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Perspectives on Behavioral Health

Intentional Peer Support: Using a Crisis as an Opportunity for Growth and Change

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In January 2013, Community Access, in partnership with the NYC Department of Health and Mental Hygiene, launched the first alternative to hospitalization program in New York City. Called a crisis respite center, the new program has several unique features that, compared to "treatment as usual," radically transform the experience for people in a psychiatric crisis, as well as the staff who work in this setting.

First impressions are important, and the respite center was designed to offer a welcoming environment for people needing a "respite" from the unrest in their lives. First, there is no reception desk. All visitors are greeted at the front door by a peer worker. In addition, institutional lighting and furniture have been replaced with comfortable residential furnishings. And the program is small—limited to seven people, leaving plenty of time for one-on-one discussions, small groups, and, when needed, solitude. Finally, our "guests" are free to come and go on their own accord.

While the physical plant is critical in establishing an atmosphere for healing and reflection, the most important aspect of the program is the carefully choreographed interaction between the staff and guests. For this, the respite center-and the companion peer-operated support line- has adopted a truly revolutionary model of care known as Intentional Peer Support (IPS).

IPS is grounded in a simple concept that is transformative in its execution. IPS views "the crisis" as an important opportunity to learn, grow and heal. To do this, there is no attempt to "stabilize" the guest, or offer advice on how to better. manage a future emergency. These "risk management" techniques are replaced by a process of learning and sharing between the peer staff and guests. It requires staff with a special gift for empathy, but also a lot of training.

Like all respite center staff, I was trained intensively in the principles and methodologies of IPS by Shery Meade, its creator and developer, along with her long-time collaborators, Chris Hansen and Beth Filson. The initial training lasted a full week and was part workshop, rite of passage, and bonding experience: a compelling mix of lecture, presentation, role play, discussion and video. Shery and her colleagues made a tremendous training trio. The model and the training process have evolved and been refined by real world experience for over two decades.

As with the respite center itself, IPS is both innovative and reflective of broader and long-term changes within behavioral healthcare as the system struggles to replace expensive hospital-based care which often comes with high recidivism rates-with something more effective.

The last several months have been instructive and inspiring to see IPS in at work. As the examples below will illustrate, I have been given a richer context in which to consider my previous professional roles as a case manager, for several years, and as an administrator at a licensed housing program.

There are three principles of IPS : (I) Learning versus Helping; (2) Relationship versus the Individual, and, (3) Hope and Possibility versus Fear. These are the prisms through which we see the work, a collaborative partnership vested in hope and promise that allows for possibility.

There are four tasks of Intentional Peer Support. They are: (1) Connection, which refers to the need to create a genuine rapport between the participant and peer worker. (2) Worldview, which asks the worker to consider the perspective of the person, what is their perspective and beliefs and how did they come to hold them? (3) Mutuality, meaning

shared responsibility for honest communication between staff and participants. And, (4) Moving Towards,which means always moving the participants towards a better way of being closer to where they want to be.

I see these tasks as grounding points to orient oneself to the guest (as we call people who come in to stay at the respite) or support line caller, beginning with making an initial connection and then charting together an aspirational and proactive plan for the future. The three principles .then guide and direct the worker to keep on track.

I've found that these approaches have much in common with how I used to try and work as a case manager: namely, to be respectful, supportive and honest. At least, that is, until it comes to "mutuality." That is where it really starts to get interesting.

In most therapeutic settings there is some kind of "filter" that strains the information that goes to a patient: conclusions and reflections about a client, and, perhaps most sacrosanct of all, the professional's own story, thoughts, and feelings.

These are absolutely unavailable to the patient. Intentional Peer Support is quite different. As IPS trainer Chris Hansen often used to say: "nothing about us with-out us" -"clinical" conversations should always be inclusive in the company of the guest. In practice, this requires that all conversations with other treating professionals or family members be conducted with the guest's consent and with him or her present.

More deeply felt by me, and a real change, is the possibility that in a professional clinical setting I can now show that I too am moved in the course of an interaction with a participant, or that if reminded of something painful in my own past hearing the story of a guest, that I would be permitted to share this and be thereby enriching the encounter for both of us. This is truly a different experience compared to traditional mental health care.

Mutuality also directs us to share when we feel in some way uncomfortable or unsafe in our interactions with a guest or caller, thereby maintaining an expectation of accountability. There is no emotional or psychological filter or professional distance at work—concerns are not dumbed-down or spoon-fed but shared in a clear, caring and respectful way.

One thing I find myself repeatedly tripping over is the use of the word "peer." While it is useful when describing the groundbreaking features of this model, emphasizing our peer workforce feels a bit like continuing some kind of apartheid (separate and unequal). If an employee is competent to do the job it is my preference to call them, simply, a *professional*, which significantly broadens the future career opportunities for these skilled and well-trained staff members.

To provide a real world example, I asked my staff to share their experiences of Intentional Peer Support in action. These two are particularly illuminating:

I received a call from a gentleman identifying himself as Mark. He began by asking for a male to speak to. I told him there wasn't presently a male peer available and asked if he wanted to talk a little with me and he could let me know what his comfort level was. He hesitated, but agreed to try. He shared he was "morbidly obese" and that he lived with a great deal of depression, anxiety and shame about his weight. He spoke about being "so alone" and that although he desperately needed to, talking about his feelings to anyone felt impossible to him. He explained that he "didn't feel like a man" if he admitted to others the shame, embarrassment and insecurity he felt daily. In using IPS, I shared with him that I also struggled with body image, and that I knew what it was like to feel discomfort, disgust, shame, and self-hatred at being in your own skin and to have no one to talk to who can truly understand that specific, constant pain. He broke down briefly, saying that not only was he shocked that someone could relate (he just "assumed" I would not be able to), but no one had "validated his pain" before. I told him I had felt the same way for a long time, only to finally realize that no one could ever possibly understand or validate my pain if I refused to risk sharing it with others. Mark spoke of having considered support groups, but had not sought that out. At the end of the call, he said he felt better and was more hopeful that there could be others that could relate to his situation. He said he realized he was alone because he kept himself alone and things could perhaps change for him with his depression if he reached out. I gave him the number for LIFENET for support group resources. He said he was so appreciative of the support line, glad he called, and thanked me. I told him the hours we were available and encouraged him to call again if he wanted.

And:

The first time I had kitchen duty with a guest, I took it upon myself to prep most of the food and also assist with serving the dish and clean-up. When the guest came down, she was very eager to help, but not much was left to be done. The guest ate the dinner, but was visibly a bit sad I remembered her cultural background as being one that places great importance on sharing food and hospitality. I brought this up, and acknowledged that I assumed it would be nice of me to take care of most of the prep, and asked if she would like to be more involved next time and she talked about the joy she finds in "feeding others." After this, the time we set aside for dinner preparation and serving was when she was most engaged in the program, lively, talkative, and happy. Being with this guest was truly a treat since then, as she was able to share many of her favorite dishes with staff and fellow guests which, in turn, has aided in the recovery of others as well.

Intentional Peer Support allows a person in crisis the opportunity to discover a new role that is simply not possible in traditional clinical settings. As I have experienced, this process can truly lead to lasting changes in the lives of the people we help, and ourselves. To learn more about Intentional Peer Support visit www.intentionalpeersupport.com.