Title

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Peer specialists in community mental health: Ongoing challenges of real-world inclusion

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Abstract

Despite the tremendous growth of the peer specialist workforce in recent decades, significant ethical, political, and procedural challenges remain regarding recruitment and retention of peer staff. This column explores such challenges and potential pitfalls by examining the limits of current accommodation practices, the complex nature of "shared" identities, and the fraught navigation of disability, stigma, and employee misconduct. Implications for human resources and the importance of proactively addressing power dynamics between peer and non-peer staff, and potential structural stigma in mental health settings are discussed.

INTRODUCTION

As of late 2016, 46 US states had implemented state-sponsored peer-specialist certification processes, and both the Veteran's Administration and CMS have formally supported the growth of the peer specialist (PS) workforce (1). Generally, peer specialists are defined as individuals with personal experience of significant mental health challenges and/or receipt of mental health services, and who leverage this experience to support other service users. Many case studies, surveys and first-person accounts point to the potential power of peer support. However, three recent systematic reviews and meta-analyses have reported underlying methodological weaknesses and contradictory findings, with some trials demonstrating no added value of peer providers over conventional paraprofessional staff (2–4). Many factors have contributed to this dichotomy, including (a) the inherent challenges of studying peer support; (b) a high level of heterogeneity in intervention models, underlying assumptions, and PS training and qualifications (2); and (c) use of outcomes measures that may be insensitive to expected change.

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Further challenges arise in the translation of clinical research to community implementation, in which peer specialist roles frequently encompass multiple activities. For example, a single PS might lead 1–2 groups, assist with aspects of case management, serve as an agency 'peer' representative on local state or county initiatives, and participate in community outreach activities. These multiple roles can render it difficult to unpack specific mechanisms and impacts in real world peer support, both direct (e.g., on clients) and indirect (e.g., on organizational culture).

Lack of clarity and role ambiguity also carry into current practice guidelines. In 2013, the International Association of Peer Supporters (INAPs) issued consensus-based SAMHSA-sponsored practice guidelines for peer support (5). However, most of the guideline directives (such as providing empathic, respectful, person-driven and strengths-focused support) could equally apply to other mental health staff and fail to clearly distinguish roles. Although the guidelines also advise "equally shared power," the reality is that paid mental health staff, whether peers or not, are hierarchically positioned over clients/participants, financially compensated for their work, and subject to mandatory reporting rules.

We concur with calls for greater investment in research on peer supports, as well as enhancement of the methodological rigor of relevant investigations. In addition, we believe that real world case studies can play an important role in highlighting ongoing ethical and pragmatic challenges and gaps in current policy and practice. Specifically, we want to clarify that the goal of our commentary is to draw attention to real-world challenges associated with the hiring, accommodation and retention of paid peer specialists with ongoing mental health challenges, not the impact or effectiveness of peer-delivered interventions. We hope that the vignette will stimulate more nuanced thinking and considerations among mental health service administrators who are considering implementing peer support in their workforce, as well as to inform potential areas for further research into specific challenges faced by peer support staff.

CASE PRESENTATION

A community psychiatrist hired a PS to work in an urban community mental health clinic as part of an NIMH-funded health services research study. The PS was to maintain a population-based registry, attend team meetings, and serve as a patient navigator. The hiring psychiatrist was familiar with the peer support literature (2), but had never previously hired a PS. HR advised posting a limited-hire "peer counselor" position at 0.40 FTE. Ten people applied, and the top three candidates were interviewed. Candidate A self-disclosed as having an anxiety disorder and a fear of dogs. Candidate B had excellent interpersonal skills, and self-disclosed experiencing bipolar disorder with prior hospitalization and family history. Candidate C, however, best matched the demographics of the majority of the clinic's patients: she displayed signs of psychosis and had experienced extended periods of homelessness. The hiring psychiatrist ultimately selected Candidate C for the position, determining that clients would be more likely to relate to her.

Candidate C (hereafter 'Shirley') accepted the position, requesting "not too many hours," as doing so might conflict with receipt of SSDI. Shirley underwent a standard hiring process,

was given desk space, began attending team meetings, and began development of a patient registry. The hiring psychiatrist introduced Shirley to other staff and gave her the option of attending on-site peer-to-peer supported employment (SE) meetings, but did not ask about potential interest in receiving assistance from an SE counselor at another clinic.

Several weeks after starting, Shirley disclosed discomfort with being referred to as the "peer navigator," claiming this title disclosed her history of mental illness and incurred potential stigma. A few months later, Shirley became visibly upset about a personal issue, pacing around non-patient office areas and speaking loudly. Clinic staff found this behavior disruptive, and reported it to the director. Both Shirley's supervisor and the hiring psychiatrist spoke with her, providing resources and constructive feedback. Notably, Shirley had very limited contact with patients in the clinic, and this behavior was not observed by them. Shirley acknowledged the impact of her behavior, apologized, and agreed to work on managing frustrations. Weeks later, however, Shirley had another explosive event.

The hiring psychiatrist again spoke with Shirley about her behavior. Though she expressed regret, Shirley appeared even more agitated at this meeting. Over the following months, she became increasingly irritable and difficult to redirect. Ultimately, Shirley ignored direct instructions, leading to a conflict between her supervisor and a case worker. As a result, HR suggested terminating Shirley's employment immediately, since she was still within her probationary period, and a delayed decision could increase legal risk. Uncomfortable with this recommendation, the hiring psychiatrist inquired about reasonable accommodations, but was told that none would apply under the current circumstances. HR told the hiring psychiatrist that if there were another episode, Shirley must be terminated immediately.

During a subsequent meeting with HR, Shirley was told that she must maintain composure at work. Shirley expressed shame and disclosed that recent medication adjustments caused her behavior. For the first time, Shirley also disclosed actively receiving vocational support services outside the clinic, and gave the hiring psychiatrist permission to talk with her supported employment (SE) counselor. Subsequently, the hiring psychiatrist began meeting with Shirley regularly and met with her SE counselor on a weekly basis. A month later, Shirley refused to follow direct instructions from her supervisor. The supervisor worked with the clinic director and HR to conduct a standard investigation, and Shirley's employment was terminated.

DISCUSSION

As the above case exemplifies, considerably more may occur behind the scenes than practice guidelines typically capture. We focus on five specific challenges:

Unclear understanding of the optimal experiential "qualifications" of peer specialists

Our case study underscores the uncertainties a hiring manager may face in discerning what qualities or characteristics are most important in a PS—for example, specific diagnoses, a background similar to that of the clients with which the PS will work, or other relational and/or interpersonal qualities. Hiring managers may also grapple with the degree of disability they are able or willing to accommodate.

Mandatory disclosure in peer specialist roles

Our case also raises significant ethical questions regarding disclosure of mental illness as a de facto requirement of employment (often built into both PS' titles and job responsibilities). Although some employers head off potential misunderstandings by clearly communicating that prospective applicants should "feel comfortable disclosing or sharing their story," the pros and cons of a decision to disclose—and concerns about the effects of disclosure and potential threat(s) to self-identity and future career prospects—are rarely clear cut, and the ethics of mandating such disclosure fraught. At least one state (Illinois) has opted to use the title "recovery support specialists" in place of "peer specialists" within its state certification program, since the former designation does not automatically convey mental health status. The disclosure of designated peer staff may also raise questions as to the rationale for mandatory disclosure on the part of one class of workers (PS), but not other providers who may also have personal experience.

Lack of attention to the complexities and consequences of power hierarchies, internalized stigma and group identity within teams

By definition, PS have (or have had) experiences with mental health services, potentially both positive and negative, and likely experienced mental health-related discrimination in some form (6). In addition to impacts on self-esteem, negative past experiences may lead to heightened sensitivity to power differentials, particularly with providers, anger or resentment about past treatment, and strong feelings about perceived coercion. A PS may identify more with patients than providers, and providers may do the same, seeding subtle but powerful in-group/out-group dynamics in mixed teams. Although existing guidelines emphasize preparing all staff for the integration of a PS, deeper tensions easily go unaddressed, including the ramifications for an individual with negative past treatment experiences of working in a setting that may elicit difficult emotions and memories. Because both internalized and perceived stigma can lead to greater emotional discomfort or relapse (7), even among those with ongoing supports (8), appropriate procedures are needed to support the potential challenges that may emerge for PS, as well as the staff who work with them. Additionally, decisions to utilize employment-related accommodations may be fraught for PS who may feel that they risk exacerbating stigma or undermining perceptions of their competence. Meanwhile, supervisors may worry that offers of assistance risk offending, or even discriminating against, employees who may not want additional support. Since the disruptive behaviors in the case study happened in non-clinical settings, there was no direct impact on patients. However, any potential impact on patients should also be considered as the field works to shore up policy and practice. Finally, accepted 'best practices,' such as mandatory disclosure of personal health challenges by PS, should be more deeply researched on both ethical and empirical grounds, and worker identity implications carefully considered.

Appropriate ADA-based work accommodations in cases of real or perceived misconduct

Our case also raises questions regarding the distinction between how to distinguish between 'true' misconduct or disruption of the work environment and misconduct directly tied to symptoms/disability. Notably, such disruptions may unfold during 'behind the scenes'

interactions with co-workers, as in our case study, or in the context of direct client work. From a legal perspective, ADA rulings have generally deferred to employers and held that the ADA provides no *prima facie* protections against firing or demotion when an employee's behaviors disrupt workplace function in a way that cannot be accommodated without 'undue burden.' Still, this legal situation does not address the deeper ethical and political challenges involved in negotiating such situations, especially in the case of PS who are hired precisely because of their experience of disability. Supervisors must strike a difficult balance between treating peer employees "like everyone else" in terms of expectations regarding performance and professionalism, while also probing the limits and boundaries of disability-based accommodation, modification and flexibility.

Stigma from providers: Attitudinal and structural

In our case study, other clinicians' concerns also played a significant role in Shirley's termination. A majority of people, including providers, are likely to have internalized at least some negative stereotypes about individuals with serious mental illness, associations that are likely to be triggered by behavior perceived as aggressive or hostile (9). The low-wage, entry-level status of peer specialists may also reinforce power hierarchies in which the *de facto* 'value' of lived experience is minimized relative to professional expertise. As such, norms of PS compensation, status and status may exemplify structural stigma (10). As sociologists have long argued, attitudinal and structural stigma are reciprocally related, and their synergistic interactions in organizational settings can be difficult to analyze. General "best practices" in peer-specialist hiring and support might circumvent some of the problems that arose in our case—for instance, detailed policy regarding accommodations, protocols for peer provider wellness plans, and steps for supporting employees through relapses and/or symptom exacerbation. However, situations characterized by "disruption" and "disability" overlap in confusing and difficult ways, and decisions overshadowed by structural and attitudinal provider stigma are likely to be common in real-world mental health settings. Further development of best practices requires that we grapple with truly complex ethical and legal challenges.

CONCLUSIONS AND RECOMMENDATIONS

Some of the challenges inherent in hiring and supporting peer staff can be avoided through adequate planning and policy development. Implicit or internalized stigma is highly likely to shape decision making across hiring, support, supervision, accommodation, and employee discipline (8). To inform a national dialogue surrounding these issues, we believe targeted research and policy development is needed in several areas.

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Box 1:

Recommended Research Priority Areas Regarding Peer Specialists

- Investigate which aspects of shared identity, experience and disclosure are in fact critical to the impact of the peer workforce, with specific attention to intersectionality, class and salient aspects of identity *other than* shared diagnosis or treatment
- Disentangle the legal and ethical distinction between 'disruptive behavior' (for non-psychiatric reasons) and disruption due directly to disability--and develop mechanisms to support individuals under such (potentially challenging) circumstances
- Develop best practices and strategies for integrating staff with ongoing, significant disabilities that continue to impact their interactions with others (and that might otherwise lead to termination) and consider the ethical implications of who gets included or excluded from the peer specialist workforce;
- Acknowledge and work to address the impact of stigma *between* co-workers located within mental health service settings and interventions aimed at addressing such stigma, in explicit, implicit and structural forms
- Unpack the individual and organizational consequences of peer specialist wage and effort levels, weighing the potential loss of SSI/SSDI benefits for staff employed full-time against the risks of creating low-wage, non-benefitted positions that fail to provide a path to sustainable employment, and the risk of structurally reinforcing the 'lesser' status of experiential expertise and peer support
- Investigate the 'necessity' of traditional peer role practices that have long been promoted but lack a sufficient empirical evidence base and ethical examination, including self-disclosure and "mutuality".

HIGHLIGHTS

- Despite the growth of the peer specialist workforce, significant challenges remain regarding recruitment and retention
- To address these challenges, the field must grapple with significant ethical and political complexities and challenges
- Adequate planning and policy development is needed to ensure workplace equity for peer specialists.