

How to Help Peer Workers Succeed

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Introduction by the column editors:

This column is based on the use of an electronic mailing list (e-list) to generate a collaborative problem-solving process. Dr. Aslam used an e-list to ask members of the American Association of Community Psychiatrists for feedback on treating individuals who serve as peer workers and working alongside those individuals on a treatment team. Readers are invited to submit suggestions for e-list discussions of management problems to column editor Jules Ranz, M.D. (e-mail: jmr1@columbia.edu).

Peer workers are current or former recipients of mental health treatment who are at various stages of recovery and who are hired to work with other mental health care recipients (1,2). Employment of peer workers is increasing, and formal processes to train and certify them are ongoing. Defining their roles and educating staff about their roles are keys to their success (3). The roles of a peer worker include acting as a coach, a bridge to the community, an administrative assistant, or a group leader and carrying out other duties at mental health clinics (3). Some individuals work and receive care in the same clinic, and addressing potential conflicts is also important for their success. Peers may fear that disclosing their mental illness to the treatment team staff with whom they work may cause the staff to react negatively and disrespect them (3).

Mark Ragins, M.D., has written about hiring peers in treatment at the Village (4) and has warned about the problem

of low expectations, which may reinforce stereotypes of persons with mental illness. Job performance expectations at the Village are at “community standards,” and almost all peer workers were initially fired and rehired several times until they performed at this level. Once the peers are well trained and receive appropriate supervision, they become adjusted and thrive. According to Ragins, although “many consumers have had significant success . . . before volunteering or working in their own clinic, this assignment was far more satisfying for them. It seems it is much more healing to be accepted alongside someone who knows how ill you’ve been . . . than by someone who doesn’t know the illness you’re hiding inside. Though it’s tempting to keep ethics clearer by hiring and volunteering only outside the treating clinic, to do so would deprive people of an important piece of healing and recovery.”

The Washington Street Clinic (WSC), where I work, is a community-based, outpatient mental health clinic at Hutchings Psychiatric Center (HPC) in Syracuse, New York, with a census of 500 clients with severe mental illness. Peers have worked as administrative assistants at WSC for years. For the past two-and-a-half years, WSC has been connected to Sunrise, a peer-run recovery center that had previously been staff run. Both WSC and Sunrise have implemented MyPSYCKES, a shared decision-making program initiated by the New York State Office of Mental Health and based on Pat Deegan’s Common Ground program (5–7). With the MyPSYCKES initiative, peers are now regularly helping other service recipients answer computer surveys and develop goals and strengths.

Nonpeer staff have raised a number of concerns about working with peer staff who are currently receiving treatment from them: discomfort in regard

to treating fellow state employees; a sense that some peer workers take advantage of their status and do not show up for appointments because they have no fear of consequences; concern about peers sharing confidential information with others who are not authorized to receive such information; concern about not encouraging patients to move on to the “real world” outside the clinic; and concern about a conflict of interest, such as a therapist’s being asked by a frequently suicidal peer worker to have his time sheet signed for hours he had not worked. A concern has also been raised about symptom relapse, which the clinic has worked through.

To find out how other recovery-oriented clinics in the United States are dealing with these situations, I sent an e-mail to members of the American Association of Community Psychiatrists (AACCP) e-list.

AACP e-list feedback

The initial e-list responses were mostly supportive of peers working alongside those treating them at the same clinic. One respondent remembered a conversation with one of the first peer worker graduates hired by her program, who was a former patient. The respondent noted how strange it seemed to be having lunch with her as a peer. “There was shared laughter . . . and things went fine.” Another psychiatrist and self-identified consumer mentioned having no problems supervising people who were her current or former patients. She argued that this situation has existed for eons. Her three supervisees, who were also her patients, had initially wanted to seek treatment at another mental health center rather than the one at which they worked. However, there was no one else in the community willing or able to treat them. When the e-list respondent knew that

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she would be supervising the new peer workers, she asked them whether it would be all right. She said that hiring former patients as peer workers was a hallmark of recovery: “It is our duty to do this.” A third e-list respondent commented on the rarity of peers being directly involved with prescribers and thought that a peer worker would be in the best position to give personal testimony about a prescriber’s helpfulness and compassion.

In contrast, one psychiatrist was concerned about the potential for abuse, such as if a peer worker were hired at a lower wage than others for performing the same tasks. Another e-list respondent pointed out that because the use of peer staff has become a politically correct approach, much useful discussion of the difficulties involved has been precluded. He questioned why value is now placed on a person’s being “out” in regard to prior or current experiences with mental illness and expressed concern that traditional staff play by one “rule book” vis à vis boundaries while peers are held to a different standard. Another psychiatrist who works with peers said, “We will not hire folks getting their care here. I realize it is a problem in smaller areas, but any employee is responsible for doing a competent job. If he or she can’t, then the person shouldn’t have the job. Reasonable accommodation is the law, but if one prioritizes the need to support peer counselors over the need to provide quality care, then I would question the priorities of the organization. If the response is that the employee is a patient, one has entered a murky morass.”

There were two contrasting responses related to stigma. One respondent said, “I cannot imagine this conversation occurring in any other area of medicine. A cardiologist not treating his partner? Until conversations like this end, the problem we have is stigma, pure and simple. Our own stigma toward the illnesses we treat.”

The other respondent said, “There is much ethical commentary . . . about treating someone with whom you have another relationship. . . . It can impair your objectivity, and if anything goes wrong, it can be emotionally devastating. This is not an issue of stigma, but one of setting up the best situation for competent care.”

Intervention

Meetings were held at the WSC to discuss the issues outlined above with HPC clinical staff and administrators and with peer workers—some employed by HPC and some not. Almost all of the peer workers expressed feeling comfortable working alongside the non-peer members of their treatment teams. Two peers described themselves as essentially open books and said that a large part of their work is wearing their history on their sleeves. As part of raising the issues, the program director and I presented examples of conflicts that had arisen at WSC in the recent past. Both administrators and peer workers were able to see how the dual roles of peer workers had given rise to conflicts. The need to actively involve everyone in discussions and thoughtfully consider issues from both the peer and nonpeer perspectives was emphasized. Peers were encouraged to seek counsel from local peer organizations and to decide how they would like to proceed with any concerns. Nonpeer staff were asked to consult with each other to accomplish the same goal.

The e-list discussion has made me feel more comfortable working in a clinic where peers work alongside nonpeer staff. It has also made me aware of my discomfort working with peer workers in our clinic who are treated by other providers in our clinic. It has been reassuring to learn that by using ongoing, clear, and open discussions, leaders in the field have made the situation work and that peer staff and nonpeer staff have thrived.

Many small towns have limited treatment options, and employing peer workers to work alongside the treatment team may be unavoidable. The situation offers staff the opportunity to grow from successes and failures, particularly when open and thoughtful discussions are the norm and can help mitigate possible harm. The discussion has begun, and we hope it will not end soon. To stop learning from those around us is to stop moving forward.

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