if not, we need to start talking about what's different and what's the same with the peer specialist present. And one of the things I like to emphasize is that in a situation of culture shift, if we get into a policing function where we're policing language and policing the right attitude – we're doomed, it'll all just go way underground. We've really got to frame this as hey, we're all growing, the peer specialists are growing, I'm growing, the team is growing, we're changing, it's uncomfortable.
Q6	***How do you distinguish the philosophy and practices of peer services, perhaps based on practice-based evidence of effectiveness?***
A6	Well, I will never subscribe to the idea that all clinical or evidence-based services are misdirected because they're not. I think many of them represent extraordinary breakthroughs in our field. Let's just for a moment highlight supportive employment as an extraordinary psychosocial intervention with a much larger effect size than any known psychiatric medication. We know that giving people the opportunity to get a job and to work if they express interest in working is powerful medicine. There is a clear distinction, I think, between clinical services and peer support. The thing that's interesting is that clinicians have their own lived experience, their own wisdom, I mean, we all are learning. That said, I think I've been very clear that there are very significant differences between a

peer support orientation. I look to people, leaders like Nev Jones, who is doing important work trying to increase the voice of people with lived experience in the research and academic world. For instance, we ask very, very different questions, which potentially can lead to very, very different kinds of inquiries and studies, which will do nothing but enrich anybody who's got a mental health challenge. The lived experience wisdom is huge, but not without error. I mean, there have been times when what works for me really doesn't work for somebody else. I like the idea of practicing humility and being open. And then recognizing that somewhere in all of this, there's good wisdom, and we're just trying to pick out the good stuff and stuff that really, really works.

Q7 ***I often find motivational interviewing (MI) skills correlate or equate to strengths-based approaches - are there places where these overlap and where it is appropriate for peers to utilize MI?***

A7 If I'm going to be doing motivational interviewing, or if I'm going to be doing cognitive behavioral therapy or DBT, then I need to be in a therapist role. And I can still have lived experience and I can, if I choose, share my experience, but I need to be a trained CBT practitioner. And I think that peers do not assess peers. For instance, motivational interviewing is a wonderful, wonderful breakthrough. However, when I say somebody is in the pre-motivation stage or the ambivalence stage, what I've just done is conduct an assessment and make a judgment. And peer specialists do not do that. Now, I'd be naive to say that as human beings, peer specialists are judgment-free, because no human being is—we all have a perspective or point of view, but to the best of our ability as peer specialists, we're trying to minimize the assessment. I do see a lot of peer specialists, particularly in the drug alcohol recovery arena, being trained explicitly at the state level for certification in motivational interviewing, and I really struggle with that. I do make the distinction there are things peer specialists do that clinicians don't do and vice versa.

Resources:

- Supervisor Checklist for Peer Supporters
- The Icarus Project: Madness and Oppression. Disponible en español: Locura y opresión
- Transformative Mutual Aid Practices (T-MAPs)
- Eight Dimensions of Wellness, SAMHSA
- The My Mental Health Crisis Plan app
- Peer support resources from the Northwest MHTTC's resource library

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