A Handbook
For Individuals Working in

Peer Roles

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Peer-to-peer support makes the world go 'round

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Introduction

Welcome to the portion of this handbook intended for people working in 'peer' roles. Whether you are working toward a job, just started or have been in a peer role for years, you will hopefully find ideas and information in this book that will support you to grow, move forward and feel 'not alone' in the work that you do.

You may be in a peer role because it's your passion to support others experiencing similar struggles and to advocate for change in the system, or maybe you're there because someone else suggested you would be good at it and you're still just trying to figure out if it's a fit for you. Either way, there's much good you can do while you're here.

Whatever your reason for investing time in peer-to-peer support, there's one very important thing to remember: It's new (at least as a formal role within the 'mental health system,' and if you don't have a clear vision of what a 'peer' role is, **and** if you don't get support from others to develop and find ways to hold to that vision, you'll probably be pulled off track. To that end, this manual strives to:

- Give you some frames of reference for what a 'peer' role is (and how to explain it to others); and
- Offer some ideas for accessing support or building your own support network for people working in 'peer' roles; and
- Offer some ideas of how to negotiate the natural conflict that occurs with change (and sustain yourself while you're doing it!)

Note: Language is used very intentionally throughout this handbook (with the exception of quotes from some sources, where word choices are beyond our control). This includes the choice to use 'they' and 'their' rather than 'she or he' or 'his or her.' Although this may produce some angst for the grammarians among us, it is done out of respect for the many people in our community who are questioning or living outside of a gender binary.

What is a 'Peer'?

Sometimes, it's important to take some time right at the start to establish the basics of what we're talking about. There's a common misconception in this work that 'peer' means something other than what it means everywhere else. For example, many people now seem to be defining 'peer' as "someone with a psychiatric diagnosis" (or similar). However, that's not how the vast majority of this world understands that word. For example, when one starts typing 'peer' into Google (at least, as of right now) the first two phrases Google offers up are 'Peer Review,' and 'Peer Pressure.'

Such a definition also separates us from the roots of where and why 'peer' roles got started within the mental health system in the first place. Thus, sometimes the way forward (to greater understanding) involves going backward.

Consider the slides to the right (used in a Powerpoint presentation at a conference). The first slide is intended to remind us that we ALL have MANY potential 'peer' groups (based on our age, profession, hobbies, school, etc.). We are all multi-dimensional people and all peers to many someones. The second slide is intended to remind us that—for most– the majority of our 'peer' support comes from our friends. Finally, the last slide is a reminder that – among our friends (and other peers)- the so-called playing field is generally flat and you are always the expert on you.

What is 'Peer'?

Pop Quiz:

1. Who is your 'peer' group?

Parent... Job... Many Peer Groups! Hobby... Age... Etc... School...

What is 'Peer'?
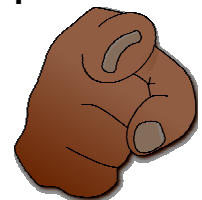
Pop Quiz:

Friends!
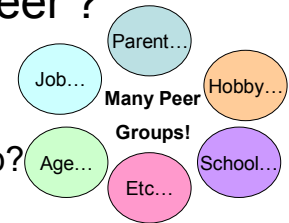
2. What is the most common source of 'peer' support for a majority of people?

What is 'Peer'?

Pop Quiz:

3. When among your peers, who is the expert on you?

What is a 'Peer' continued…

Why do these very basic (and admittedly somewhat silly) slides or the ideas behind them matter so much? Because if we understand those concepts, then we can make the leap to 'peer support' within the context of the mental health system and understand that:

- 'Peer' is not some isolated identity within the mental health system, but rather a way of relating to one another over some commonalities
- 'Peer' support happens naturally in our lives, and we can look to what some of those natural peer-to-peer opportunities look like to learn more about what qualities we may be seeking I formal peer-to-peer support
- Even the most formalized peer-to-peer support should be as free of power differentials as possible. It's *never* about one person being the expert over the other.

Sometimes, reflecting on what people already know within the context of their own lives can be a great way to engage them in conversation, and begin to build understanding of the parallels between what they know to be true for themselves and what we want them to understand about others.

Engaging someone in this conversation, for example, can lead to additional helpful dialogue with questions like:

- What are your 'peer' groups?

- When hanging out with your 'peers,' how do you respond/feel if they tell you what to do?

- Can you think of a time when someone in one of your peer groups started acting like they knew way more than you about something and should therefore be able to tell you what to do? How did that feel? How did you respond?

- When you go to one of your peers with a problem, what helps you feel heard? What gets in the way?

If people around you don't understand that 'peer' support within the context of mental health is essentially founded on the same ideas as 'peer' support within their own lives, it's going to be all the more difficult to move the conversation to a deeper point of really 'getting it,' and supporting you in the fullest way possible.

The Declaration of Peer Roles

Unlike the first two pages of this handbook that aimed to create some very basic understanding of the most general framework of what peer roles are about, the Declaration aims to go much deeper. It takes a much closer look at the elements that keep peer roles 'peer-to-peer' (as well as what can damage that peerness). It also looks at some of the history within the mental health system (power dynamics, etc.) that make it so critical to have peer roles in place.

The Declaration of peer roles grew out of an effort on the part of the Western Massachusetts Peer Network (WMPN) to respond to an early attempt by the International Association of Peer Supporters to develop international standards for peer work. WMPN felt that some of those early efforts were too far in the direction of making people in peer support roles seem like they needed to be treated like children (requiring them to make 'self-care plans,' etc.) among other concerns, while other efforts circulating at the time were far too general. Thus, WMPN decided to set out on their own and took over a year to thoughtfully consider, review and edit a strong Declaration that would speak clearly to the integrity of these roles. Along the way, input was gathered from people living as close as neighboring parts of Massachusetts and as far as Texas and New Zealand.

The completed Declaration follows here:

Origins: This document originated with the Western Massachusetts Peer Network in 2013 and grew from there to encompass many voices.

Our Objective: Peer-to-peer support is well-established in many contexts from cancer survivor groups and bereavement groups to twelve-step groups and beyond. Our objective in producing this document is to clarify the concept of the peer role in relation to the mental health field. It is a support tool to guide practice and explain activities and values of peer roles. It was created with the contribution of many voices. Our goal is to see these concepts and values integrated into all peer roles and ultimately to filter into all aspects of the mental health system.

Definition of Peer: According to Merriam-Webster, a 'peer' is one that is of equal standing with another. We each have many 'peer' groups based on our age, work, hobbies and other facets of our identity. In the mental health system, peer support is offered by an individual who identifies as having lived experience with trauma, psychiatric diagnosis and/or extreme emotional states. The term 'peer' does not simply refer to someone who has had a particular experience. Peer-to-peer support is primarily about how people connect to and interact with one another in a mutual relationship.

Peer-to-peer roles are different from traditional roles that happen to be filled by someone with lived experience. Someone working in a traditional role, such as a clinician or nurse, may have

had similar experiences as those who are using their services (e.g., a nurse may also be a cancer survivor). This still does not make that person a 'peer' in the sense that we are discussing here. They may share their personal experience, but they are still operating within their primary role as a clinician or nurse. There remains a substantive difference between peer and non peer roles, although both have value. The definition of the peer role within the context of the mental health system is further clarified by the values and actions that follow.

There are three essential areas of focus for peer-to-peer support:

- **Mutual peer support:** Here, mutuality refers to operating from as equal of a playing field as possible where the connection is the focal point and no one person is the 'fixer.'
- **Change agent:** Based on wisdom gained from personal experience, people in peer roles advocate for growth and facilitate learning within the mental health system and beyond.
- **Remaining 'in' but not 'of' the system**: This refers to working in the mental health system while holding values that are specific to the peer role and not taking on responsibilities that dilute purpose.

Our Values: Our experiences are diverse. While some people receive positive support from the mental health system, there are many others who feel the need to heal from the impact of how they've been treated.

Historically speaking, many of us have been labeled as 'client' or 'consumer' or a diagnosis that represents only what people see as our 'sick' or 'broken' parts. We have commonly been approached for assessment and evaluation, while few people have asked to hear our own stories or ways of making meaning. Often, we've been taught that others are the experts, that there is a professional who has 'the answer' and knows what is best, and that there are only rigid versions of truth.

Additionally, problems have typically been regarded as the result of our faulty brains, rather than, at least in some instances, due to the ways we've been impacted by trauma or other environmental factors. People around us have frequently operated from a sense of responsibility and fear of liability that have driven decisions and limited tolerance of risk taking, sometimes eliminating choice entirely. All too often, we've been taught to have low expectations and focus on maintenance rather than the prospect of a full life. These experiences (as lived by ourselves and/or those around us) have driven the creation of the values below.

1. **Human Potential and Vision:** We believe in the probability that all of us can and will heal. Our focus is on the vision of a full and meaningful life for all, not just day-to-day survival.

2. **Prioritize Self-Determination and Choice:** We put a high value on the healing power of simply having choices and refuse any participation in force or coercion.

3. **Dignity of Being a Whole Person:** We are the experts of our own experience. We regard each person as whole, with many strengths and contributions to make.

4. **Easy-to-Understand Language:** We value clear, human, non-clinical language that creates space for each person to explore and find their own meaning in life and their experiences.

5. **Mutuality:** We are committed to reciprocity and being honest and real in our connections. We recognize the fluidity of human experience and our various roles and the ability of each of us to learn from one another.

6. **Approach Each Other with Genuine Curiosity:** We seek to understand each person's worldview. We are dedicated to learning about people from them and not from files or meetings where they are not present.

7. **Honesty, Truth and Transparency:** We believe in people's fundamental resiliency and are upfront with them about limitations, concerns and conflicts. We are never complicit in decisions about people without them.

8. **See Challenges as Growth and Learning Opportunity, Not as a Crisis:** We choose to regard our times of greatest distress as a potential sign of change to come and as an opportunity for growth. This is not intended to deny the deep pain that people may experience, but rather to value and have faith in what can emerge from that place.

9. **Recognize the Need for Transformation in the Mental Health System and Society:** We believe that, for change and healing to be sustainable and real, it must happen throughout our communities and systems. It is not solely the responsibility of each individual seeking help.

10. **Focus on Moving Forward:** We seek the development of something better and healthier than the power structures and approaches that have harmed many of us in the past. We will consciously avoid compromising our values or replicating past wrongs.

11. **Recognize Our Connectivity and Our Part in a Movement:** Our work is a part of a civil rights movement. We strive to have our fundamental connectedness to a history of oppression and fight for human rights recognized and understood.

12. **The Importance of Community Involvement:** We believe in the importance of human connection in healing. A person in a peer role can support someone to find resources within and from the community to meet this need and make sustained change.

Our Actions: We see this as an ongoing process and are aware that there are peer roles (as of this writing) that are not currently consistent with what is written here. We recognize that our roles are also influenced by the systems and programs within which we work. We do not wish to leave behind anyone who is committed to working toward these shared values and actions, even if there is a long way to go. The following are the actions we strive to include in our daily practice.

1. We actively advocate and support people to find and use their own voice.

2. We share our experiences, strengths and wisdom without giving unsolicited advice.

3. Our primary responsibility is to those we support.

4. We avoid speaking in diagnoses and pathologizing language and will not refer to people using words like 'client,' 'consumer' or other systematized terms.

5. We respect the power of simply 'being with' (though it may appear to others that we are doing very little) and are flexible in spending time with people in this way.

6. We consider the support of others in peer roles central to our work, including reaching out to people working in isolated environments.

7. We stay connected to one another and our work by participating in meetings, events and gatherings geared toward learning and new ideas. We consider this an essential responsibility.

8. We treat each other (and ourselves) with compassion, but not as fragile. We demonstrate this through a commitment to honesty, transparency and a willingness to work through conflict.

9. We act as change agents within the system, sharing new ideas, challenging the status quo and inviting others to join us.

10. We support a culture of questioning and asking 'why' to help both ourselves and those around us understand and be well informed about how practices and beliefs have been shaped.

11. We are committed to being aware of and transparent about our own power and privilege in our roles and to examine that on an ongoing basis.

12. We do not consider it consistent with our values to participate in activities that run the risk of further increasing power imbalances. This includes (but is not limited to):

- Involvement in medication administration
- Acting in the role of Representative Payee
- Routinely talking about people without them present in individual or team meetings
- Participating in routine documentation (e.g., progress notes)
- Reading or creating files on people
- Assessing, diagnosing or writing treatment plans or other system documents
- Any actions that make us complicit in force or coercion

13. We are also aware of our environment and how it may impact our ability to engage in mutual connections. We give input about elements of the environment not in our control (e.g., 'staff only' signs, institutional looking furniture, etc.). We avoid the following wherever possible:

- Wearing name tags or badges
- Meeting with desks between us
- Having individual/staff-only areas when not absolutely necessary
- Visibly carrying around lots of keys (especially where there are lots of locked doors)

An invitation to all: We are a part of a movement in the spirit of all civil rights movements that have come before us. We invite those of you who are working in provider roles to join us. Many of the values and actions contained herein do not need to be specific to 'peer' roles. We invite all organizations to make space for this work to be done in a real way. Change does not happen overnight and tension can be a natural and positive sign of progress. In the end, a truly healing system will lead us all to be more humble and human with one another.

Signed,

The Western Mass Peer Network

Declaration of Peer Roles: Frequently Asked Questions

1. **Can you explain why medication administration, being a representative payee, talking about people in team meetings, participating in routine documentation, reading files, writing treatment plans, etc. are a problem or are not consistent with peer roles?**

All of these activities have the strong potential to increase power differentials and create a barrier between you and the person you're trying to support. They also just don't make sense within the context of a role that is intended to be on a 'level playing field.' For more on this topic, see the section called 'Is That Really a Part of a Peer Role?"

2. **How about wearing name tags/badges, meeting with desks between you, having individual/staff-only areas, visibly carrying around lots of keys? Why are those things issues?**

Name Badges: Having a name badge is a strong visual indicator that you are an employee. Historically, being an employee has meant that you are the expert, in charge and the one in power. Whether you intend it to or not, wearing a name badge communicates these same messages to the people you're supporting. Wearing a name badge visibly (around your neck, clipped to your clothing, etc.) also communicates the message that knowing who is the 'employee' is important at all times which carries its own set of messages with it, including that the one with the name badge is the one who should be listened to, asked questions, afforded credibility and trusted. These things are communicated not only to you and the person you are supporting, but everyone around you. Ultimately, this is not helpful to working in *partnership* with another person, nor is it helpful in sending them the message that their voice counts.

Meeting with Desks Between You: Being behind a desk immediately communicates authority and power. As with so many of the other items, this can create additional and unnecessary barriers between you and another person. It's also not considered 'trauma-informed' for much the same reasons.

Staff only areas: Having staff only areas can communicate a great deal to people you're trying to support. 'Staff only' bathrooms or kitchens, for example, communicate things like, "You're dirty," or that the person is so fundamentally different than you that you can't use the same toilet or re-frigerator to meet your basic needs. Even having your own office can communicate a strong message that you are important and respected in the way that the person you are supporting is not. That's not to say that all offices should b e banished. Sometimes 'staff only' are truly needed, but they are generally needed far, far less than they actually exist within the system and are often used far, far more than they should be when they are available. In your own role, it's important to ask yourself if an office is something that you really need. For example, are you writing grants or working on developing training curriculums (or other projects that require quiet and private workplace) with such regularity that having your own set workspace is necessary?

Carrying Around Keys: It is reasonable to expect that you will have one or more keys for just about any job. However, it's important to be conscious of where you keep them. Carrying around keys (especially large numbers of them) can be seen as a sign of power. Especially on locked units where people aren't able to freely come and go, it can be very hard to see someone else walking around so openly with the keys that will let them out whenever they want.

3. **What if the place I work isn't consistent with the Declaration. Does that mean my role somehow doesn't count, or that I can't do any good for others?**

No! Peer-to-peer roles are a part of a movement. As the word 'movement' implies, progress happens in stages. It's almost guaranteed that any peer role you enter will NOT be consistent with the Declaration right at the start. There's just too much lack of understanding and discrimination against people with psychiatric diagnoses that still exists for that to be otherwise. However, part of the intent of the Declaration is that it might be a tool that you can use to support you and the organization you work for to take steps to improve. Meanwhile, you can still do good work by being transparent about your limitations with the people you're supporting, and by using a 'harm reduction' approach to anything you have to do that feels inconsistent. (See the 'harm reduction' section for more on that!)

4. **Are there actually any workplaces where the Declaration is actually fully upheld, or is it an impossible dream?**

It's definitely not impossible! There are many organizations that are entirely peer-to-peer (the Western Massachusetts Recovery Learning Community being one of them) that work hard to stay consistent with these values. More importantly, although rare, there are traditional provider environments that have invested a great deal of time in holding true to the intent and integrity of peer roles. For one example, see the 'Interview Across Roles' section in the Provider portion of this booklet.

5. **Wait, are you saying I shouldn't be taking any notes? What if I just want to be sure to remember something?!**

The part in the Declaration about routine note taking is NOT meant to put a ban on all pen and paper. Just as you would in the rest of your life, there are times when you'll want to write something down so you don't forget. That is substantively different, however, than writing routine progress notes about someone after each visit. Why so different? Well, for one, the type of notes we all take in our life is something to which both you and the person you're supporting have equal access, and you also both have complete control over who else sees them. Routine progress notes, however, are generally only completed *by* employees *about* the person being supported and are accessible to any number of others who work there (as well as funders).

6. Shouldn't a lot of these values also apply to other people working in the mental health system? Why just peer roles?

Absolutely! Many of the values in the Declaration speak to the way we wish everyone approached one another. However, at least as the mental health system is currently set up, there are some employees who simply must take on the role of creating treatment plans, taking notes, writing reports, administering medication and so on. While they can learn to do those things in much more transparent, healing ways that create far more room for self-determination and responsibility for the person they are supporting, they still need to be done under the current structure. Part of the point of the Declaration is that it's absolutely essential that peer roles be protected from those other responsibilities, so that someone who's struggling to heal and move forward can have support from someone who's attention and priorities are not divided and whose focus is primarily on making sure that that person knows their choices and has a voice. Having that type of support can make all the difference in whether someone sees themselves as having the power and potential to move beyond the system, or just gives up and sees themselves as hopelessly broken.

7. Isn't the Declaration unnecessarily divisive and negative toward providers?

It's not intended to be. It's simply intended to be clear and direct, and part of being clear and direct means looking back at the realities of a very difficult history and the real challenges of moving forward. As noted at the end of the Declaration, the hope is to have providers join with people in peer roles to move the values forward.
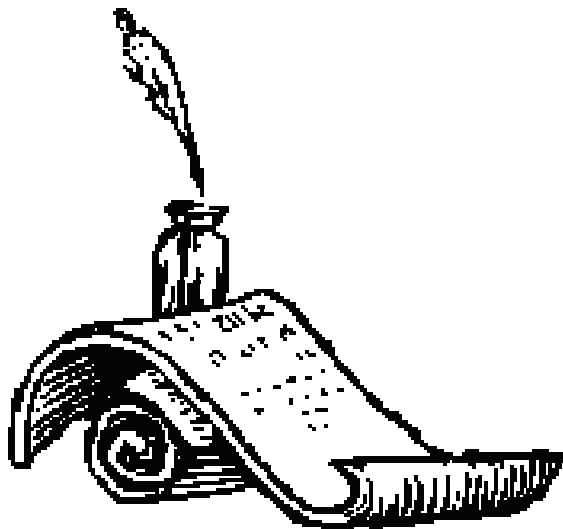
Is that really part of a 'peer' role?

Peer roles can come across as very abstract at times. In spite of the lengthy detailed Declaration of Peer Roles you just read through, it can be hard to picture what it all really looks like. What constitutes a 'day in the life of a peer supporter?' For better or for worse, there really is no such thing because peer-to-peer support is so fundamentally based in genuine human relationships that are flexible and based on that particular connection.

However, another way to look at understanding peer roles is to have a grasp on what they aren't or what tasks should not be included. Below is a chart designed to help build understanding in that way. In fact, this section is so important that we printed it twice: Once in the section directed toward people working in peer roles and once in the section for providers.

Whether or not a task is consistent with a peer role can become a complicated question, especially when it's wrapped up in issues of limited budget and limited understanding of the peer role itself. However, as someone working in a peer role, it's critical that you develop understanding so that you can share it with others and protect the integrity of your own work.

There are three main categories of work that is not consistent with peer roles fits into. These include:

- **Busy Work:** Is this just busy work because you don't know what else to do with a peer worker and/or there is no one else who wants to do a particular task? Are you not recognizing the special skills and training that a peer worker has, and giving them only the tasks that anyone could do?
- **Agenda:** Are you asking the peer worker to focus on a particular agenda (other than that of the person they're supporting)? Are you seeing them mainly just as a way to get information for the rest of the team? Are you seeing their activities as defined by provider paperwork like treatment plans?
- **Power Imbalance:** Are you asking the peer worker to do something that will increase the power imbalance (or perception of power imbalance) between them and the person they're

Activity/ Topic	Consistent with Peer Role	Not Consistent with Peer Role
Medications	Supporting someone to evaluate and communicate their concerns and desired changes regarding medications; Supporting someone who is withdrawing from medications to come up with other supports; Supporting someone to gather information/resources pertaining to meds; Supporting someone to come up with a plan toward independence with med management, changes, etc.	Administer medications; Become certified in the Medication Administration Program (MAP); Use your own lived experience to encourage someone to comply with their medication orders; Report back as to whether or not someone is taking their medications, etc.

Activity/Topic	Consistent with Peer Role	Not Consistent with Peer Role
Fund Management	Work with someone to build skills (balancing their checkbook, etc.); Work with someone to come up with a plan to regain independence of their funds; etc.	Become someone's representative payee; Make decisions about how someone can and can't use their own funds; Any other fund-related activity that is likely to be seen as coercive or having control over the person's money
Giving Rides	Because the person trusts you and wants you to go with them; Because you're trying to build a relationship with the person and offered to give them a ride; Because you're going with the person to advocate/support them at an appointment	Because everyone else has something more 'important' to do, so you've become a taxi driver; Because they hope you'll convince the person to do/not do something on their way to an appointment; Anything else that comes across as using you routinely as a taxi
Cleaning Someone's Apartment	Because the person trusts you and asked you to help; Because you're trying to build a relationship with the person and offered to help	Because everyone else has something more 'important' to do, so you tend to get assigned the tasks no one else wants to do; Because the provider thinks you've got the best chance to talk the person into changing their cleanliness habits; Because cleaning is in their treatment plan, and someone's got to do it whether or not that person wants to
Assessments	Support the person to collect their thoughts and have their voice heard in the process; Support the person to understand what is written about them; To be present while the assessment is happening as a support person	Giving your opinion about how the person is 'functioning'; Completing written assessment paperwork
Treatment Plans	Supporting the person to get their voice heard during the treatment planning process (by being present, helping them plan before the meeting, and/or advocacy); Supporting the person to change their plan as desired; Advocating to keep treatment goals that are not self-identified or are otherwise inconsistent with a recovery-oriented approach out of the plan	Writing a treatment plan; Focusing 1:1 interactions with the person around what they're supposed to be working on according to their treatment plan; Writing routine progress reports on treatment goals

Activity/Topic	Consistent with Peer Role	Not Consistent with Peer Role
Meetings	Advocating to not talk about the person without them; Supporting the person to be present and heard at treatment team meetings that pertain to them; Supporting the person to gather information and understand the content of meetings; Asking clarifying questions at meetings to support understanding; Meetings that are about policy setting, establishing overall best practices, etc.	Routine attendance at meetings where individuals are being discussed without them being present; Giving your own opinion about what should happen with someone (particularly where it is not consistent with that person's own desires)
Forced hospitalization/ Commitment Hearings	Advocate for the person's voice to be heard in the process; Stay with them as a support during meetings, assessments and while waiting; Help them gather information, understand what is happening and what is likely to happen next; Help them understand their rights; Help them get personal belongings that they're asking for; Help them make plans for taking care of pets, bills, etc.; Help them present WRAP plans/Advanced Directives to relevant personnel; Helping to educate their lawyer; Helping them plan what they will say when testifying on their own behalf; Accompanying them to court; Testifying as an advocate if you think your testimony might help offer support/educate the court	Transporting forced hospitalization paperwork; Testifying against the person; Making your own recommendations to the court/lawyers (especially when inconsistent with the person's own wishes)
1:1 Visits	When they are requested by the individual (or when you offer and they accept); When you and the person have a mutual agreement to meet at the same time each week; When you are open to talk about/do whatever makes sense for where that person is at in the moment	When the provider wants you to visit, even if the person tells you no; When the visit is focused on treatment plan goals (unless at the individual's request) or trying to get someone to do something they don't want to do

Activity/Topic	Consistent with Peer Role	Not Consistent with Peer Role
Reading files and treatment plans	When you are supporting the person to know what is in their file; When you are supporting the person to understand their current treatment plan; When you are supporting the person to seek to have something added/removed/ changed in their file	When the provider has asked you to read the files as a part of a routine; When you are reading the file as a way to get to know the person
Job searching	When the person has asked for your help; When you are sharing some of your own wisdom gained in from your own job searching process; When you and the person have agreed to work together to look for employment resources, etc.	When your employer has told you that employment needs to be the focus; When you are focusing on employment only because it's in the treatment plan
Housing search	When the person has asked for your help; When you are sharing some of your own wisdom gained in from your own home searching process; When you and the person have agreed to work together to look for housing resources, etc	When your employer has told you that housing needs to be the focus; When you are focusing on housing only because it's in the treatment plan
Answering Phones	When you're just occasionally helping out around the office because you happen to be there; When it's your own phone that you're answering; When you're answering a line that is designated for peer-to-peer support calls only	When you're routinely answering the phone because no one else wants to; When answering the phone means you are reasonably likely to find yourself in a position to have to assess or 'triage' calls for level of crisis and transfer to clinicians
Filing	When you're just occasionally helping out around the office because you happen to be there; When it's papers from a project or training you are personally working on/organizing	When the papers contain personal information about particular people; When you're routinely filing because no one else wants to
Social Events	When it's a part of your relationship building; When you're supporting someone to explore things they have fun doing; When you're supporting someone to get to know community resources or other people; When it's just something you both agreed you wanted to go do	When it's all your ever asked to do (i.e., the 'peer' role has been minimized to being purely recreational); When you're asked to take someone somewhere who doesn't want to go there or doesn't want to go with you

Is that Really a Part of the Peer Role?: The Why of It

Medications (Power Imbalance): Whether medications are good or bad, wanted or unwanted, handling someone else's medications is a tricky thing to do. First of all, there's a history of coercion and force around medications that is relatively undeniable, no matter where you stand on other related issues. In fact, many people currently being supported in the mental health system are under some degree of force to take medications. As people working in peer roles are tasked with working on as equal of a playing field as possible with people they're supporting, getting involved with meds can immediately throw that goal off based on the history alone. Perhaps more importantly, for every 'privilege' that someone working in a peer role has, that someone receiving supports does not, the barrier between them gets bigger. That is to say, if someone in a peer role is administering medications, that is because the person receiving them does not have the control or access to do it themselves. Thus, at least in part, it's not even about the fact that we're talking about medications or anything else. One of the main issues is that of privilege, and there is nothing positive to be gained by increasing power imbalances in a relationship that is supposed to be as free of power imbalances as possible.

Fund Management (Power Imbalance): Similarly, there is a history of loss of power and control in the realm of representative payeeships. There is little that can throw off power imbalances further than having access and control over someone else's funds. This simply doesn't work within the context of a peer-to-peer relationship.

Giving Rides (Busy Work): This one is tricky for another reason. That is because giving someone a ride in a way that is consistent with peer-to-peer values can look very similar to when it is not consistent. Really, it comes down to this: Is the person in a peer role being used as a taxi to drive around people with whom they do not particularly otherwise have a relationship? Did the request come from the individual needing a ride or from a boss delegating responsibilities? Is it occasional or routine? Is the peer role being valued overall? There's nothing to say that someone working in a peer role can't occasionally help out in a pinch by giving someone a ride. However, if they are routinely used in this way that is a clear sign that their role isn't being valued, because if it were, they simply wouldn't have the time.

Cleaning Someone's Apartment (Busy Work/Agenda): Similarly to the 'giving rides' topic, this one can go either way. If someone has asked the person in a peer role to help out, that's great and up to them to negotiate with one another. However, if a boss has asked, then it's an issue, especially if it's frequent. In some ways, it's an even bigger issue than the rides one, because entering someone's home and touching their personal belongings can feel very personal. Thus, doing this in a way that is not invited by the person themselves can violate any existing or future trust needed for actual peer-to-peer support to occur.

Assessments (Power Imbalance): Participating in assessments is problematic for two reasons. First, people working in peer roles are trained to steer clear of judgment and talking for people as much as possible. Stepping into an 'assessment' role immediately pulls them out of that place. Perhaps more importantly, part of the point of the peer role is to support the person's voice to be heard. People receiving mental health service often report not feeling heard or like their voice holds no credibility in a room full of clinicians. Although someone in a peer role generally isn't seen as having the same credibility as a clinician, they are typically seen as having more credibility than the person they're supporting simply by virtue of the fact that they are a paid employee. Thus, if the person in a peer role begins participating in the assessment process, they become just one more person whose voice is being heard louder than the one the assessment is about.

Treatment Plans (Power Imbalance/Agenda): Responsibility for writing a treatment plan about someone is an incredibly powerful role. While it can be done both poorly and well, it still creates a power imbalance even under the best of circumstances. Additionally, many treatment plans are subject to pressures from system expectations and so it can be very difficult to keep other agenda from seeping into provider plans.

Meetings (Power Imbalance): There is little in this world that can leave someone feeling more powerless than knowing there is a meeting taking place about them without them present. As such, it becomes a position of power and privilege for a peer worker to be present in those situations. In a way, it also makes the peer worker complicit with the practice of talking about people in this way which can also be seen as a violation of trust.

Forced Hospitalization/Commitment Hearings (Power Imbalance/Agenda): Although it's somewhat unusual for peer workers to be asked to be involved in these activities from a provider perspective, it does happen. For example, there are people working in peer roles who report having been asked to take commitment paperwork with them to the hospital when they're on their way to support someone who very much does not want to be forced into the hospital. Some have also reported being asked to testify at commitment hearings in ways that are not consistent with what the person they're supporting wants. These actions represent not only a power imbalance and focus on an agenda that is other than that of the person being supported, but they will also been seen by most people as clear signs of dishonesty and breach of trust.

1:1 Visits (Agenda): Visits one-to-one between a peer worker and someone they're supporting can be really powerful and important times to build connection and explore issues. However, when they occur because the provider wants them (as opposed to the individual themselves), or when they're constructed around the need to accomplish specific treatment plan goals, control over the agenda gets lost. It's critical to the essence and potential impact of the relationship between a peer worker and the person they're supporting that the connection be seen as something that they together own and control. When others step in with outside agendas, it defeats that.

Reading Files (Agenda/Busy Work/Power Imbalance): One of the most common reasons people are asked to read files during their training period is for lack of anything else for that person to be doing in that moment. Other common reasons include that it is simply standard practice ("the way it's always been done") to ask someone to read the files of people with whom they'll be working. Additional and well-intentioned reasons include wanting to make sure that people know any historical issues that might be of current concern, and so on. However, learning about someone through the provider's eyes clearly orients someone to the provider's agenda and ways of interpreting various events and experiences. It's also a clear power imbalance for the person in a peer role to have that level of access of information to the person they're supporting, when the person they're supporting has no information about them.

Job & Housing Searches (Agenda): Does the person see job or housing searches and related skill building as a priority? Do they see you as a person they trust and want to work with on that priority? If yes, then great. If not, then the peer worker is being pulled into someone else's agenda.

Answering Phones (Busy Work/Power Imbalance): Is there any reason for someone in a peer role not to pick up the office phone? No, there's no blanket reason, and if it happens once in a while that's fine. However, there is a reason to not station them in that role—several, actually. First, it's just not a good use of time and if it happens regularly, it suggests that the peer role isn't being used well at all. It's even more important that it not happen, however, when people who answer calls are expected to 'triage' them. This puts someone in a peer role in a position to have to 'assess' the needs of the person calling, which puts the person in a peer role in a power position and just simply isn't consistent with the intended focus. One final consideration: If a person in a peer role is answering the office phone, that necessarily means they are in an office. That's not inherently wrong, but if it is often the case, it suggests that that person isn't spending enough time where they really should be: with people in the community. Even being in an office with staff is indicative of a power imbalance that can damage the formation of relationships.

Filing (Busy Work/Power imbalance): Again, there's nothing wrong with helping out once in a while, but it shouldn't be a regular thing or it becomes busy work. It also shouldn't include confidential information, as access to clinical files represents a power imbalance. If the information that needs to be filed is information someone receiving services could also handle, then there's nothing wrong with a once in a while thing.

Social Events (Busy Work): Social events can be a great way to connect, but we've also heard people and organizations speak about peer roles as if 'social outings' are their main focus. Going out for coffee, to a concert, etc. can be a great way to build a relationship, but if the social outing is the end focus even over the long-term, it may just be busy work.

Respect Vs. Discrimination

There's yet another layer to understanding peer roles, and
particularly, understanding the difference between supporting and
being respectful of peer roles verses perpetuating misconceptions and
discriminating against people who have been given psychiatric
diagnoses. And, like the elements mentioned in the previous section,
it can be difficult to tell them apart at times.

It's an unavoidable fact that most people still have preconceptions about individuals with
psychiatric labels. Frankly, this is true of people in provider roles, the general public, and
people who have been diagnosed themselves. The messages that people who are psychiatrically
diagnosed are sick, can't be trusted, or are even dangerous are fairly pervasive and hard to
avoid. Thus, it doesn't make someone a 'bad person' for having taken some of those messages
in, but it does mean there's even more work to be done to move things forward and have peer
roles be taken seriously.

Although there are many more possible examples, below is a chart of certain actions that can
represent either respect or discrimination/lack of respect, depending on what's behind them.

Respectful	Discrimination/Disrespectful
Re-evaluates Human Resource policies for EVERY employee to make sure they are consistent with an environment that offers reasonable support and flexibility to its workers when they're going through a difficult time	Doesn't expect you to attend regularly because you're in a peer role. **Even Worse:** Asks you to complete (and, in some instances, share it with people at your workplace!)
Supports you not to attend team meetings where people are being talked about because they understand its inconsistent with your role to do so.	Supports you not to attend team meetings where people are being talked about because they're afraid you'll be "triggered" by the difficult topics being discussed.
Offers you very part-time hours because it's what meets your needs in your life at the moment (or it's all they currently have available.)	Assumes you wanted very part-time hours because you're not 'capable' of more, and doesn't consider you for an increase, or questions your capability when you ask.
Supports you to work through how and when you may want to share parts of your story in your work. **Even better:** Supports ALL employees to do the same.	Expects you to share parts of your story on demand, but only the parts they're comfortable with. **Even worse:** Shares parts of your story with others without your permission, because your story is now seen as *their* 'tool,' too.

Supports you not to be involved with medication administration and other tasks of that nature because they understand that it conflicts with your role.	Doesn't involve you in medication administration and other tasks of that nature because they think it's beyond your capabilities to do it well.
Supports you to attend trainings, even if that means going outside of the organization to find trainings that are specific to your role.	Supports you to attend trainings, but only internal ones that are the same as what everyone else gets. (While this may seem 'equal,' it's important to remember that the people in those other roles are getting training that is consistent with what they actually do, and you are not.)
Invites you to a policy or advisory meeting because your voice is valued as is the perspective of people who have received services in general.	Invites you to a meeting because they want to be able to say they involve people who received services in all decisions, but doesn't take your input seriously or gives you a hard time for what you say.

Human Resources Policies: The best organizations will have consistent policies across the board, and will have an understanding that everyone and anyone could have something come up at some point that will get in the way of their doing their job for a period of time. This could include anything from a difficult divorce to a death in the family to cancer treatment, and so on. Those organizations that treat people in peer roles as if they are more fragile and more likely to need time off and thus create special rules for them are often doing a disservice to everyone and are treating people in a discriminatory manner (unless someone has specifically requested particular accommodations). Unfortunately, because peer roles can be so high stress and because people who take peer roles have often experienced so much prior trauma (including trauma within the mental health system), there very well might be times when some people may feel the need to take time off from work. In some instances, depending on the type of job they are being asked to do (e.g., being a sole peer advocate in a locked hospital unit can be very difficult to sustain as a result of the work environment paired with the isolation of the role), this may even be more often than others. (Though, this is likely more a sign of a problem in the work environment than a problem with the individual.)   However, both reliable and unreliable employees can be found in peer and provider roles and all should be treated the same. Automatically treating all people in peer roles differently is a show of lack of respect and belief in their overall capacity to do the work simply for having a diagnosis.

No organization (peer-to-peer or traditional) should *ever* require someone to do a Wellness Recovery Action Plan (WRAP) or self-care plan for themselves. Requiring someone to do a WRAP is against the very ethics of WRAP itself, and is discriminatory and invasive toward the employee. (This does not preclude employers from making information about these resources available.)

Team Meetings: Attending team meetings where people are routinely discussed without them   present is a real concern (as noted in the previous section). When someone working in a peer role is not required to attend these meetings, it's pretty much always a positive. However, if the reasoning behind that is because others see that person as 'too fragile' to handle it, that's a problem, and is discriminatory. Does this mean we should be fighting to attend team meetings just to prove people wrong? No, of course not. However, when someone suggests you're not attending   because it might be too upsetting for you to be present, it's a great opportunity to educate them about just how strong you are, and the real reasons behind your lack of attendance.

Part-time Hours: There are several real reasons why someone may want to work very part-time hours. These reasons can include anything from having a child at home for whom they want to be present, to having another job, to being in school, to receiving Social Security benefits and needing to be careful about how much they earn. However, the assumption that they can't work more because they are in a peer role is discriminatory. In fact, not providing any opportunities to work full-time may, for some people, prevent them from having any chance at successfully getting off of Social Security. The best supervisors will always be *asking* their employees what they want for their future in the organization (rather than making assumptions), and that includes people in peer roles.

Sharing Stories: Sharing your story is trickier than it may seem at first. Often, peer roles are boiled down to little more than people who walk around sharing their story to inspire others. However, on the flip side, organizations can sometimes have very limited ideas about what it's 'okay' to share and can still penalize people in peer roles for what they perceive as 'going too far.' Meanwhile, still others can misunderstand, and begin to use pieces of someone's story for them, in their absence and without their permission. (This can come across as very disrespectful and disempowering unless you have permission to do so.) Organizations that approach this issue respectfully will support someone to find their own way in what they want to share. They offer that person flexibility and support them even when it seems they have taken a misstep to learn from what happened. They don't expect that person to tell their story on command, nor do they expect them to share things they're not comfortable sharing just because the employer requests it. (They don't see themselves as 'owning' the personal information and stories of those in peer roles any more than they do for the rest of their employees.) The very best organizations will support this process for all employees, regardless of their roles.

Involvement in Medication Administration, etc.: The misconception that someone in a peer role should not be involved in medication administration (or similar) because they're not capable of handling it is not uncommon. However, as discussed in the prior section, there are much better reasons why this should not happen. When this misunderstanding comes up, it's a potentially teachable moment, and here's one way to approach it:

> To be a good chef requires a great deal of skill and focus. While some chefs may also make great hosts, managing calls for reservations, greeting and seating people, and tracking open tables would act as a tremendous distraction to their ability to run the kitchen and prepare delicious food. Thus, most would agree that it's a conflict to have the chef also acting as host, and would hire someone else to fill that role. Few people would assume that the chef isn't acting as host because they aren't capable of doing so. It's a similar issue with peer roles. We're capable of taking on those sorts of responsibilities, but they would interfere so substantially with our ability to do the core parts of our job, that it needs to be avoided.

That people do sometimes make this assumption about people in peer roles can reflect lack of understanding of the role itself and/or discriminatory attitudes toward people who have been given psychiatric diagnoses.

Attending Trainings: It's great when employees development is prioritized and employees are supported to attend training. However, asking people in peer roles to attend all the same trainings as people in traditional roles, especially without also providing them additional training access that is specific to their role, is a problem. It also often acts as evidence that the organization doesn't really grasp just how different the peer role is from others being trained. Imagine having lots of colleagues to talk to over the water cooler, and policies that were based on your role existing for many years. Then imagine what it would be like for those entering that environment who have no or few other colleagues employed in the same type of role and who are generally not fully understood by the majority of other employees. For the person in a peer role, not having access to training that is specifically focused on peer-to-peer support can leave them feeling more isolated and less able to hold to the integrity of their role. Training is great, but not all trainings are created equal and the best organizations that are genuinely interested in supporting the peer role to fully develop will be willing to explore meaningful training opportunities for all employees.

Policy/Advisory Meetings: Sometimes organizations are required to include the voice of people they are serving (or who have received services in general). Sometimes they have decided on their own that this is something that they want to do. However, signs that it is being done in more of a 'token' manner include specifically inviting people who don't typically speak in meetings, or inviting someone who speaks up but then telling them that what they said was unacceptable, or made people too uncomfortable. (That's not to say that sometimes people may legitimately cross lines in meetings, but all too often this sort of feedback has more to do with people not liking to feel uncomfortable than that the person who spoke up did anything wrong.) It can be really hard to point to this when it really happens, and getting support from others in peer roles on how they've handled it can be really valuable.

None of these examples are meant to suggest that all people in provider roles are awful people who will constantly discriminate against you, and just because these issues frequently come up doesn't mean that you'll necessarily experience every one of them. It can also just get exhausting to be the one to have to be responsible for 'educating' everyone all the time on how they are (however unintentionally) discriminating against or nut understanding you or your role. Often, approaching people with the knowledge that we all have unlearning to do and most of us want to do the best job we can, can go a long way toward opening the door to addressing problems.

In some instances, sharing this section of the handbook with others with whom you work may even be helpful!
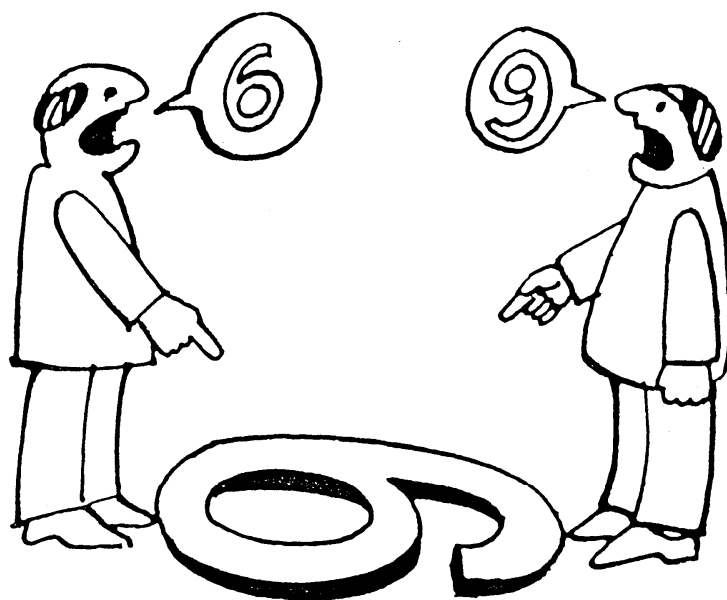
An Interlude: A Bit of Humor About Some Difficult Issues We Face in Peer Roles

Top Ten Signs You May Be Co-Opting the Movement
Adapted from: The Staff Survivors Network, 2005

10. You consider hiring the first peer role in your organization as something more than just a starting point.

9. You think of your peer employees as something less than as one of your colleagues.

8. Your peer employees have pretty much the same job as the rest of your staff, but with a different title.

7. Your most common response when your peer employee speaks is to smile and nod.

6. The statement, "I'm okay with peer roles, but I'd be really uncomfortable if one of my colleagues came out as having a psychiatric diagnosis," really resonates for you.

5. You don't understand why the one and only peer employee in your organization thinks of their job as 'high stress.'

4. Any personal disclosure beyond, "Hi, my name is x and this is my diagnosis. Now I'm recovered!" makes you uneasy.

3. You use the word 'peer' like it's just the next PC word for 'client' or 'consumer.'

2. You view the question, "How do you know what you know," as a simple request for a bibliography.

1. You think, "Nothing about us without us," is just another pop song you've never heard.

Language Overview

Some people will inevitably say that the language conversation has gotten old, but the truth is that using different language than the language being used within the mental health system is **one of the easiest things you can do to make a difference,** and that's why we're going to spend some substantial time here. It requires no change in policy and no participation from others. You can do it immediately and without any cost or other tools.

But why bother? Not everyone will be impacted by language in the same way. However, there's at least a few reasons why it's important that people in peer roles pay attention to how they speak to and about others.

1. **Some language automatically indicates a power differential:** As noted in previous sections, it's central to the peer role to limit power differentials as much as possible. But what happens when you're 'staff' and the person you're supporting is 'client'? While it's important to be transparent about the fact that you're in a paid role, it's not necessary to strengthen that separation by how you speak in your day-to-day work. 'Staff' is also a strengths-based word (as it is based in gainful employment, being the one 'in charge,' etc.), while 'client' (in this context) is not (as it suggests the one being helped or who has problems, is in the subservient role, etc.).

2. **Some language is not trauma sensitive:** Most (if not all) people who are receiving services in the mental health system have experienced some significant trauma. Part of almost all trauma is feeling powerless, less than and/or objectified. For at least some people who get labeled (particularly those who live in residential or hospital settings and don't get to here themselves referred to in other ways very often), 'client' or 'consumer' can have JUST that affect. In other words, being boiled down to 'client' can—over time– leave someone feeling helpless, hopeless and boiled down to a 'broken person.' Obviously, not everyone is impacted in this same way, but it's worth considering even if just a few people are affected.

3. **Using non-systems language can help people see themselves beyond the system:** Regardless of what role people are working in, most people nowadays will agree that they would like to see people heal move beyond the system. However, when someone is referred to every day as 'client' (or any other number of labels used in the system), they can start to form an identity that is very closely tied to that world. Once that identity is in place, it can be all the more difficult to see a life beyond that place. On the other hand, referring to people in more open terms (and particularly just by name or as people wherever possible) can support them to see a broader world and more opportunities to re-envision who they are and who they want to become.

Language—What are We Really Talking About Here?

During language trainings, it's commonplace for providers to say, "Can you give us a list of 'bad' words and the words we should use instead?" Unfortunately, it's not quite that simple. While we can point to some specific words (or types of words) that are problematic, there is no single 'good word' list. Most of the time, it boils down to understanding the values BEHIND why we choose words, and then integrating that into how you speak to and about others.

Some Categories of Problematic Words:

1. **Identity Labels:** Identity labels include some of the words focused on the previous page: Client, Consumer, Patient, Peer, Participant, Guest, and any number of other one word labels that replace the person's name or other words that link them to the broader community (individual, person, someone, etc.). It also refers to phrases like 'The mentally ill," as well as some of the two-word combinations that are used within the system as if they were one-word labels and essentially have the same effect (e.g., person served). The truth is that any single word (or short word combinations) that becomes 'systemized' and used always and only to refer to the person who has been diagnosed and/or is receiving services becomes a problem. Instead, it can be valuable to use person first language, avoid tying the person unnecessarily to the system whenever possible, and leave space for them to say who they are themselves.

For example: Not everyone receiving mental health services or who has been given a psychiatric diagnosis identifies as mentally ill! Instead, they may identify as having survive trauma, as going through a spiritual emergency, as having particular sensitivities, as experiencing emotional or mental distress and so on. Thus, referring to them as 'the mentally ill' not only boils them down to just that one piece, but also ignores and erases who they say that they are. Needless to say, feeling erased and ignored does not generally lead to forming partnerships that support healing.

Try: It may feel really hard at first, but try dropping all the language mentioned above and experimenting with phrases like those mentioned in the 'More Language Examples' section. Also try to pay attention to all the times when someone refers to 'client' (etc.) and everyone would have known exactly what they were talking about if they'd used a more general word. (For example, in the sentence that starts, "Clients in the Monday wellness group...," who wouldn't understand the same meaning if they said instead, "People in the Monday wellness group?") That absolutely are whole communities of people who successfully transition to speaking in this way, so it is possible!

A few additional notes on identity labels and person-first language:

Why saying 'We asked them what they want to be called, and they said x," isn't enough: Approach a group of people who have been in the system for a long time and/or have never heard there are any other options, and ask them what they want to be called. Chances are, more often than not, you'll get either exactly what they're used to hearing or something quite similar to it. While

there certainly is a value in asking people their opinion, doing so without taking any responsibility for exposing them to options hasn't really accomplished much. (Note: Although one should never correct someone on how they refer to themselves, that doesn't mean that someone else should ask them how they want to be referred to and that word should be used to refer to them for ever after. Leaving space for people to make their own meaning, AND to learn, change [if desired] and grow are all important.])

Person-first language is NOT for everyone: While person-first language is critical within the mental health system, it doesn't mean that applies equally everywhere. For example, within the autistic community, many of the strongest advocates will argue strongly against 'person-first language' for them. They feel that it implies autism is a bad thing or a deficit rather than simply a difference and separates them from what they really do see as a key part of themselves.

2. **Acronyms:** Although it's a potentially minor point in comparison to others, it's important to recognize that using acronyms—especially regularly– represents a sort of 'in' knowledge and can be perceived as demonstrating power for that reason. Sometimes, when people speak in lots of acronyms it leaves them feeling good and more connected to the group with whom they're identifying.   However, for that same reason, it can leave others in the room (who don't get the acronyms) feeling left out. It's also sends a particularly powerful (and disempowering/othering) message to boil people receiving services in the system down into acronyms (e.g., referring to people as 'SMI' which stands for Serious Mental Illness).

Try: Counting how many acronyms are used around you in a week at work. Also try not using them yourself. We all slip into it sometimes, but it is possible to break the habit overall.

A few additional notes on acronyms:

While it's best not to use them, it can be empowering to know them!: While it's best to model not using acronyms, it can nonetheless be empowering to yourself and those you support to make sure you all know what they mean!

One of the most disempowering acronyms are the ones that come after people's names: As exciting and satisfying as it can be to complete a degree or certification program, putting all those letters after your name all the time can also be a way to divide you from those around you or suggest that you are better or more 'the expert' than them. Also consider: Many people who are on the receiving services end have also completed degree or certification programs, but that typically gets ignored when their name is written within the system!

3. **Diagnoses and Other Clinical Terms:**   There are many diagnoses to be found in the Diagnostic and Statistical Manual (DSM) and it's not unusual to hear them used within (and beyond) the system as if they have great meaning.   However, in reality, people can have very different

experiences and just like with terms such as 'mental illness,' some people will strongly identify with their diagnosis and others will feel alienated and misunderstood by it. As noted elsewhere in this section, it can be useful to create some separation between the person and the diagnosis (where and when a diagnosis must be used). For example, instead of referring to 'the schizophrenic,' or even someone 'with schizophrenia,' it can be useful to say, 'x has been diagnosed with schizophrenia.' (That leaves that person room to say how that diagnosis is meaningful to them.) Other words in this category are those like 'baseline,' 'non-compliant,' 'decompensating,' 'baseline,' 'labile,' 'manipulative,' and so many others. Similar to with acronyms, using these words can often make someone feel more 'in the know' and 'professional,' than using everyday words, but the impact on those around them can be just the opposite. See the 'more language examples' page for more information and ideas!

Try: Try paying attention to the diagnostic and clinical words most commonly used in your workplace. Make a note of them as you hear them. At the end of a week or so, list them out and partner with others working in peer roles (if available) to brainstorm alternatives.

An Additional Note:

Change for Change's Sake: Another reason to change your language is simply because doing one thing differently helps everyone understand that other things are also being looked at differently. On the other hand, doing one thing the same as always can lead to someone slipping into auto-pilot, even when they don't mean to. (Who hasn't gone into auto-pilot mode while driving a familiar route, and driven right past where they meant to turn off to get to somewhere new?)

Of course, while changing our own language is relatively painless and an easy place to start, people working in peer roles are also meant to be change agents for how others think and act and that will mean, at times, giving people around you feedback about their language, too. Ideally, some people will pick up on the changes simply by hearing you, but others will need more time and dialogue to understand the reasons behind the shift. And, as always, with every change comes tension. It will be helpful to your efforts if you have some sense of how you're likely to be challenged and how you might respond. What follows are the five top ways that the 'language' conversation is typically discredited and what do to do about each one.

Top 5 Ways the 'Language' Conversation Gets Dismissed

1. **That's just the new 'PC' (politically correct) word:** When someone says this, it's often a way of saying, "We might have to use this word to appease person(s) x, but it doesn't really have any deeper value or meaning." Statements like this can also be a way of expressing very real frustrations that language can feel like an ever-moving target without any real explanation. However, for people who have really invested time in the language conversation, the meanings run deep and have great impact.

    When someone says something like this, it may be helpful to simply ask them what they mean when they say that or to ask them if they'd be open to a conversation about the deeper meaning behind a particular word or change.

2. **No one will understand me if I talk like that:** When someone says this, sometimes it really may be about a concern that the language has gotten to flowery, generalized or detached from the familiar system lingo. However, more often than not, a statement like this also reflects that particular person's lack of sense of connection to the word(s) they're being asked to use. Interestingly, *most* of the accepted language in the mental health system is also fairly generalized ('mentally ill,' 'schizophrenic,' etc.) and non-descriptive of an actual person, and the sense of understanding what each other means when those words are used can be a bit of an illusion. Thus, it often comes down to a sense of shared agreement about which words are most familiar moreso than the actual information being communicated. In reality, when we make a switch to using common-day, non-clinical language most do understand.

    When someone says something like this, it may be helpful to simply ask them to speak more about their concern. It also might be helpful to ask them what the worst thing is that might happen if the person they're talking to doesn't understand what they mean at first. (Sometimes, when someone doesn't understand and has to ask about the meaning, that can actually be a good thing!)

3. **It makes it hard to speak if I'm always worried I'll say something wrong**: More often than not, this is an expression of frustration at the frequency of language conversations and/or the way they're being approached. It's also natural for people to feel uncomfortable when they're being asked to change something that's pretty ingrained in how they move through their day-to-day. Ultimately, it's important to recognize that there has to be a time when speaking feels more awkward until a different way of speaking becomes the automatic. Tension, discomfort, awkwardness, etc. are all a natural part of the experience of change.

When someone says something like this, it may be helpful to reflect back that they sound frustrated or validate that the process can be frustrating, and to ask them how the conversation could be approached in a way that would feel better to them. It may also be helpful to have a more general conversation about how change feels.

4. **You're just the language police:** Labeling someone as the language police often reflects frustrations from someone who feels like language is coming up too often. However, it can feel very silencing to the person who gets so labeled. It is important to remember that it can get difficult to hear if someone is constantly harping on a particular topic. However, it is also hard to be one of only a few people (or sometimes the only person) who is in the primary role to bring up these sorts of difficult topics. Ideally, the responsibility for paying attention to language should fall on the whole organization. Constructing a practice where everyone holds this responsibility makes change all the more likely and makes everyone's job easier.

   When someone says something like this, it may be helpful to ask someone what 'the language police' means to them. It may also be helpful to ask how often feels too often to them to discuss language and to talk through how often it's really coming up. (In reality, although many people have made this statement about language, the frequency with which language conversations actually happen pales in comparison to most topics in mental health organizations and systems. The feeling that they happen too much more often reflects the level of difficulty or discomfort that comes along with the conversation rather than the actual frequency.)

5. **It doesn't matter what words someone uses, it's what they mean that counts:** People want to be recognized for caring and doing a good job, and rightly so. Sometimes language corrections can feel like a slap or an accusation, and that can make the actual message harder to hear. However, at the same time, language really does matter and the ***intent*** really can be different than the actual ***impact***. Words carry powerful messages, and often people on the 'hearing' end of them are hearing what that word has meant in their broader lives and not digging for the meaning of that particular person.

   When someone says something like this, it may be helpful to ask them to offer an example and to really explore how that word or phrase may be heard by people depending on what their background has been.

Interlude: Language In & Out Of the System

At this point, it seems worth taking a quick (and hopefully humorous) look at a sampling of words and what they mean inside and outside of the system.

WORD	IN THE SYSTEM	OUT OF THE SYSTEM
Identity Labels		
Client	***The disempowered version:*** The individual receiving provider services within the mental health system, wherein the ***provider*** is typically seen as the key decision-maker.	***The empowered version:*** The role of the valued and paying customer of an advertising agency, a lawyer, architect, etc., wherein that ***individual*** is typically seen as a key decision-maker.
Consumer	The individual receiving provider services within the mental health system, usually from a provider who they had little or no role in selecting.	The much sought after customer who is typically in a position to choose from an array of products and services available in the free market.
Peer	The individual receiving services within the mental health system, often subject to the decisions and agenda of that system; OR The individual who used to receive services who now works within that same system in a role particularly designed for people who have had this experience.	A person or group with whom you share some common quality, activity or interest (age, profession, etc.)
Acronyms		
CPS	Certified Peer Specialist (a professional training and certification for individuals working in peer roles.)	Child Protective Services
ISP	Individual Service Plan	Internet Service Provider
MAP	Medication Administration Program	One of those funny pieces of paper that tells you where you are or how to get somewhere else
MI	Mental Illness; OR Motivational Interviewing	Michigan?

WORD	IN THE SYSTEM	OUT OF THE SYSTEM
Diagnoses & Other System Terminology		
Borderline	Short for 'Borderline Personality Disorder'; A psychiatric diagnosis found in the Diagnostic and Statistical Manual.	On the edge or near the 'border'; OR uncertain/debatable; OR a Madonna song from the 1980's.
Decompensating	The movement toward increasing emotional distress and/or decreasing ability to function in day-to-day life	Nothing. No, really: Nothing. The act of 'decompensating' is only meaningful in the medical world. Until very recently, it didn't even appear in most dictionaries. Microsoft spell checker will still tell you it's misspelled because it does not recognize it as a real word.
Baseline	A particular person's normal level of day-to-day functioning	A sports term. For example, the line between bases that a batter must run, or the line on a tennis court that marks the end of the 'in-bounds' area.
Compliance	Provider standards, recommendations and plans to which the *individual* is expected to adhere.	Service or product standards to which the *provider or producer* is expected to adhere.

THE POWER OF WORDS

Important Concepts in the Language Conversation

1**. Pin Prick Principle:** Who do we worry about more: The person who flinches or gets mad when certain system/diagnostic words are used in reference to them, or the person who has accepted those words wholly? If our goal is to help people *move on* from the mental health system and an identity of being 'sick,' then at least in some instances, the people we may want to worry about most are people who most strongly identify with the language used in that system. (Please note: This isn't intended to discredit people who find their diagnoses useful, etc. It more refers to people who refer to themselves as 'clients' wherever they go, or refer to them selves in system acronyms like 'MI' or talk about 'decompensating, etc. That said, regardless of what language people choose for themselves, it's NEVER our role to correct them. However, it is our role to make sure they're aware of other options!)

2. Who are you when you're all alone?: Most of us have many identities to draw from: Parent, child, sister, brother, student, teacher, trainer, employee, partner, artist, athlete, etc. However, when someone has been in the mental health system for many years and particularly when most or all relationships in their lives are with people who are paid or other people receiving services, one's identity can start to feel very one-dimensional and attached to the system. When we refer to people as 'clients,' 'consumers,' 'participants,' etc. we re-enforce the a belief that they may already hold… That that is who they are at their core. If that is not what we want to do, then it is important to consider changing that practice. If a person – sitting alone in their home – were to write an answer to the question, 'Who are you,' and that answer still primarily focuses on them being 'mentally ill,' a 'client,' etc, it's going to be all the more difficult for them to see a life that includes moving beyond the system.

3. Absence of Negative Messages: People naturally gravitate toward the messages that are consistent with what they already believe. For example, if someone believes that they are stupid and 99 people compliment them on their intelligence while one person says, "Yes, you ARE stupid," the natural human response is to hear that one person the loudest. Following that principle, it is not enough to change only a few messages in one's environment in order to promote healing and moving forward. Attention needs to be paid to all messages that someone might be receiving, including (and often, particularly) how they and their experiences are getting talked about.

Open Language vs. Closed Language: When someone enters the mental health system, they are generally told what is wrong with them and why. If they have their own story as to what is wrong and/ or why, it is often ignored or pathologized as a part of the problem. This sort of way of speaking generally uses 'closed language.' That is to say, it uses language that speaks more to the providers (or someone else's) interpretation and judgments than it does to what the person is actually experiencing. Language that is open, on the other hand, reflects more directly what is actually being shared/happening, is factual rather than interpretive, and leaves room for the person's own beliefs and meaning making. Having the space to make meaning out of one's own experiences can be absolutely critical to their own process of healing.

See next page for examples of open vs. closed language.

Open Vs. Closed Language: Examples

Jeannie is schizophrenic (or has schizophrenia) vs. Jeannie has been diagnosed with schizophrenia

CLOSED	OPEN

The open version of this statement is simply stating a fact: Jeannie met with someone in a clinical role who formally diagnosed her with a particular psychiatric label. It still leaves room for Jeannie to say how she feels about that, if she disagrees or has a different interpretation, if another clinical person has a different interpretation, and so on. The closed statement projects the interpretation that the diagnosis is the actual truth of what is going on with Jeannie and leaves no space for her or anyone else to make meaning in a different way.

George is non-compliant with his medications vs. George doesn't want to take these medications

CLOSED	OPEN

The open version simply reflects that George is not wanting to take particular medications. He may disagree with those medications or all medications. They may be making him feel sick. On the other hand, the term non-compliant carries with it the assumption that George SHOULD be taking medications and is somehow doing something wrong by not doing so.

Luis is experiencing auditory hallucinations vs. Luis is hearing voices

CLOSED	OPEN

The open version simply reflects an experience without judgment or interpretation. Saying that Luis is hearing voices doesn't necessarily indicate that hearing voices is bad or needs to stop. It leaves room for Luis to say that the voice is his deceased mother (or any other number of explanations), and doesn't necessarily assume that his explanation is false. Whereas the closed version very quickly leads to the assumptions that the experience is bad, wrong and best if stopped somehow. It clearly indicates that the voice(s) are also not real. It also distracts us from the fact that it's far more important how someone is ***actually being impacted*** by what they believe, rather than what they believe being comfortable or agreeable with what others believe. (Remember: The vast majority of people who hear voices never seek help for that whatsoever.)

Supporting people to make their own meaning of their experiences can be one of the most powerful things we can do!

More Language Examples

Ultimately, it's important that you find language that fits with the values of peer-to-peer support, but ALSO fits with you, Genuine relationships are at the heart of everything we do, and so using language that consistently feels fake or alien to you won't work in the long run. (That doesn't mean you wont' have to work through some awkwardness in your language when you first start out.) It also bears repeating that it is really important to remember that you should never correct how people talk about THEMSELVES. Your job is to support them to figure out their story, even if you don't agree with or understand it. Below are some additional examples of system language and alternatives you may want to consider! Not all of them will match in every situation, but most of them leave the door open for the person you're talking with or about to make their own choice about who they are and what they're experiencing.

Systems Word	Possible Alternatives
Client, consumer, person served, participant, peer, patient, etc.	Person, people, individuals, someone, someone I'm working with, someone I'm supporting, a person who's hospitalized here, etc.
Mentally ill	Struggling, experience mental or emotional distress, given a psychiatric diagnosis, a person in crisis, a person who struggles with x (e.g., lots of ups and downs, periods of being so sad they can't get out of bed, etc.), someone who's been through a lot of trauma, etc.
Decompensating	Not doing so well right now, having a really hard time, going through x (describe what they're actually going through), etc.
Delusional	X has some unusual beliefs about…, X believes they are the president (name the belief rather than labeling it as delusional), etc.
Non-compliant	X disagrees with their treatment plan, X doesn't want to do what the treatment team has suggested, X is making another choice, etc.
Bipolar	X is diagnosed bipolar (and may or may not agree with that diagnosis), X deals with a lot of really high highs and really low lows, X is experiencing (describe whatever they're experiencing), etc.

A Poetic Interlude:

Break the Mold *by Erin Levesque*

Language. Sign, written, spoken, is our first impression. It unsympathetically tells our secrets. It displays our   emotions, carries our messages and tells other people about who we are. It tells of our education, our moral beliefs, the way in which we were raised, where we came from, where we aspire to go to and the interim between the two.

Language is powerful.
It can honor or oppress, imprison or set free. It can empower. It can liberate. It can, yet so often it does not.

The words that we use are like colors on a pallet, our voices, the paintbrush. Our stories, our descriptions, our depictions, paint a vivid picture for our audience. They tell people what parts of our stories are sad, are happy, are painful or are filled with joy. The words that we use will teach other people our beliefs because communication is the most integral part of our learning process.

A process that begins at an early age when we are still filled with love and acceptance, boundless forgiveness and unrestrained truth. Before we learned that passing judgment, holding grudges and telling lies were all socially acceptable behaviors. Before we were taught to fear the truth through negative responses to our honesty. Before we learned to fear what we do not know because it was described to us using language that belittles and ostracizes anything unfamiliar. With a process that begins on the concept of acceptability being determinable by the approval and disapproval of those we love, it becomes clear that we were not taught to be ourselves, we were not taught to be freethinkers, believers, imagineers or captains of our own ships.

We heard our parents and caretakers using language that influenced our beliefs before we were aware that we even had beliefs at all. By the time that we began forming our own opinions they were so tainted with other peoples beliefs that they became mere fragments of what we genuinely believed.

We are told through our communications with others, what it is that we should think, do, be and not be. We have been molded. With intention or without, the fact remains.

Now we as adults are the molders. We are the teachers. Every conversation, every interaction, is an opportunity to set someone free, to paint a different picture. Now we choose what message we want to deliver in our words. Will we liberate, empower, or follow suit?

Changing the language we use can change the essence of who we are and what we give to the people around us. Using progressive language that supports the concept of resiliency and promotes strength, courage and perseverance, can and will change the face of our lessons. It is imperative that we decide to make the language we use, an important factor in our teachings; to our youth, to each other, to the world. Finding a way to speak to each other and to refer to others that is inclusive and not offensive, is not just a good first step in this process, it is the only step we can afford to take.

You & Me *by Debbie Sesula*

If you're overly excited
You're happy
If I'm overly excited
I'm manic.

If you imagine the phone ringing
You're stressed out
If I imagine the phone ringing
I'm psychotic.

If you're crying and sleeping all day
You're sad and need time out
If I'm crying and sleeping all day
I'm depressed and need to get up.

If you're afraid to leave your house at night
You're cautious
If I'm afraid to leave my house at night
I'm paranoid.

If you speak your mind and express your opinions
You're assertive
If I speak my mind and express my opinions
I'm aggressive.

If you don't like something and mention it
You're being honest
If I don't like something and mention it
I'm being difficult.

If you get angry
You're considered upset
If I get angry
I'm considered dangerous.

If you over-react to something
You're sensitive
If I over-react to something
I'm out of control.

If you don't want to be around others
You're taking care of yourself and relaxing
If I don't want to be around others
I'm isolating myself and avoiding.

If you talk to strangers
You're being friendly
If I talk to strangers
I'm being inappropriate.

Partnership

This book is not meant to be nor to replace full peer-to-peer support training. However, it would be foolish to not point out how central the concept of 'partnership' is to peer-to-peer support.

This concept has been interwoven between the lines of every page of this handbook thus far. But, what does that really look like?

Some key points to think about:

1. **Partners are NOT fixers:** When you jump to telling someone what they should or should not do (so hard not to do sometimes!), you move into the fixer role. This can have the undesirable effect of putting you in the power/control role and shutting down the person you're trying to support (or increasing their sense of helplessness).

2. **Partners do NOT have all the answers (nor are they supposed to):** Instead, partners are willing to share what they do know (some of their story, resources available, options they're aware of, etc.) and partner with the person they're supporting to find out more.

3. **Partners DO look to the person they're supporting to make meeting:** That doesn't mean that the person they're supporting has all the answers off the top of their head, either. However, skillful partnering looks like exploring, asking questions and sitting in silence with someone while they figure it out.

4. **Partners DO prioritize making sure the person they're supporting gets heard:** That doesn't mean that you necessarily agree with what the person is saying, but you understand the importance of making sure their voice is in the lead role at the table.

5. **Partners advocate WITH and not FOR:** That doesn't mean that you might never speak on someone's behalf at their request, but it does mean that your voice and priorities don't take precedence over theirs.

Intentional Peer Support (IPS—one of several trainings 'out there' that focus on peer-to-peer work) is one training that does a really nice job of exploring what partnership can really look like. Intentional Peer Support was developed by focuses on four core concepts:

- **Connection**
- **Worldview**
- **Mutuality**
- **Moving Toward**

See the next page for a quick IPS Overview

Quick IPS Overview

Below is a summary of the four core concepts:

1. **Connection—** Peer-to-peer support can't happen where there is no connection. It is a pathway to building trust. Connection is not a constant. In order to be 'in' a relationship, attention needs to be paid to when connection is there and when it's not, and people in a relationship need to both be willing to work at it when the connection is not there.

2. **Worldview–** This speaks to the importance of understanding how each of us have come to know what we know. Our 'knowledge' of ourselves and our worlds comes from a combination of cultural background, family background and all of our individual experiences. This means that there are multiple truths and many valid ways of understanding various experiences. A deeper understanding of each of our worldviews can support connection and also be a first step to making change where change is wanted.

3. **Mutuality–** This is where we must acknowledge that each and every relationship effects us all and we can all learn and grow as a result, regardless of whether we identify as the 'supporter' or one being supported in a given moment. Thus, part of approaching things from a mutual standpoint involves re-defining 'help' as a co-learning and growing process.

4. **Moving Forward–** Often the mental health system focuses on moving away from negative experiences, or frames moving forward as no longer doing or experiencing something that was identified as 'bad.' Instead, we try to focus more on moving forward toward what we do want, finding enjoyment and faith that healing happens when one's environment creates space for that process more so then when one is always focused on what is 'wrong.'
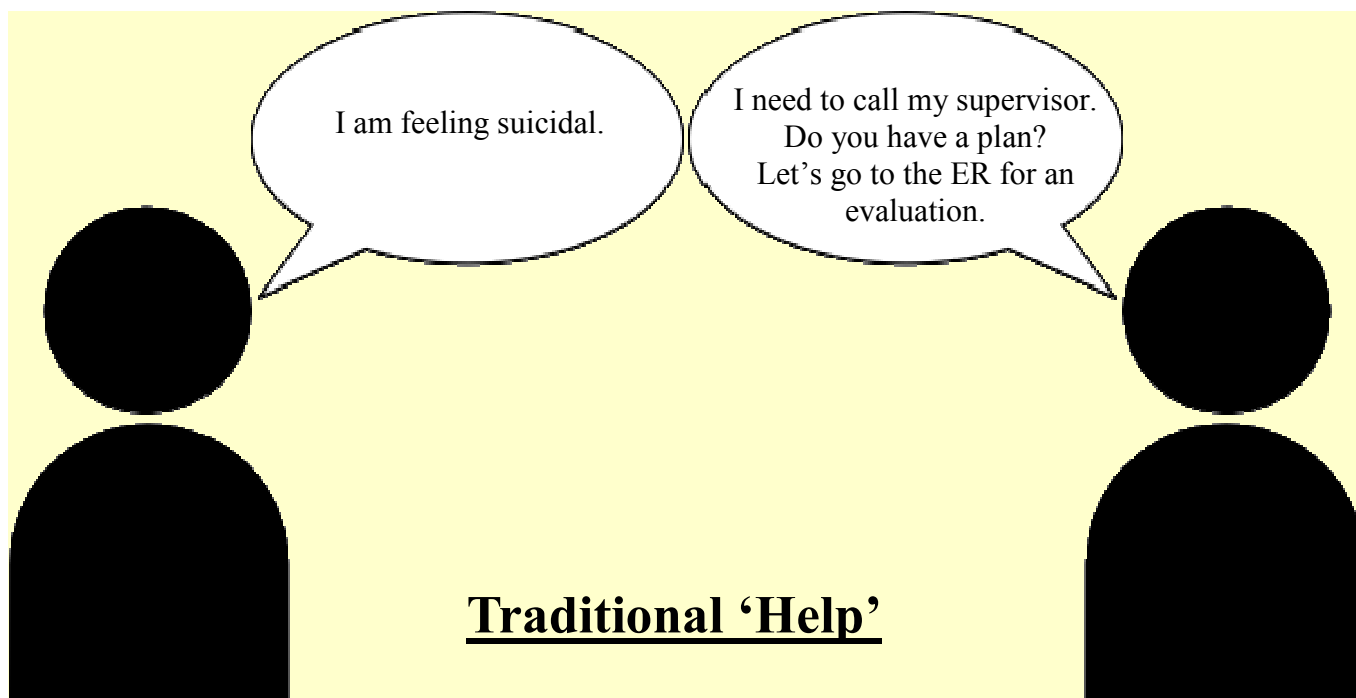
Although the language of partnering is not specifically used, but particularly the first three concepts blend nicely with the idea of being and exploring with someone side-by-side.

On the next page, you will find some examples of what at least a piece of this approach can look like in the moment, and how it differs from traditional approaches.
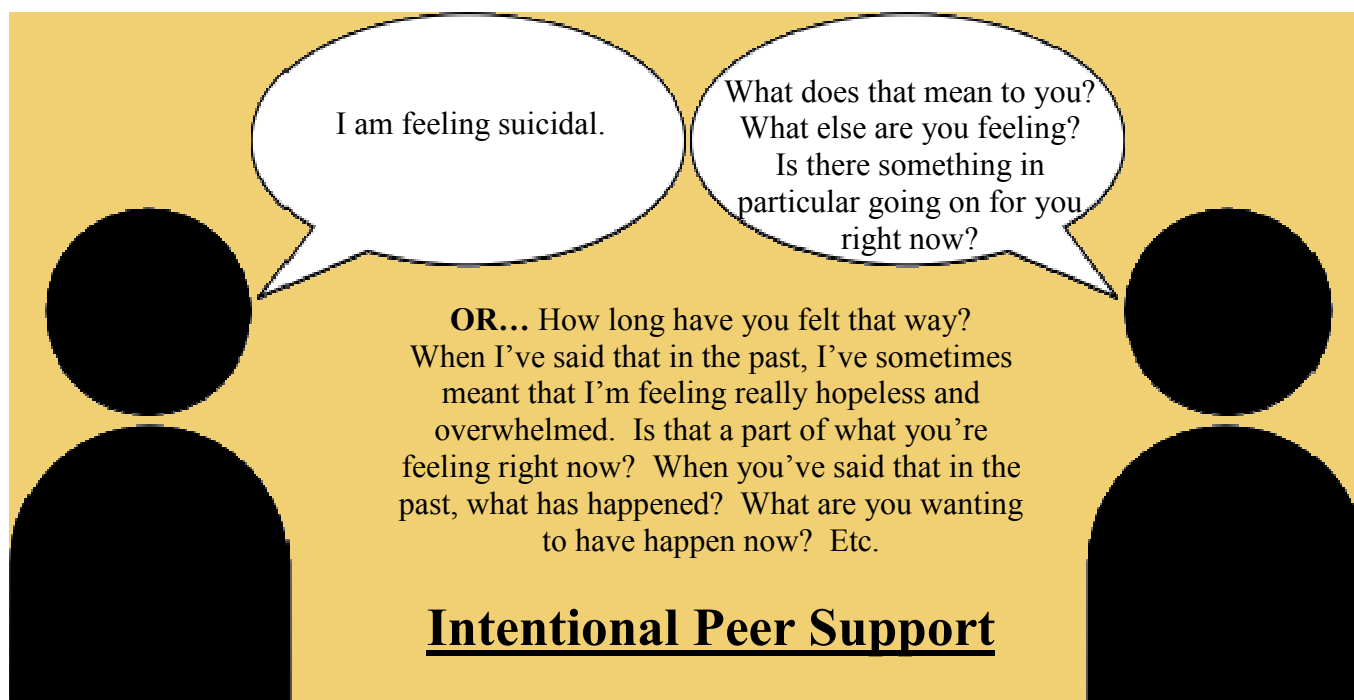
Intentional Peer Support was originally developed by Shery Mead and is used as a foundational concept in many peer-to-peer environments around the country and even internationally.
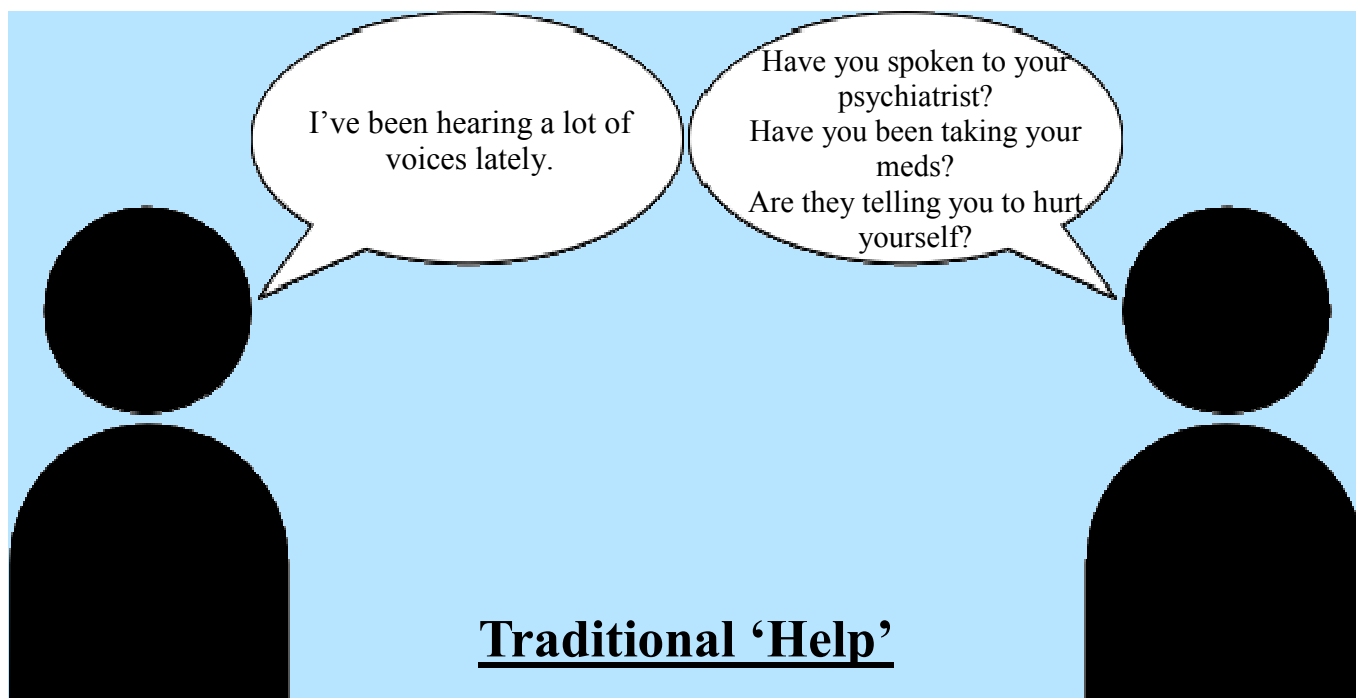
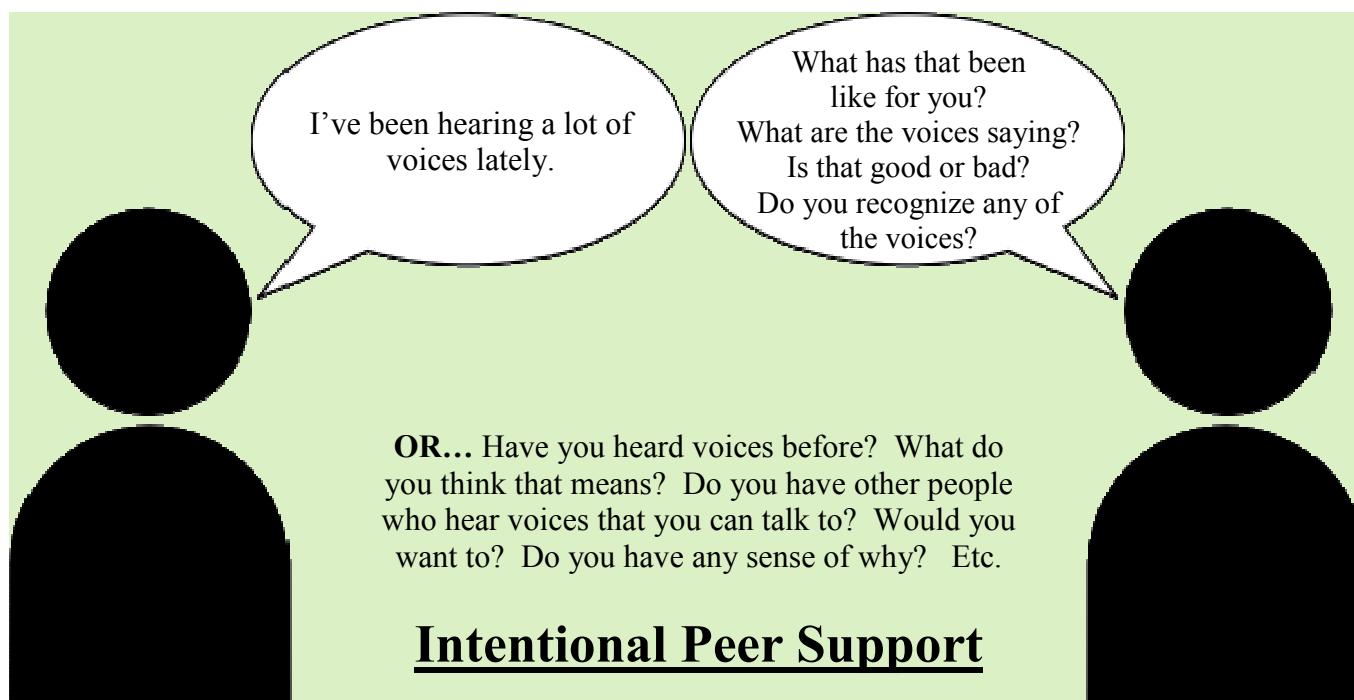**More information can be found at www.intentionalpeersupport.org**

Traditional 'Help'

EXAMPLE 1

Intentional Peer Support

Traditional 'Help'

EXAMPLE 2

OR... Have you heard voices before? What do you think that means? Do you have other people who hear voices that you can talk to? Would you want to? Do you have any sense of why? Etc.

Intentional Peer Support

Making the Argument: Peer-to-Peer Support Works!

There are many tools on the 'Provider' side of this booklet that can help support your argument that peer support works and should be a valued part of what is offered to people who are receiving services. For some, this argument may be to convince an organization to implement its first peer roles. For others, it may be to increase numbers or hours, or just to take them more seriously.

Sections that you might find particularly helpful include:

1. **A Brief History (pages 6-8):** This section will offer you some of the information you may need to educate others on the fact that peer-to-peer support has been around for a while and is growing rapidly.

2. **The Evidence Base (pages 14-21):** This section offers a substantial amount of information about the success of peer support, along with a listing of many articles with even more evidence in support of peer roles.

3. **An Interview Across Roles (pages 65-68):** This section offers an interview with three employees from a particular organization (including someone in a peer role, someone in a 'Director of Recovery' role, and a clinician) who speak unanimously to the success of peer roles in their organization.

Other Approaches That Can Help:

1. **Don't be the only voice making the argument in your organization:** Figure out who your supporters and allies are in the organization, and ask them to chime in, too.
2. **Invite people from other organizations to take part in the conversation:** Sometimes, hearing from people outside of your organization can shed new light on the topic (or at least catch people in a place where they're more willing to listen)
3. **Invite someone in your organization to attend a relevant event with you:** For the same reasons as #2, sometimes getting out of a familiar space and hearing from unfamiliar people can open up new vision.
4. **Look for relevant films on the topic and share or schedule a screening event:** If no live people/events are available, sometimes a film can at least get a conversation started.
5. **Try bringing up the topic in a different way:** Instead of arguing why something should happen, try looking for shared goals and inviting people to brainstorm with you.
6. **Go outside of the organization:** Peer-to-peer supports are often most successful when they are developed outside of a traditional organization. Are there any peer-to-peer organizations in your area that could better support you to do what you want to do? Are there any other organizations that might be willing to act as your 'umbrella' if you found a small grant to work on a particular project?
7. **Ask others in similar situations for ideas:** Check in with other people working in peer roles that might be dealing with similar challenges and see what they've tried!

Managing the Conflict of Change

Conflict is NOT a bad thing. In fact, if there's no sign of conflict you may not be doing your job. The reality is that change brings conflict. When you ask people to change, they may have a number of reactions including:

- Fear (If things change, what does that mean for my job?)
- Anger (Why are you doing this to me?)
- Shame/Guilt (What I was doing wasn't good enough.)
- Defensiveness (Are you saying I did something wrong?)
- Resistance (I want to keep doing what I know.)
- Worry about increased work load (Is what you're asking of me going to require more effort?)
- Etc.

All these feelings are completely normal and should be expected at least some of the time. The question then becomes how to move through them. First, it's important to note that you won't win everyone over, and it can be a waste of time to try. It's much more important to figure out who you have a shot at getting to open up and working with them to become allies in your process.

Some strategies you may want to consider on the path to developing allies:

1. **Build your own credibility first:** If you start out your first day on the job challenging everyone, it's far less likely that anyone will listen. Few people respond well to someone who's brand new, but thinks they know everything about what's going on. Take some time to get to know everyone and do a good job first.
2. **While you're getting your feet wet at your job, ask key questions to explore people's perspectives and get a sense of where they stand:** Most people want to feel appreciated and understood. Asking people what they enjoy about their work, what they haven't enjoyed, what they wish were different, etc, might go a long way to not only helping you understand who they are, but also helping them be more open to you down the road.
3. **Take time out to recognize and appreciate those you see doing good work:** Again, this can go a long way to building relationships and leaving people more open to what you might have to say. (It also can have the additional effect of re-enforcing that particular way of being both for that person and others who might be around at the time.)
4. **Get good at telling your own story and use it to support the changes you want to see:** If you though sharing your story was only for the people you are supporting, think again! Many people respond much better to personal stories than to dry research articles (though those have their place!). Sharing a key piece of your story that reflects something that you want to change, can really help get people's attention.

5. **Figure out what's most meaningful to the people with whom you wish to ally:** Are they most driven by budget issues? (If so, you may want to be sure to emphasize any potential long or short-term cost savings related to what you want to do.) Do they care if the organization is seen as 'cutting edge'? (If so, letting them know what other 'cutting edge' organizations are up to, might spark some sense of interest and/or competition!) Are there specific licensing requirements that have most of their attention? (If so, then researching how what you want to do can still fit in any licensing requirements will be top priority.) How much are they impacted by the feedback from people receiving services? Knowing the answer to all these (and more) questions can help guide you in what approach to use.

6. **Invite your supervisor (or other potential ally) to partner with you on problem solving:** This approach may be particularly effective in situations where you want to see a change because you're being asked to do something that is not consistent with a peer role. For example, say you are being asked to administer medications. In that situation, you could take the Declaration and/or the Certified Peer Specialist code of ethics (if one exists for your region and is supportive to your argument) and/or any other relevant document, and sit down with your supervisor (or other ally) and ask them for help figuring out how to work through the fact that the conflict between what your job is supposed to be and what you're being asked to do. Regardless of the issue at hand, asking someone to help you solve a problem is likely to garner a very different response than if you walk in, announce there is a problem and demand that they fix it.

7. **Ask why:** Sometimes it's far more effective to ask why something is the way that it is, than it is to immediately argue against it. Asking 'why' puts people in a position of needing to think beyond the fact that whatever you're asking about is simply how it's always been done. Follow up questions to 'why,' might include "What is the goal of doing it that way?" "Have you ever tried doing it another way?" "Who originally decided it should be done that way?" "What other options might there be?"

8. **Use your allies to win more allies:** As noted in the previous section, it's always helpful to have more than one voice in the organization advocating for the same change. If it's your voice too often, people may be less likely to listen.

9. **Find people in the same role as the person you're trying to win over to support your argument:** Psychiatrists are (far) more likely to listen to other psychiatrists. Hospital administrators are more likely to listen to other hospital administrators. And so on. And there are people in every field who are avid supports of peer-to-peer roles, so if you aren't finding someone at or near your own organization, try looking on-line and see if you can make allies there!

10. **Find people from outside your organization to come offer presentations/trainings:** Is there a statewide peer organization where you live? Are there any international speakers from the movement coming to your area soon? (International accents can be useful in getting people's attention!) As mentioned in the previous section, bringing in people from the outside (or going to an event together) can open people's ears to change in a new way.

11. **Offer to take on any change-related extra work yourself:** Sometimes someone's may reason for not being willing to consider change is because they don't have the time or already feel stressed or overloaded. Where possible, offer to take on all or pieces of any work associated with the change you're suggesting.

12. **Be sure to keep bringing it back to what you all have in common:** Presumably, you all are invested in supporting people to move forward and heal. You're also all likely invested in developing a strong, caring and talented workforce. More often than not, most people will also say that they feel invested in doing a good job. If you find yourself getting caught up in being on opposite sides of an issue, it may be just the right time to bring it back to what you all can agree on before pushing forward again.

13. **Be sure you're listening to them:** If you want people to listen to you, it will be important to demonstrate that you are listening to them, as well. This absolutely does NOT mean you have to agree with anything they are saying, but look for ways to show you are hearing them both in your body language and in your responses. For example, if someone is saying to you that they don't want to change something they've been doing in the same way for the last ten years, that might be an opportunity to simply recognize that you hear that they've got a lot of experience handling that particular issue/situation. Similarly, if you're advocating for the organization to create space for someone you're supporting to take a risk, and the person you're talking to is saying how that's not possible because the person could end up really hurt, that might be an opportunity simply to recognize that it sounds like they really care about what happens to that person. And so on.

These approaches won't fix everything, but keeping them in mind may significantly increase your chances at making progress!

Harm Reduction Approach

Sometimes you won't be successful in making change, at least not right away or with everything all at the same time. So, what do you do when you have to do something you think is wrong?

The vast majority of people working in peer roles are asked to do things that are not consistent with a peer role. Most of them have to make a choice: Do I do this or do I risk losing my job?

First of all, it is important to think about what are the 'deal breakers' for you. What is your bottom line? The thing(s) you'd rather walk out on your job than do? Talking through these questions with others in peer roles and with your friends and family (or anyone else who might support you to find your own answers) can be really important.

But, for all those issues that don't meet the 'deal breaker' place (because you have faith that you'll be able to change them over time or for any other reason), you may want to consider a 'harm reduction' approach. Harm reduction approaches give consideration to all the ways in which you may still engage in the particular activity while reducing the potential for harm.

Below are a few examples:

1. **Making routine progress notes:** Be upfront with the person you're supporting that your job requires you to make notes *before* your interaction, including what sort of things you'll be asked to write notes about. Ask them to sit down with you and decide what should be written. (If you can't have them actually do the notes with you because you have to do them on a computer back at the office, then write out the notes on paper for you to type in later.) Find out what the options might be for the person to access their notes so they can read them directly (whether they're on-line or in book).

2. **Administering medications:** Be upfront with the person that you are required to observe and document them taking their medications (and anything else for which you are responsible). Let them know that, even though you are observing and documenting, you are not telling them what they have to do. Tell them that it is their choice, and you aren't there to force them. Offer to sit down and review all the medications, potential positive and negative effects, etc. If the person is telling you they don't want to take them, offer to sit down with them and strategize about how to communicate their wishes back to others at the organization. Be open to conversations about how the person feels about you being responsible for their medications.

3. **Attending meetings where people are being talked about without them present:** Be upfront with the person that this is happening. Acknowledge that the one upside of this is that you may be able to speak up on their behalf, rather than having no one in the room who is representing their perspective. Strategize with them before the meeting about how they'd like you to represent their point of view, wishes and requests.

Whatever the issue is, being transparent with the person you're supporting and involving them in how to reduce harm will be critical!

Taking Care of Yourself

As much as we don't want others routinely forcing 'self-care' and WRAP plans on us, it would be a mistake to not acknowledge that many peer positions are really hard jobs. All though peer roles can vary dramatically based on the environment one works in, some of the reasons they can take a lot out of people include:

- Often being one of few (or the only) in that particular role in an organization
- Being in a position to constantly explain and justify peer roles
- Frequently being asked to do things that are in conflict with your job
- Witnessing so many people being treated in ways that your experience tells you are hurtful
- Working in the same type of environment where you may have previously felt hurt or experience trauma
- Having to hear people regularly talk disparagingly about people who are going through similar things that you've gone through
- Supporting people who are going through really difficult times
- Etc.

This can lead to a serious need to recharge on a regular basis! Some tips for taking care of yourself include:

1. **Create buffers for yourself:** In some peer-to-peer support roles you're free to give out your cell phone number, e-mail and even your Facebook page. However, that may mean that people essentially have access to you 24/7. Even if you don't answer, getting a message late at night can put you on edge and interfere with your ability to rest and get ready to go back to work. This isn't an argument not to share your personal information as you choose, but it is a suggestion to think carefully about how and when you want to do that. For example, instead of giving out your private cell phone number, could you ask your workplace to set up a private voicemail so that people can still leave you private messages, but you don't have to be aware of it unless you're at work? Or, can you leave an outgoing message on your phone that is clear about how often you'll check your voicemail, how quickly you're like to respond and what hours you're likely to be available? Being transparent about your ability can take some of the stress off of you in deciding whether or not you feel obligated to respond right away, and longer waits are likely to be better received by others if they're not expecting you might answer or call back right away.
2. **Take time for the things (and people) you love:** It's easy to push your own needs to the side, but you become all the more likely to burn out on your job. What are the things you really enjoy doing? Make yourself a list, if that's a helpful reminder.

3. **Remember the world won't end without you:** People in peer roles can make HUGE differences in people's lives, but that doesn't mean that the world will end if you're not available today. Most people receiving services in the system have had to learn many ways to survive and get their needs met. If you don't find ways to set clear limits for when you have to be 'on' or available, you may be at higher risk for burn out. Sometimes turning off your phone altogether or making plans to leave the area for a weekend can make a huge difference!

4. **Remember that your goal isn't to make the person you're supporting dependent on you:** The focus of peer-to-peer support is to walk with people as they find their own path, not to become just another person that they're dependent on. Over extending yourself not only puts tremendous pressure on you, but can perpetuate the idea that the person you're supporting can't grow and learn to be okay in the world without you (or someone else in a paid role).

5. **Remember that one of the four core concepts of Intentional Peer Support is Mutuality:** Mutuality essentially means that both people (the peer supporter and the person they're supporting) can learn, grow and change because of their relationship with one another, and that the connection needs to work for BOTH people involved. This is just another way of emphasizing that your needs really do matter, including the need to take care of yourself!

6. **Seek out others doing the same work and create opportunities to spend time with one another:** Talking with other people who just fundamentally 'get' what you do and how hard it is can be tremendously energizing. If you don't have people like that in your immediate area, try looking on-line.

7. **Write about your experiences:** For some people, private journaling or public writing about the work you're doing can help you vent bad experiences in a productive way, gain new perspective, and give you energy to keep going. (For those who like the idea of public writing, places like www.MadinAmerica.com can be good potential venues.)

8. **Go to an event, training or conference focused on peer-to-peer support:** Although some events and conferences are better than others, it can be helpful to take a break from your day-to-day routine and get around lots of other people who do the same work you do and are talking about their struggles and successes!

9. **If the job is taking too much out of you, consider doing something else:** Sometimes people carry an assumption that anyone who has personal experience psychiatric diagnosis and trauma and who is good at peer-to-peer work should be working in a peer role. For better or worse, that's just not true. It's important for you to determine for yourself both what you're good at AND what feeds and energizes you. Doing a job that you're good at, but that you are drained by may not be so sustainable. Additionally, some difficult jobs simply aren't meant to be done forever and really benefit from having people with new energy come into them every few years. (Some have suggested that when you can no longer get in touch with your natural curiosity about people, it may be time to move on.)

Whatever you do, just remember that you do matter in this work!

Setting Up a Support Network for People in Peer Roles

Although not the norm, the Western Massachusetts Peer Network has had some real success in bringing together people working in peer roles throughout the region to offer support to one another and to claim a leading role in the development of 'peer' roles in the area. The Network began in 2010 with a monthly meeting hosted by the Western Massachusetts Recovery Learning Community (RLC) over pizza and salad.

Meeting regularly had at least a dozen attendees (often more) from several different organizations. The stated goals of the meetings were (and continue to be):

- **Supporting and offering a sounding board to fellow people working in peer roles throughout Western Mass (and, at times, beyond!)**

- **Acting as a leading voice and influence in the development and integration of peer roles throughout our region**

- **Supporting Providers to understand and successfully implement meaningful peer roles via consultation and training**

Efforts that helped the Network to develop included:

- Developing an e-mail list of all people in peer roles who had attended or were interested in attending meetings and sending out reminders
- Choosing a regular, consistent meeting time and publicizing it as much as possible
- Enlisting the RLC to reach out to various providers and explain to them why it was important that they let their peer employees attend (and advocate for it to be on paid time)
- Asking employers to provide direct e-mail and/or mailing addresses for peer employees so that the Network could reach them directly and make sure they were aware of meetings
- Organizing events that brought providers and people in peer roles from a number of organizations together
- Reaching out to employees at the Department of Mental Health (the primary funder for most providers) to participate in events and support the Network

In fairness, these efforts were supported by resources that may not be available to everyone. For instance, the RLC set aside some of its budget to support pizza each month and to fund the larger events that were held. They also offered free space and provided technical assistance with projects and advertising. Of course, not all areas will have an existing peer-to-peer organization to take this on. And even with the support of the RLC, the Network has faced many challenges and ups and downs in participation.

For example, when organizations ran into budgetary difficulty, paid time at the Networking meetings, mileage for travel to the meetings and so on were some of the first things to get cut in some organizations. Also, as people in peer roles got busier, it became increasingly harder to keep prioritizing attendance. Additionally, sometimes projects would take up so much time that there wasn't enough left just for supporting one another and brainstorming through challenges some or all were facing.

That said, the Network continues to exist—although it has recently switched to quarterly meetings, and has just begun to distribute a quarterly newsletter, as well. The group is always learning from its successes and challenges, and it remains meaningful to have a network of this nature especially given that most people in peer roles don't otherwise have much contact with others doing the same work.

So, how might you learn from the Network's efforts and set something up in your area? **Below are some tips to getting started:**

1. Find out if there is a peer-to-peer organization in your state that could support you or that has experience setting up these sorts of networks.
2. Do a scan of the area and how many people working in peer roles there are within an hour or so radius of your home base. (If there is a peer-to-peer organization in your state, they may already have this information.)
3. Contact the local organizations that employ people in peer roles and ask them for ways to reach out to them (work addresses, etc.).
4. If you're having trouble finding other organizations with people in peer roles, try calling your local Department of Mental Health and asking them if they know which organizations employ peer roles. Explain what you're doing and ask if they can help you reach out to them.
5. If you're able to pull together several e-mail addresses, send out an on-line survey (SurveyMonkey.com is free for up to 10 questions!) and try to assess interest and availability to get together. (If not, call people if you can.)
6. Create a flyer and send it to local organizations that may have peer roles.
7. Post an ad on meetup.com and craigslist.com (or any other relevant sites). You never know who might be reading them!
8. Scope out spaces in the area. (Hopefully you could find one that is free and ideally not located in a traditional provider building?)
9. Once you have found a space, set an initial meeting date and time and invite people to join you. (Even two other people at a meeting of this sort can be really productive.)
10. Establish how often you want to me and a regular set time. Talk about whether you want the focus to be just on support, on special projects or both. (It's hard to sustain both. The Network is currently focusing on support in its regular meetings and holding sub-committees for projects.)

11. If you can't find a physical space, or people working in peer roles are really spread out, consider meeting on-line using Skype (there is a fee for multi-user on-line chats), Google Hangout or other on-line resources. If getting together all at the same time is hard, you can also try setting up a Google Group (or similar) for everyone who's interested. This allows there to be one e-mail address (e.g., peernetworking@googlegroups.com) that all of you can e-mail to send out questions, requests for support, etc. and it will automatically reach everyone else who's on the group.

12. If part of the mission of your group is to educate providers about peer roles, consider setting up a sub-committee to plan an event to raise awareness of your group and bring people together to talk about important issues. (Event planning can also help bring some excitement to your group or attract additional people who may not want to participate as much in a support-focused meeting.)

If none of this works or is appealing to you (or if you just don't have the time to give), you can also look for communities on-line where people may already be gathered who are either employed in peer roles or are invested in peer-to-peer supports.

Two possible places to look include:

1. Mad in America (www.MadinAmerica.com): Although this site is not focused on peer-to-peer support, people working in peer roles do blog there with relative frequency, and the comments sections can be a good place to voice your own experiences and connect with others.

2. The Icarus Project (www.TheIcarusProject.net): The Icarus Project is a large on-line community dedicated to people who have personal experience with trauma, psychiatric diagnosis, etc. Many people who are a part of the Icarus community have worked in peer roles (in the traditional system or informally through peer-to-peer support groups, etc.), and they have a number of forums in which you can post and read others thoughts.

Additionally, another resource you may want to check out is Madness Radio (www.MadnessRadio.net). Although this resource does not allow for on-line conversation with others, there are a number of interviews on the site with people who are invested in peer-to-peer support and listening to those interviews may support you to feel less alone, even if you can't talk back and forth.

Remember, in this work, connection is important and can be life (and job!) saving!!

> ## Not sure if your state has a peer-to-peer organization?
>
> At least 40 states have peer-to-peer organizations, and the National Empowerment Center offers a national listing of peer-to-peer organizations here: www.power2u.org/consumerrun-statewide.html

Event Ideas

Sometimes organizing an event focused on peer roles can be just what is needed to build awareness, raise energy and enthusiasm and gain momentum. The Western Massachusetts Peer Network has agreed to share their past event ideas with you, so that you may replicate or build upon them. Note that all events were organized by inter-organizational members of the Network.

1. **Myths & Misconceptions of Peer Roles:** This event (held in 2011) focused on getting people in peer roles together in one room and talking to one another. Lunch was served (sandwiches and salads) and much focus was given to reviewing several Myths and Misconceptions on Peer Roles. The following are steps that were taken to organize the event:

- A date and location were set. (In this instance, the Network had a budget that allowed for renting a banquet hall and providing a basic lunch, so a menu was also set at this time.)
- A subcommittee of the Network worked on developing content
- Invites were sent out (about two months ahead of the date) to all organizations that already employed peer roles, some that were considering it (or that the Network hoped would consider it in the future), the statewide peer-to-peer organization, and the state offices of the Department of Mental Health. The invites specifically requested that the organization send a certain number of providers and people in peer roles to the event. Each organization then received follow up e-mails or calls to ask them who they would be sending.
- The agenda was developed and finalized a month ahead of the event, and people who would be responsible for each part of the agenda were identified.
- The presentation content (see following pages) was developed and finalized two weeks ahead.
- RSVPs were tracked and an assigned seating plan was developed so that each table contained a mixture of people in provider and peer roles from different organizations.
- Questions were developed to be placed on each table to spark conversation over lunch. (E.g., What do peer roles look like at your organization? What positive impacts have you seen from peer roles? What are your thoughts overall on how the system is changing? Etc.)
- A program (just a half a page printed on card stock) was developed to be handed out at the event
- Content was gathered and copied for an informational table at the event (flyers for Peer Networking meetings, upcoming events, information about peer roles, relevant articles, etc.)
- Individuals who would be responsible for speaking at the event got together a few days ahead of the event to run through the details.
- Supplies and equipment were set aside in a box in preparation for the day of the event (copies of materials, a guest list and seating details, a projector and lap top for the presentation, etc.)

Ultimately, the event brought in around 90 guests from several different organizations and the Department of Mental Health. See the following pages for some of the content that was presented. For a copy of the full presentation, you can also visit www.westernmassrlc.org/wmpn

Agenda:

Time	Item
11am – 1140am	Lunch and Table Talk
1140am – 1200pm	Who IS the Western Mass Peer Network?
1200pm-100pm	Myths & Misconceptions about Peer Roles
100pm – 110pm	Break
110pm – 210pm	Defining the Peer Role
210pm – 230pm	Into the Future

Who is the Western Mass Peer Network?

The Western Mass Peer Network is made up of individuals in a variety of peer roles connected to the mental health system who have come together to support one another and shape the development of peer work throughout our region.

Organizations Represented Include:

HRU HUMAN RESOURCES UNLIMITED

The Carson Center For Human Services

The Brien Center for Mental Health & Substance Abuse Services

communitycrisis response team

the TRANSFORMATION center

bhn

Western Mass Recovery Learning Community

servicenet innovative mental health and human services

freedom center

nami Western Massachusetts National Alliance on Mental Illness

Clinical & Support Options CSO Enhancing Lives. Strengthening Communities.

we are CHD

WM Peer Network Purpose:

- Support and act as a sounding board for each other through the bumps, growing pains and successes of our peer roles

- Act as a leading voice and influence in the development and integration of peer roles throughout our region

- Support providers to understand and successfully implement meaningful peer roles via consultation and training

Conditions for Success

Research has found that the rate of success for implementation of new approaches or service components is dramatically affected by whether or not there is an oversight body and process involved.

Over the course of 3 years, where there is a clear process for overseeing implementation, the success rate can be as high as 80%.

During the same period, where there is no clear oversight body, the success rate can drop as low as 17%.

Myths & Misconceptions:

Shedding the Misunderstandings As a First Step to Progress

WRONGWAY

Myths and Misconceptions

1. Peer Workers are just 'mini mental health counselors,' and a logical next step in their career path would be to aim to become a mental health counselor or clinician.

This is a specialized profession with its own career ladder.

Director of Recovery Services

Peer Respite Director

Peer Community Coordinator

CPS Trainer

Peer Specialist

Peer Mentor

Peer Facilitator

* Not intended as a comprehensive list of possible peer roles!

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Myths and Misconceptions

2. Peer Work is a type of Voc Rehab for individuals working on their recovery.
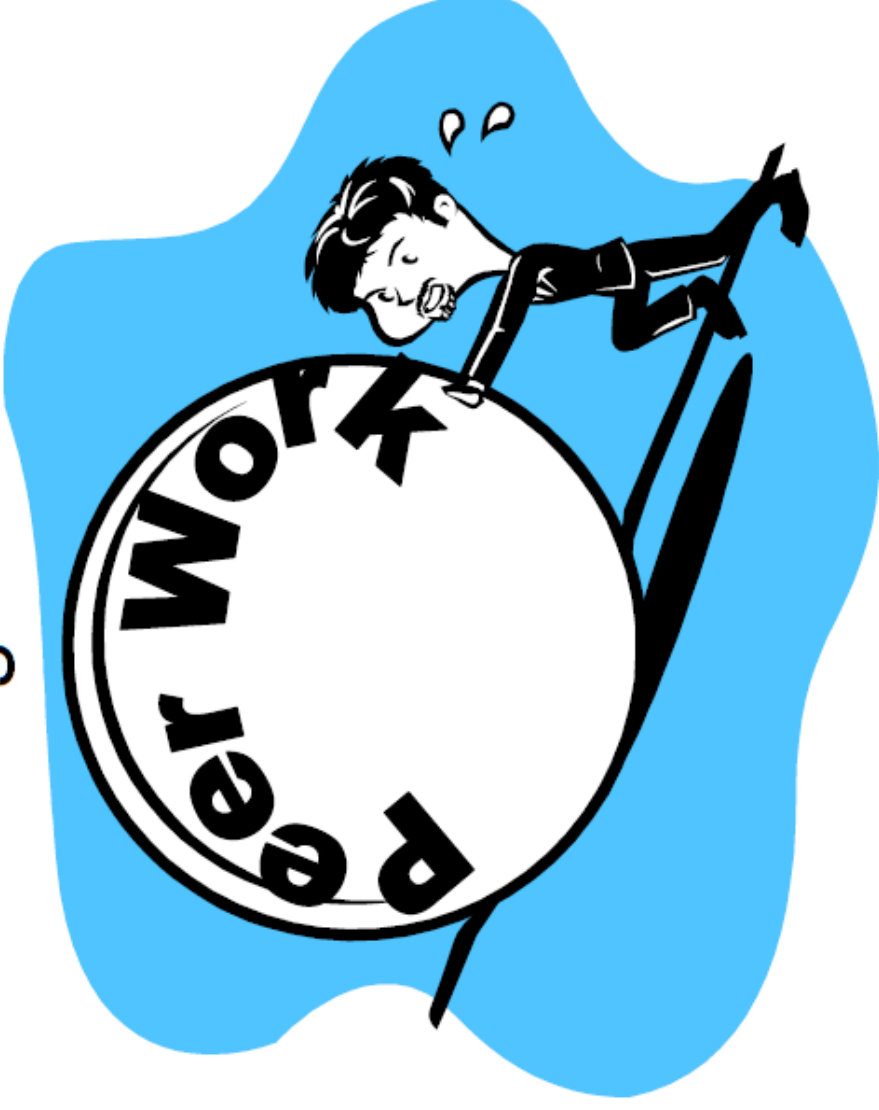
Work can help all of us as individuals to feel good, productive and valued, but that is not the main purpose of peer work.

Myths and Misconceptions

3. ANYONE who has received mental health services will automatically make a good Peer Worker, and ANYONE who has not just wont be able to relate to people from a human experience perspective.
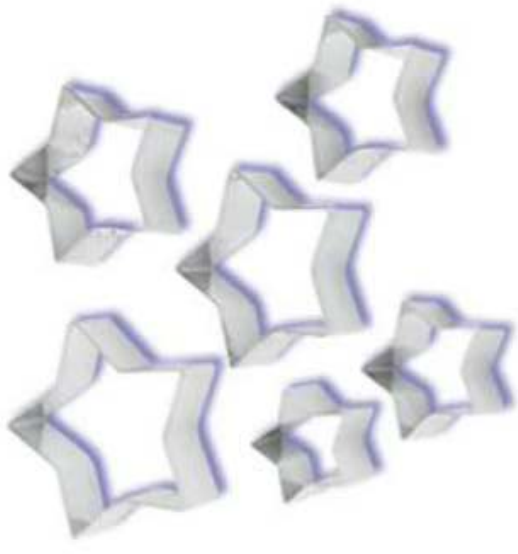
Peer Work - just like teaching, nursing, childcare, being an artist, mathematician or any other profession – is NOT for everyone.

We all have our own strengths, goals, hopes and dreams.

Myths and Misconceptions

4. One of the primary uses of Peer Workers should be to uncover information about an individual receiving services to bring back to the rest of the team.
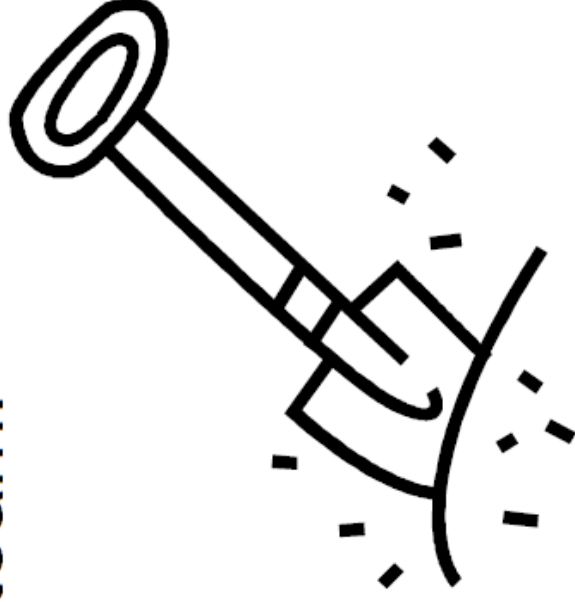
Peer Worker ≠ Mole
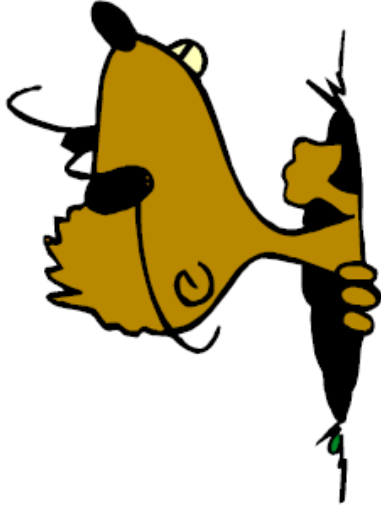
While it's true that individuals *may be* more open with peer workers for a variety of reasons, peer workers should not be used as a tool of the system so much as a tool for the individual seeking support.

Myths and Misconceptions

5. Peer Workers should never engage in conversation about tricky topics like suicide, medications, or other treatment expectations.

This perpetuates the idea that peer workers are only there as a part of their own recovery and/or are junior counselors who aren't trained to handle anything but the 'light' stuff.

Welcome to Café Small Talk

No Serious Topics Allowed

Myths and Misconceptions

6. There are no boundaries in peer work.

BoRn To Be WiLd
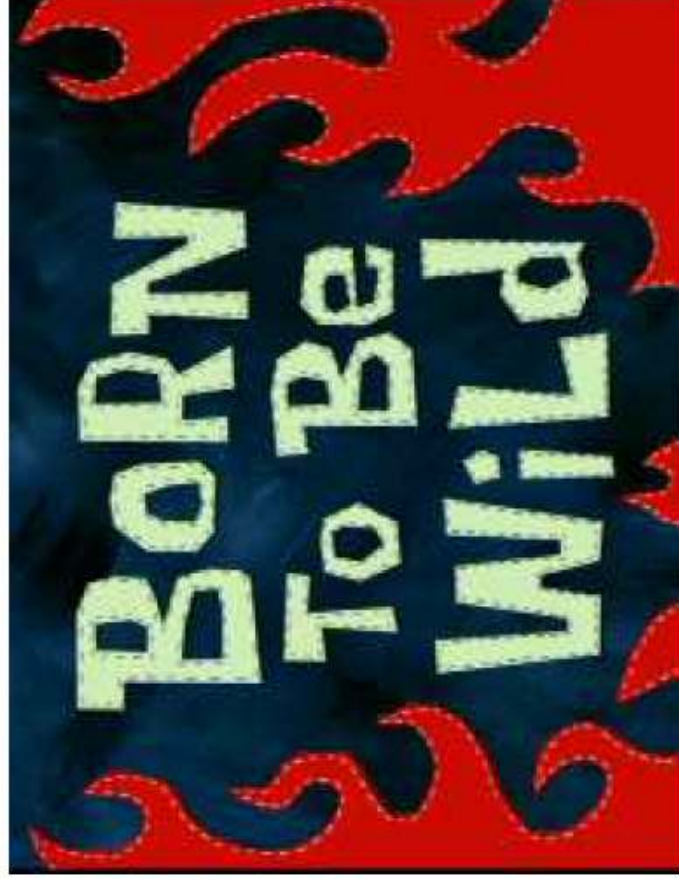
Boundaries may be approached differently in peer work. However, in a profession where the relationship is the focus, conversations about individual boundaries are actually quite frequent and for Certified Peer Specialists in particular, there is a very clear Code of Ethics.

Accurate Definition of Mutuality: A focus on the relationship between two or more people and how all involved are impacted and can learn and grow from that point of connection

Myths and Misconceptions

7. The primary defining characteristic between a Peer Worker and a non-peer provider is that the Peer Worker has lived experience and can share his/her recovery story.
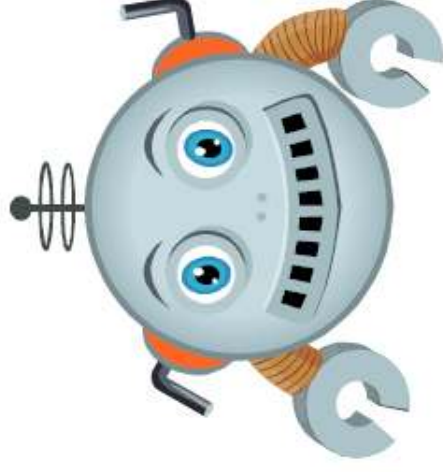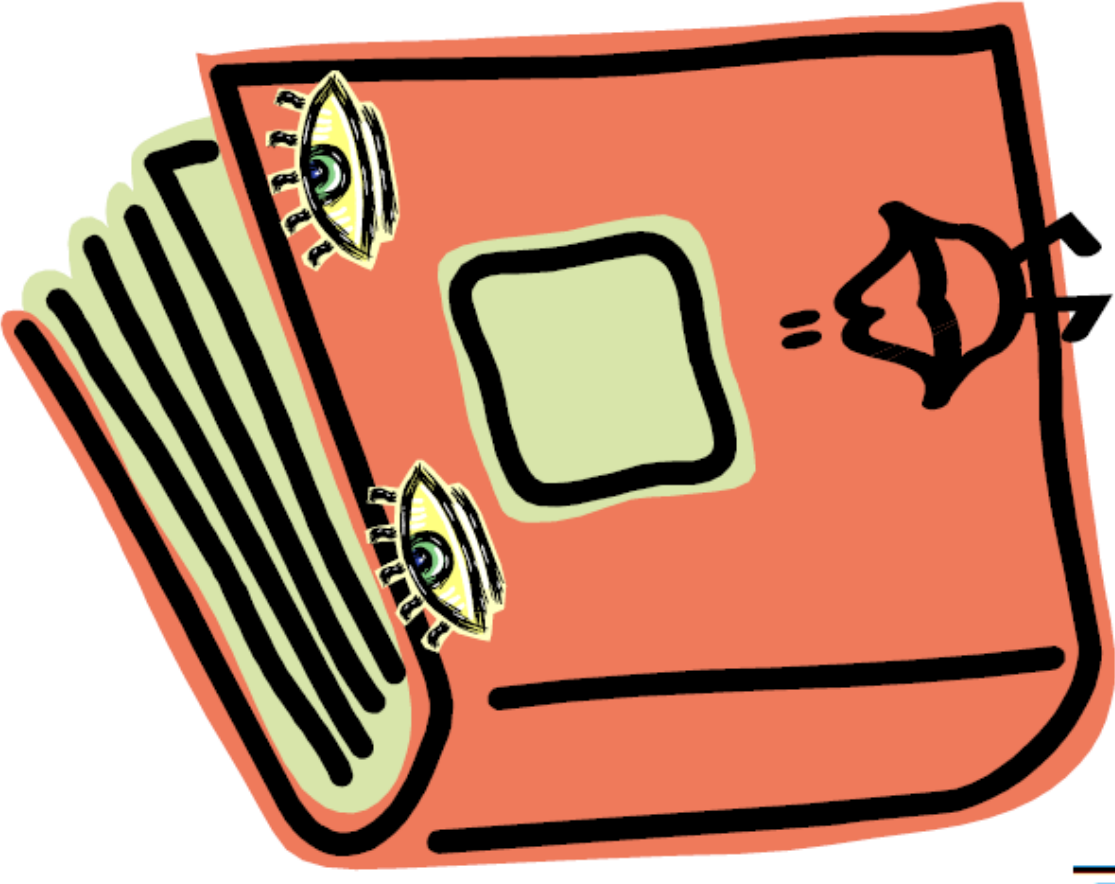
Not Just a Walking, Talking Story...

When we say that our story is one of our main 'tools,' it doesn't mean that talking about ourselves is all or even most of what we do. We are advocates, supporters, change agents and more and we draw on our life experience in an intentional way to inform our actions in each of those roles.

'Staff' are People, too!

We are all human and able to approach our work from the perspective of our human experience.

Impenetrable Wall of Staff
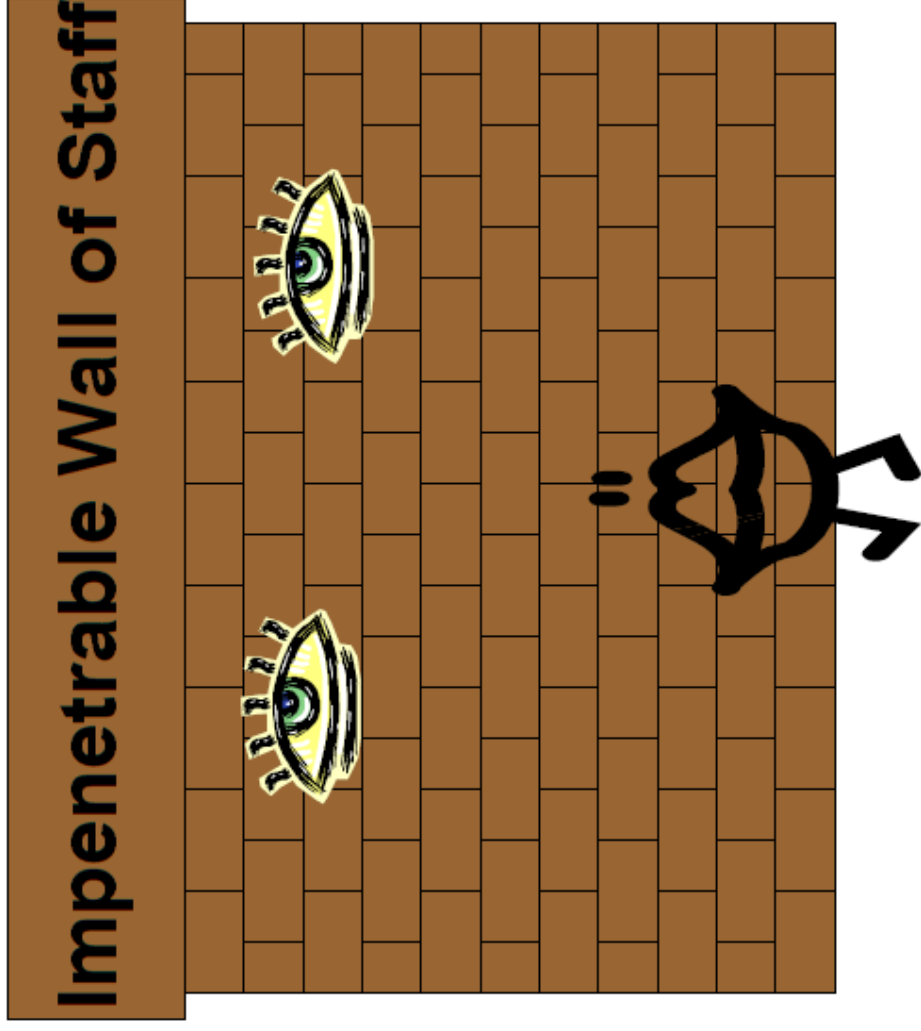
Myths and Misconceptions

8. Antipsychiatry is really common in the peer movement, and many Peer Workers are likely to tell individuals who receive services to get off their meds or go against what their treatment providers want them to do.

TEAM ANTI-PSYCHIATR

While there are many who consider themselves survivors of the mental health system, the 'norm' amongst Peer Workers is to want to find ways for EVERYONE to heal and move forward to something better, not to just to stir up trouble.

Some of the newest peer-lead movements coming to the US are even decidedly *PRO* collaboration between individuals with lived experience and providers.
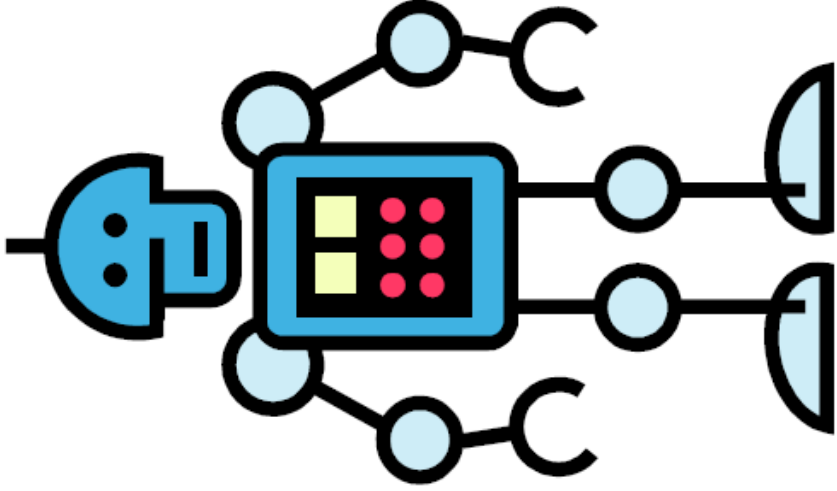
HEARING VOICES NETWORK USA

Myths and Misconceptions

9. An organization needs to develop special personnel policies for Peer Workers and learn how to evaluate who is and isn't stable enough for the role during the hiring process.
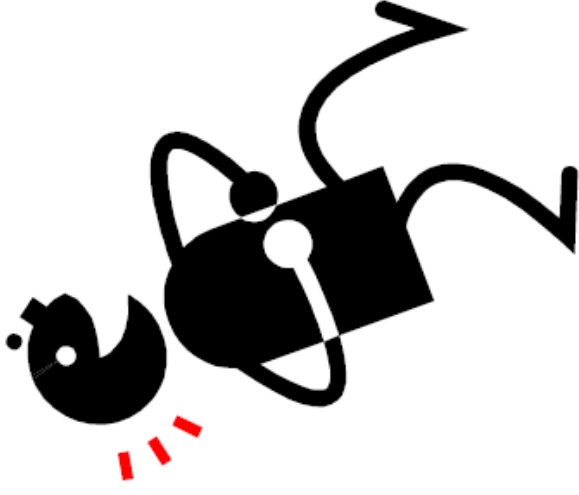
'Regular' Staff =

- Completely reliable?
- Always predictable?
- Never has issues outside of work that interfere with the job?
- Performs consistently at all times?

Myths & Misconceptions

10. As long as we're all invested in integrating peer roles into our organization, and take all the right steps, this should be easy, right?

More often than not, this means that either the peer workers are being asked to and are doing essentially what mental health counselors or other agency employees were already doing and/or that they are not being given a forum in which to express their concerns and advocate for change.
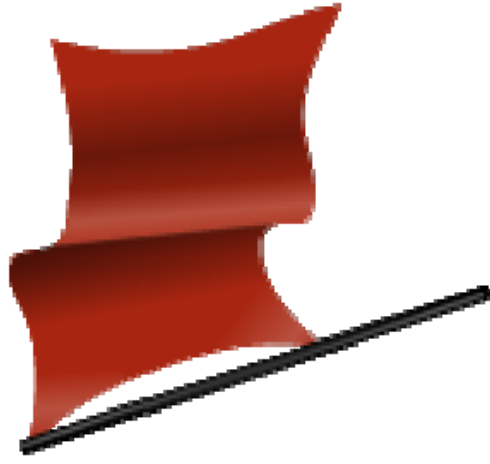
Although integrating peer workers into your organization shouldn't be downright painful or full of constant conflict, experiencing some tension and 'growing pains' are normal and often a positive sign of real change.

2. **A New King of Speed Dating:** The Network's second event was held in 2012 and was a twist on 'speed dating.' One to two representatives from any organization (both from traditional and peer-to-peer organizations) was invited to have a table at the event, as was a representative from the statewide peer-to-peer organization and the Department of Mental Health's Office of Recovery and Empowerment (where individuals who identified as having received services were in leadership). Similar to the previous event, invites were then sent out to all local providers to send people to participate. The idea was that each person who was representing an organization at a particular table would have five minutes to explain how they've developed peer roles and what creative groups, trainings or other work they're doing related to peer-to-peer support. A bell would then sound, and people would switch tables and repeat until everyone in the room had made a stop at each table. The idea was to offer a quick and fun way to demonstrate all the different types of peer roles that were developing and inspire new ideas and investment in supporting the work.

Planning went as follows:

- A date and location were set. (In this instance, the budget was quite small and a large room was secured at a nominal fee at a community space. No food was provided at this event.)
- About three months ahead, organizations with peer roles were invited to identify two people to cover a table at the event.
- Invites were sent out (about two months ahead of the date) to all organizations that might be interested in learning and participating (including community providers, hospitals, etc.).
- The agenda was developed and finalized a month ahead of the event, and people who would be responsible for each part of the agenda were identified.
- Two practice sessions (at about a month and two weeks out) were held to help people develop material to talk about at their table.
- RSVPs were recorded and organizations that hadn't responded were followed up with a few weeks before the event.
- Content was gathered and copied for an informational table at the event (flyers for Peer Networking meetings, upcoming events, information about peer roles, relevant articles, etc.)
- Individuals who would be responsible for speaking at the event got together a few days ahead of the event to run through the details.
- Supplies and equipment were set aside in a box in preparation for the day of the event (copies of materials, etc.)

In the end, there were about 10 organizations that covered tables and about 60 people who participated in making the rounds. Feedback suggested that people really appreciated getting a picture of possibilities for peer roles.

3. **A Celebration of Peer Roles:** A celebration of Peer Roles is being organized for December of 2014 (not long after the first edition of this handbook will be distributed). The goal of this event is to bring providers and funders together to celebrate success and demonstrate just how powerful these roles can be. A key part of the celebration will focus on awards. The Network is specifically going to offer awards not just to people in peer roles, but also to people in provider and ally roles in an effort to demonstrate how important support from providers and allies can be in developing these positions, particularly in traditional environments. Lunch will be served at this event, and the 'Declaration of Peer Roles' will also be introduced. The Network also invited the Department of Mental Health to be a co-sponsor of the event.

Planning is anticipated to look like the following:

- The planning committee and event date were set four months ahead in this instance. (The longer time was particularly needed due to the awards element, as well as needing to reserve banquet space and identifying a menu.)
- Award categories were developed and finalized three months ahead and distributed to the community (via printed flyers, e-mail and local newsletters) shortly thereafter.
- A 'Save the Date' notification will go out at the same time, with more formal invites at the two month mark. (Invites will go to all local hospitals and providers, the local and statewide offices of the Department of Mental Health, and the statewide peer-to-peer organization. An open invite will also be posted on Facebook.)
- Actual awards to be given out will be finalized (ideas include gift cards, a certificate, and a mug that says 'I was recognized by the Western Mass Peer Network.'
- About a month ahead of the event, people will be identified to be responsible for each segment of the event, and a program will be developed.
- Nominations are set to be due about a month ahead of the event date, and a sub-committee will gather to review the nominations and identify winners in each category shortly thereafter.
- Nominees will be notified on the same date as nominations are due, and final awardees will be notified as soon as results are determined.
- Two weeks prior to the event, intros for each awardee will be written and distributed to those responsible for introducing them, and awards for each awardee will be in hand.
- Organizations that haven't responded will be followed up with two weeks before the event.
- The committee will meet at least one final time to ensure that everything is covered a week before the event occurs.
- Content will be gathered and copied for an informational table at the event (flyers for Peer Networking meetings, upcoming events, information about peer roles, relevant articles, etc.)
- Supplies and equipment will be aside in a box in preparation for the day of the event (copies of materials, awards, laminated copies of the Declaration for each table, etc.)

See the following page for a copy of the nominee form being used.

Awards Nomination Form
Western Mass Peer Network

Name of Person You're Nominating: _____

Organization: _____

What is their job title/role: _____

Is this a provider or peer role: PROVIDER   PEER   ALLY*

Is this a volunteer or paid role: VOLUNTEER   PAID

How long have they worked in this role: _____

What is their phone number: _____

What is their e-mail: _____

Circle the award for which you are nominating this person (one award per person):

Ally Award	**Change Agent - Peer**	**Change Agent – Provider**
Innovation	**Living the Values**	**Pioneer - Peer**
Pioneer - Provider	**Exceptional Volunteerism**	**Up & Comer**

Please attach a statement about why you believe this person should win this award. Please be sure to include information about the work they've done, how it relates to peer-to-peer support and/or furthering the development of peer roles in the region. Your statement should be at least one full paragraph (minimum of five sentences), and no more than one page. Please be sure to type or print clearly, as illegible nomination forms will be disregarded.

Your name: _____

Your phone number: _____

Your e-mail address: _____

Your relationship to the person you're nominating: _____

THIS FORM MUST BE RETURNED BY 5PM ON MONDAY, NOVEMBER 10th.
Forms may be returned to info@westernmassrlc.org, by fax to 413.561.3266, or by mail to Western Mass Peer Network, C/O, Western Mass RLC, 187 High Street, Suite 202, Holyoke, MA 01040

* The 'Ally' designation is intended to represent a group of people who are not working in any formal role in the mental health system, but are nonetheless connected to and supporting our work in some way.

Awards Nomination Form
Western Mass Peer Network

The Western Mass Peer Network wishes to recognize some of the growing numbers of outstanding individuals working in and/or supporting the development of peer roles in our region. At our event on Friday, December 5th, we will be recognizing nine individuals with the awards listed below. Please help us with this process, by nominating people you know and appreciate!! See the back of this page for a nomination form and instructions. **Nominations are due by Monday, November 10th at 5pm.**

- **Ally Award**: The Ally Award will go to someone who is **not** working in a formal 'peer' or provider role. They will have demonstrated a strong commitment to valuing the voice of people who have 'been there,' and will have consistently played a supporting role in creating space, changing minds and furthering the reach of this work.

- **Change Agent Award – Peer Role:** This award will go to someone who has been working in a paid peer role connected in some way to the traditional mental health system for at least one year. In that role, they will have demonstrated a fearlessness in challenging belief systems and approaches in combination with tremendous skill in building bridges and finding allies.

- **Change Agent Award – Provider Role:** This award will go to someone who has been working in a traditional, mental health provider environment as a clinician or administrator for at least one year. In that role, they will have demonstrated a willingness to challenge old standards and an absolute commitment to supporting the organization to move forward in new and creative ways that are consistent with building a values-driven, trauma-informed, person-centered approach that opens the door to peer roles and other innovations.

- **Exceptional Volunteerism Award:** This award will go to someone who has been exceptionally giving of their time in a peer role on a volunteer basis. Their activities may include organizing events, serving on committees, facilitating groups, etc. Regardless of their activity, their time and energy has come to be invaluable to the organization or community of which they are a part.

- **Innovation Award:** This award will go to someone who has been working in a paid peer role and who has played an instrumental role in the development and implementation of a particular project related to peer-to-peer work or values. This can include a new type of group, a one-time event, an educational or outreach initiative, etc. (Be sure to describe the innovation in detail!)

- **Living the Values Award:** This award will go to someone working in a paid peer role for at least one year who has really gone the extra mile to exemplify the values for which they stand. Compassion, flexibility, integrity and curiosity all come to mind when you think of them!

- **Pioneer Award – Peer Role:** This award will go to someone who has worked in a paid peer role in a traditional organization for at least one year. They will have participated directly in furthering the development of peer roles in that organization both through exemplifying the value of peer roles in their own work **and** through other specific activities designed to further the integration of peer roles in that environment.

- **Pioneer Award – Provider Role:** This award will go to someone who has been working in a clinical or administrator role in a traditional organization for at least one year, and who has demonstrated unwavering support for **and** taken actions toward developing peer roles in a way that is consistent with the integrity of peer-to-peer work.

- **Up & Comer Award**: This award will go to someone who has been working in a paid or volunteer peer role for around one year or less, but who has really 'jumped in' with both feet! They have lots of ideas, positive energy, and/or the willingness to help out with a variety of tasks. They really stand out as having the potential to impact this work in great ways in years to come!

A Word from Other People Working in Peer Roles Around the Country

Have you witnessed positive effects on people and the organization that are the result of peer roles?

"Yes, I have seen my colleagues change their perspectives about the people we serve, and move from a paternalistic viewpoint to one that is more person centered."

"I have seen many people overcome obstacles with the help of peer specialists. Many people have become more social and have gotten out in the community more than they would have on their own."

"Providers actually seek me out now for my perspective. It definitely wasn't like that at the beginning!"

"Sometimes I wonder what I'm doing. Sometimes I'm just sitting next to someone, and it feels like I'm not doing enough. But, later on, they always tell me how much of a difference I made. One time, a woman I was supporting told me that my just being there with her was all that kept her from trying to kill herself or ending up in the hospital."

"I believe people are going back to work, going back to school, getting out of the house more, going to Clubhouses and learning things like computers. People are getting better with their finances, and communication skills."

"I have seen the impact of peer roles with other staff as well as with persons I support. People I support have begun to find their voices and are becoming more empowered. My coworkers have a better understanding of the difficulties people encounter and are more understanding of the recovery process."

"Sometimes someone will come into our center and they'll see and hear about my disabilities and they'll decide they don't need to apply for social security after all. Sometimes they will learn from my example and they will take action. Peer stories offer hope."

"The changes have been incredible. People are speaking up more. They have hope that they'll be heard, so they're not as afraid to try anymore."

"Sometimes I'm skeptical about how much I'm impacting the organizational culture. There's so much that needs changing! But then I'll take a step back and see that the language is changing. The way people are talking about hearing voices and self-harm is changing. I think I'm really making a difference here. It's what keeps me going."

"I can't count the number of times people have told me that interacting with me was the first time they really felt heard."

What have you learned about peer roles that you really wish you'd known at the start?

"How incredibly important just being there in the same room with someone is"

"How to be an effective advocate without alienating those who are in a position to help us. I am finding they are often willing to cooperate and form alliances with us if they are treated gently at first despite the obvious power imbalance and the pain they often cause without realizing it."

"How hard of a job it can be."

"That recovery has many doors."

"How much work it would take to learn not to jump in and try and fix it. How hard it can be to sit with someone in so much pain, and know that all you often do is just be there with them."

"How long change can take, and how frustrating that can feel."

"How much potential people have to recover, no matter how bad a place they are in right now."

"I wish I'd known better how to sit with not knowing if I was doing or saying the right thing. I've learned over time that I may not know right away how I'm impacting someone. But now, I've had more than one person come to me and say, 'you know that thing you said six months ago? It made a huge difference.' That was really powerful for me."

And what advice would you give to people just starting out in peer roles?

"Be educated. Speak up and know your role. Learn how to strategize and use local resources for support. Learn also to collaborate without being told. Train train train."

"Figuring out who your allies in the organization are will make a huge difference. Some people are eager to support you, and some will never be. The people who are eager can help you tap into all those people in the middle."

"Know that you will sometimes feel alone and isolated in your role when you work in an   organization that uses a more traditional medical model. Reaching out will be so important to hanging in."

"This is hard work, but you're making a difference, even if you can't always see it yourself."

"You're a pioneer. You're leading the way, and making change. You rock."
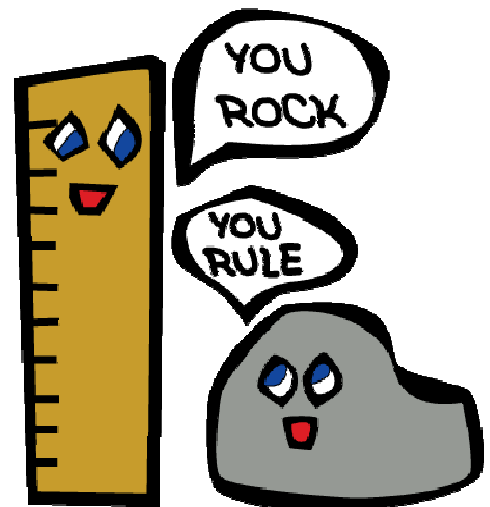
Conclusion

We thank you for taking the time to review the 'peer' side of this handbook, and encourage you to check out the other side when you have time!

If you have questions, please contact us at info@psresources.info

If you have additions, subtractions or edits to suggest, please also e-mail us as we expect that this handbook will evolve over time.

Be sure to also visit www.psresources.info for the most up-to-date version and other related materials.

Just a handful of other websites you may want to check out include:

For trainings:
- **Certified Peer Specialist Training**—A listing of national CPS trainings: sites.utexas.edu/mental-health-institute/files/2014/07/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview-2014-Update.pdf
- **Copeland Center**– Wellness Recovery Action Plan trainings and notifications: www.copelandcenter.com
- **Hearing Voices USA**– Training and notifications on hearing voices and related issues: www.hearingvoicesusa.org
- **Intentional Peer Support**– IPS and related trainings: www.intentionalpeersupport.org
- **National Association for Rights Protection & Advocacy**– Annual conference: www.narpa.org
- Western Mass Recovery Learning Community– A variety of trainings and training notifications including Hearing Voices and Alternatives to Suicide facilitator trainings: www.westernmassrlc.org

Peer-run Technical Assistance Centers (TA centers offer supports around peer-to-peer support development in a variety of states, on-line trainings and resources, etc.):
- Café TA Center: www.cafetacenter.net
- National Empowerment Center: www.power2u.org*
- Natoinal Mental Health Consumers' Self-Help Clearinghouse: www.mhselfhelp.org*
- Peerlink: www.peerlink.org*
- STAR Center: www.consumerstar.org
* *These TA centers share responsibility for organizing the annual Alternatives conference*

Miscellaneous:
- Icarus Project- On-line community: www.theicarusproject.net
- International Association for Peer Supports– Resources, annual conference, etc.: www.inaops.org
- Mad in America- Relevant blogs and opportunities to comment, etc.: www.madinamerica.com
- Madness Radio– Relevant podcast interviews: www.madnessradio.net
- Mindfreedom, Inc.– Resources, info, projects, etc.: www.mindfreedominc.org
- National Coalition for Mental Health Recovery– Information and issues advocacy, etc.: www.ncmhr.org
- National listing of statewide peer-to-peer organizations: www.power2u.org/consumerrun-statewide.html
- Open Paradigm Project– Relevant videos and information: www.openparadigmproject.com
- Peers TV– Variety of relevant videos and interviews: www.youtube.com/users/peerstv