Advocates
Caring Partners. Creative Solutions. Better Lives.

FAQ Peer Support- Philosophy and Approach

What is peer support as provided at Advocates?

Peer support at Advocates is one person, a Peer Specialist or Recovery Coach or Family Partner, with lived mental health experience, substance use and addiction recovery experience, or family member experience, supporting a person(s) we serve who have similar lived experiences and wish to connect around the mutuality of those shared experiences for support, information and resources that they determine as necessary for their ability to move their life forward in any direction that they choose. We provide peer support in a wide array of behavioral health programs and we are currently just beginning to provide peer support to people that we serve in Developmental Services programs, including Brain Injury, Autism and Shared Living/Adult Family Care programs.

What are the responsibilities of the people providing peer support at Advocates?

The primary responsibility of our peer support staff is to partner with people we serve and provide support and access to information and resources that people might want to meet their own needs, wants, and goals. Peer support staff are guided by the principle of **self-determination for all and in all circumstances**. The only time that we stray from this principle is when a person is clear that they want to end their own life or physically harm someone else and they will not remain engaged with us.

In addition to the support of the people we serve, Peer Specialists, Recovery Coaches and Family Partners (our peer support staff) are responsible for addressing issues related to environments, language, culture and attitudes that may present a barrier to a person we serve moving their life forward in any way that is meaningful to that person. Examples include:

- The condition of the homes that we operate – externally and internally – are they in good condition, are they clean, are they decorated, are needed repairs made quickly – these things convey a clear message that we either value and respect and want to lift up the people we support, or that the people with whom we work are not deserving of these things.

- The language that is used in programs – we reference the importance of language in both The Advocates Way philosophy and our Intentional Care Performance Standards. We have a made a commitment to not use pathologizing, diagnostic, or illness-model language in speaking with or about the people we serve. Examples include labels like “client,” “member,” “consumer,” “schizophrenic,” “bipolar,” “decompensation,” “perseveration,” “frequent flyer,” “high utilizer,”

"borderline," "manipulative," "non-compliant," "treatment resistant," etc. Using shorthand terms, abbreviations, acronyms and other industry jargon also emphasize "power over" people. These labels and terms serve to depersonalize the relationship with people we are trying to help and reduce them to stereotypes, objects, or a collection of "symptoms," and only contribute to the already seriously damaged self-image of the person with whom we are engaged. We must always consider the experience of oppression that people involved in the public mental health system have faced and the deep impact that it has had on their hope, self-esteem, personal agency and willingness to connect with mental health professionals. The effect of these experiences is cumulative, and we do not want to do anything to increase or magnify the damage these seemingly small transgressions can have on the people about whom we care so deeply.

Instead, members of the peer support team advocate for the use of "person-first" language, not as another way to label a person, as in "person with Schizophrenia," but in a way that is observational and descriptive, using plain, experiential language. An example of alternatives would be, "a person who hears voices" or "a person whose needs are not being met" or "a person who is having a difficult time" or "a person that we support." These are expressions that do not label people and can be used to describe more accurately and more respectfully experiences that are more universal and applicable to any of us.

- The culture of our programs is also vital to the way the people we support see themselves in the world. If staff are always in the office with the door closed; if staff are on the telephone speaking a language the person does not understand; if people are conducting personal business while working; if overnight staff are asleep in programs when they should be awake; if Community meetings are not being held; if information regarding events and activities is not consistently shared and those events and activities made accessible; if we are not always focused on helping the person with whom we work to live out in the community and the world and instead our focus is on protecting that person from the world and protecting the world from that person; if staff, including psychiatrists, therapists, clinical staff, crisis clinicians and direct support staff are holding or participating in meetings about someone we support and that person is not in the room or has not been included – all of these things contribute to a culture that conveys to the people we serve that they are not at the center of the support we are supposed to provide and that they are not deserving of that support.

- Finally, attitudes. Working in this system is extremely difficult. Per The Advocates Way – "We have to remember, too, that the staff of Advocates often face great difficulties in doing their work. Staff have a great burden of paperwork, not enough resources, competing needs, low pay for their hard work, and sometimes anger from the community. Advocates staff need and deserve support and encouragement to practice The Advocates Way, day in and day out." We acknowledge how hard these jobs are – we see it in the massive amount of turnover that occurs and the way that impacts our ability to form trusting, mutually respectful partnerships with people. Yet, we cannot allow our frustration to negatively impact the people we support. Imagine if you were in the shoes of the person with whom you work. How would you react? Imagine being moved into a program with little to no say in the decision. Imagine living with

seven strangers, all having difficulty navigating the world, that you do not know. Imagine being told that you "need" to take medicine that is highly toxic in many cases, is likely to shorten your lifespan considerably, and has unintended, but powerful effects like permanent involuntary muscle contractions, dry mouth, difficulty urinating or defecating, tremors, tooth decay, blurry vision, heavy sedation, sexual dysfunction, metabolic syndrome, diabetes…then imagine being told that you should work or go to school or attend a day program that is so painfully boring you can barely stand it. Imagine living in the community, paying rent, and being told that you cannot go out into the community without staff accompaniment. Does that deepen the trust and connection between you and the staff that are supporting you? Are you likely to go to that staff person when you are in crisis and desperately need help? Now imagine that you are poor on top of all of this, and you are ashamed, and you are fearful and your prospects for an intimate, sexual, personal relationship in your lifetime feel almost non-existent. How would you feel? These attitudes and their impact are why we created The Advocates Way and Intentional Care in the first place.

What can peer support staff at Advocates do in the context of their role?

Peer support staff at Advocates can do almost anything that the person they support wants to do. The peer support staff have helped people with job applications, treatment planning, transportation, phone support, assistance with benefits, housing advocacy, psychiatry appointments, team meetings, Open Dialogue network meetings, family support, addiction treatment, developing supports outside the system, cleaning, grocery shopping, budgets, exercise, accessing hobbies, community participation, crisis support and many others. They can go for walks, go to the movies, play tennis, sit outside, go to concerts, participate in Advocates' activities. They can help people access The Living Room, support them through a psychiatric evaluation, visit in the hospital, help people get money for clothing or to pay bills, and assist with voting. They also facilitate groups, both in person and virtually. In ACCS, peer support staff work in every group home and with people in their own homes who want peer support. They are full team members and should be participating in integrated team meetings, staff meetings, individual team meetings for the person(s) we support – unless the discussion is about the person(s) we support and they are not present. We do not participate in meetings about someone we support, unless they are present or have explicitly empowered us to participate on their behalf, the parameters of which would be determined by the person we support.

What are peer support staff at Advocates prohibited from doing in their role?

Since everything we do to support a person is driven by the relationship that we have with that person, mutuality and trust are absolutely essential to the success of that partnership. As the mutuality of the relationship is compromised from the outset by the fact that we are paid and the person we are supporting is not, full mutuality, as would exist in a friendship, is not possible. However, other than that barrier, we have made a conscious and deliberate decision to not put additional barriers between us and the person(S) we support. That means that we do not:

- Read a person's clinical chart prior to meeting them or ever.
- Perform assessments or evaluations.
- Write treatment plans.
- Write clinical notes.
- Take Crisis Intervention Training of any kind that involves physical interventions (restraints).
- Administer medications or take any position on the use of medication other than to share one's personal experience.
- Function as a Representative Payee or have any power over a person(s)'s money.
- "Monitor" a person in the community.
- Wear name tags or badges.
- Meet with desks between us.
- Visibly carry around lots of keys (especially where there are lots of locked doors).
- Participate in meetings or conversations about a person we support without their presence.
- Use pathologizing, diagnostic, illness-model language that depersonalizes and objectifies a person(s). Including possessive language, i.e. "my client" or "my member."
- Use labels of any kind to refer to the people we support. We use a person's name, or we refer to "people with whom I work," "people we support," "people we serve," etc.
- Intimidate, threaten, harass, bribe, coerce, use undue influence, power, physical force or verbal abuse, or make unwarranted promises of benefits to the people that we support. This includes the use PES as a "punishment for "non-compliance" or "bad behavior."
- Compromise the privacy and confidentiality of those we support by sharing the content of our conversations or activities with anyone without their presence or permission.
- Enter into dual relationships or commitments that conflict with the interests of the people that we support.
- Engage in sexual/intimate activities with the people we support.
- Provide support or services to another when under the influence of alcohol or when **impaired** by any substance, **whether or not it is prescribed**.
- Accept gifts of significant value from the people we support.
- Use other industry jargon, abbreviations, shorthand terms or acronyms that demonstrate power over the person we are supporting.

How do I refer someone for peer support?

Any person we support throughout Advocates, staff person, clinician or family member can request peer support for someone with whom we work. However, the person we serve must want the peer support! Receiving peer support is voluntary. It is the only way it aligns with our values and it is the only way that it is effective. Staff should orient the person to peer support at Advocates – what it is, what it isn't – informing them that it is completely voluntary and that it is about supporting them in anyway helpful to them, even if it runs counter to, or conflicts with, the perspective of other team members like the psychiatrist, therapist, clinical director, program manager, direct support staff or family member. If prior to making a request for support, the person making the request would like a consult to learn more

about peer support to determine appropriateness of making the request, then they are welcome to reach out to the Vice President of Peer Support and Self-Advocacy or the Director of Recovery and Peer Support.

A request for peer support should be made to the Director of Recovery and Peer Support, or the VP of Peer Support and Self-Advocacy or designee. The request should include an acknowledgement that the person on behalf of whom the request is being made wants peer support and has given explicit permission to share the request and provide contact information. The next step is the Director of Recovery and Peer Support or designee will reach out to the person the request is being made for to have a discussion to determine factors that will be considered in making the assignment such as gender, age, and lived experience. Further discussion is often necessary to clarify what peer support is and isn't. A Peer Specialist, Recovery Coach or Family Partner is then assigned and will contact the person being referred within 48 hours. They will introduce themselves, ask the person what kind of support they need, and how much they think they might need. Then, unless there are adjustments to be made based on the connection between the two people not being a good fit, they will begin working together. The relationship will last as long as the person receiving support feels is necessary. From time to time, due to the changing nature of employment and peer team needs, assignments may need to be reorganized. In this case, the Director of Recovery and Peer Supports will reach out again and begin the process of determining the next appropriate Peer Specialist, Recovery Coach, or Family Partner to take over. Any concerns about the peer support relationship should be directed to the Director of Recovery and Peer Supports.

I am a clinical or direct support staff and I have lived experience of my own and I disclose it to help the people with whom I work. Isn't that a peer support relationship?

It may be a wonderfully supportive relationship and it is always desired that any employee at Advocates feel safe and supported to share their lived experience when it might benefit others. Those connections may run deep as a result and have aspects of peer support embedded in them, but they are not peer support relationships as we define them here at Advocates. The main difference has to do with power and the ability to use power "over" people we serve. People working in clinical settings with clinical responsibilities, including direct support staff, program managers, integrated team clinicians, clinical directors and other staff - have power over people we support. They can write up restrictive plans without a person's consent. They can develop staff action plans without the person's consent. They can request or issue a Section 12 to force the person into an emergency room to be psychiatrically evaluated. They can insist that a program structure requires a person we support to have a staff person accompany them into the community for the first 30 days. They can refuse to provide rides if a person is rude or not "complying" with their instructions. All of these things create barriers to mutuality and are not consistent with the Peer Specialist Coe of Ethics. The exercise of these responsibilities in relationship with the people we serve is antithetical to the values of peer support and therefore does not meet the criteria we have for "peer support."

I have heard of this program run by Peer Specialists called The Living Room. What is it and how does it work?

The Living Room was developed to be a completely peer-run alternative for people from anywhere in the community – any community – who may be experiencing difficulty in living, who find the emergency room to be a traumatizing and oppressive environment, and who would like to get support while they are having a crisis without giving up control over their lives and choices.

The Living Room:

• Creates an alternative to an emergency room visit (or other more invasive and costly interventions) for people who are facing difficulties that are essentially non-medical in nature.

• Centers on peer-to-peer support provided by our Peer Specialists and Recovery Coaches and the expertise of people who themselves have experienced a variety of life-interrupting challenges.

• Fosters a home-like environment and embraces a hospitality model to avoid the sterility and impersonal nature that is found in so many institutional settings.

• Aims to build a sense of community and togetherness.

• Has a daily structure that is flexible and based on the needs of the guest.

In other words, it starts from a place of creating a welcoming environment that centers on kindness, compassion, and acceptance. The focus is on creating a space full of light, warmth, and openness that minimizes 'us' and 'them' attitudes and rejects the "power over" approach that characterizes so much of the mental health system. Unlike hospital emergency rooms, where people may be left alone to wait for hours on end only to then be met by someone who often only sees them as their diagnosis and the sum total of their "symptoms." The focus of the Living Room is to create connections, offer choices and opportunities for exploration. There is no assumption that simply quieting discomfort is enough or even the desired approach. Peer Specialists at the Living Room know that there is much to be considered and learned through the process of struggle.

The model is also founded upon the idea that choice and self-direction are essential parts of healing. When speaking of the origins of the Living Room, William Anthony (a pioneer in the psychiatric rehabilitation model) wrote, "There is no such thing as forced recovery." This speaks to the fundamental reality that the journey is as important as the destination when it comes to one's own life, which in turn speaks to the importance that The Living Room places on the idea that each person is the expert on their own wants, needs, hopes, and dreams. All of this is in alignment with how Advocates' Peer Specialists approach peer support.

With all of this in mind, Advocates developed the Living Room in a space that allows us to offer support to up to eight people at a time between the hours of 8am and 9pm each day, and up to six people overnight. All guests are there of their own free will. **The program is completely and absolutely voluntary. The Living Room is not a place to drop people off or bring people because someone else**

has decided that they need that support. People are free to come and go as they please. The Living Room does not require guests to even give their name.

Strong attention was given to the trauma-informed principle that distress is often rooted in a failure to have basic needs met. This means we ensure the availability of food, the ability to catch up on sleep, and maintain the space with a sense of warmth and personal safety in mind. It also means all Living Room team members have been trained and supported to consider the following:

Safety: How can I re-define the term 'safety' to mean creating an environment where it is 'safe' for someone who is struggling to explore what is happening for them? Am I doing all I can to be mindful of the physical and emotional safety of others?

Trustworthiness: Am I being clear and consistent with my expectations and interactions with others? Am I creating an atmosphere of respect and acceptance free of judgment?

Choice: Am I helping to create conditions so those I interact with experience opportunities of choice and control over their own lives?

Collaboration: Am I mindful that an approach of collaboration and sharing is at the center of my interactions?

Empowerment: Am I fostering an environment where an individual's own strengths, experiences, and uniqueness can be highlighted and built upon?

The interior space is decorated in a homelike manner and offers access to a variety of activities ranging from peaceful introspection to group interaction. A variety of resources are available on site to flexibly meet the needs of each guest. We offer all guests access to computers/iPads, phone, Sorenson Video Relay, fax, books, wellness planning tools, art supplies, sensory toys, weighted blankets, movies, an extensive community resource guide and more. In addition to being informed by their own experiences, Peer Specialists at The Living Room are trained to have the basic knowledge necessary to support individuals in choosing and making use of all the various resources available. Perhaps most importantly, they are trained to partner with people to explore different options, even when they lack personal expertise. Not having familiarity with something is always an opportunity, and never the end of a conversation.

People from anywhere in the state who are struggling with a variety of issues related to emotional or mental distress will be able to approach the Living Room directly, without needing to navigate their way through red tape or other barriers or be "referred" by anyone. They can simply call or knock on the door and they will be welcomed with open arms and open minds. They will have a conversation orienting them to how the program works and what guests can expect from us and what we expect from them.the country, psychosocial assessment will be replaced with a chance to tell some of their story and what's happening for them in the moment. Together, the Peer Specialist(s) and the person seeking support share with each other what is needed or available and determine whether the Living Room is a good fit.