Peer Specialists in Community Mental Health: Ongoing Challenges of Inclusion

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

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

Further challenges arise in the translation of clinical research to community implementation, in which peer specialist roles frequently encompass multiple activities. For example, a peer specialist might lead one or two groups, assist with aspects of case management, serve as an agency peer representative on local, state, or county initiatives, and participate in community outreach activities. With these multiple roles, analysis of the specific mechanisms and impacts of peer support—both direct (e.g., on clients) and indirect (e.g., on organizational culture)—can be difficult.

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

We concur with calls for greater investment in research on peer supports as well as enhancement of the methodological rigor of relevant investigations. In addition, we believe that case studies can play an important role in highlighting ongoing ethical and pragmatic challenges and gaps in current policy and practice. Specifically, the goal of this column is to

HIGHLIGHTS

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

draw attention to the practical challenges associated with the hiring, accommodation, and retention of paid peer specialists with ongoing mental health challenges, not the impact or effectiveness of peer-delivered interventions. We hope that the case study will stimulate more nuanced thinking among mental health service administrators who are considering implementing peer support in their workforce and will inform potential areas for further research into specific challenges faced by peer support staff.

Case Presentation

A community psychiatrist hired a peer specialist to work in an urban community mental health clinic as part of a health services research study funded by the National Institute of Mental Health. The peer specialist was to maintain a population-based registry, attend team meetings, and serve as a patient navigator. The hiring psychiatrist was familiar with the peer support literature (2) but had never hired a peer specialist. The clinic's human resources (HR) department advised posting a limited-hire "peer counselor" position at 0.4 full-time equivalent (FTE). Ten people applied, and the top three candidates were interviewed. Candidate A self-disclosed as having an anxiety disorder and a fear of dogs. Candidate B had excellent interpersonal skills and self-disclosed experiencing bipolar disorder with prior hospitalization and family history. Candidate C best matched the demographic characteristics of most of the clinic's patients: she showed signs of psychosis and had experienced extended periods of homelessness. The hiring psychiatrist ultimately selected candidate C for the position, determining that clients would be more likely to relate to her.

Candidate C (hereafter Shirley) accepted the position, requesting "not too many hours" so that she could continue receiving Social Security Disability Insurance. Shirley underwent a standard hiring process, was given desk space, began attending team meetings, and began developing a patient registry. The hiring psychiatrist introduced Shirley to other staff and gave her the option of attending on-site peer-to-peer supported employment (SE) meetings but did not ask about potential interest in receiving assistance from an SE counselor at another clinic.

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

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

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

Discussion

As the case exemplifies, practice guidelines do not always address the difficulties that arise when integrating peer specialists into community mental health settings. We focus on five specific challenges to peer support and recommend research areas to help uncover solutions (Box 1).

Uncertainty about the optimal characteristics for suitability in a peer specialist role. Our case study underscores the uncertainties a hiring manager may face in discerning what qualities or characteristics are most important in a peer specialist—for example, specific diagnoses, a background similar to that of the patients with whom the peer specialist will work, or other relational or interpersonal qualities. Hiring managers may also grapple with the degree of disability they are able or willing to accommodate.

Mandatory disclosure in peer specialist roles. Our case also raises significant ethical questions regarding disclosure of mental illness as a de facto requirement of employment, often built into both peer specialist titles and job responsibilities. Although some employers head off potential misunderstandings by clearly communicating that prospective applicants should "feel comfortable disclosing or sharing their story," the pros and cons of a decision to disclose—and concerns about the effects of disclosure and potential threats to self-identity and future career prospects—are rarely clear

BOX 1. Priority research areas regarding peer specialists

- Investigate which facets of shared identity, experience of mental health conditions, and disclosure of mental illness are critical to the impact of the peer workforce, with specific attention to intersectionality, class, and salient aspects of identity other than shared diagnosis or treatment.
- Disentangle the legal and ethical distinction between nonpsychiatric disruptive behavior and disruption directly resulting from disability and establish mechanisms to support individuals under such potentially challenging circumstances.
- Develop best practices and strategies for integrating staff who have ongoing, significant disabilities that affect their interactions with others (and that might otherwise lead to termination) and consider the ethical implications of who is included or excluded from the peer specialist workforce.
- Acknowledge the impact of stigma among coworkers located within mental health service settings and develop interventions aimed at addressing such stigma in explicit, implicit, and structural forms.
- Analyze the individual and organizational consequences of peer specialist wages and effort levels, weighing the potential loss of Supplemental Security Income and Social Security Disability Insurance benefits for full-time staff against the risk of creating low-wage, nonbenefited positions that fail to provide a path to sustainable employment and against the risk of structurally reinforcing the "lesser" status of experiential expertise and peer support.
- Investigate the necessity of traditional peer role practices, including self-disclosure and mutuality, that have long been promoted but lack a sufficient empirical evidence base and ethical examination.

cut, and the ethics of mandating such disclosure are fraught. At least one state, Illinois, has opted to use the title "recovery support specialists" in place of "peer specialists" within its state certification program because the former designation does not automatically convey mental health status. Ethical inquiry may also raise questions about the rationale for mandatory disclosure among one class of workers (peer specialists) but not other providers who may also have personal experience of mental illness.

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

Appropriate ADA-based work accommodations in cases of real or perceived misconduct. Our case also raises questions regarding the distinction between "true" misconduct, or disruption of the work environment, and misconduct directly tied to symptoms or disability. Such disruptions may unfold during nonclinical interactions with coworkers, as in our case study, or in the context of direct client work. From a legal perspective, ADA rulings have generally deferred to employers and held that the ADA provides no prima facie protections against firing or demotion when an employee's behaviors disrupt workplace function in a way that cannot be accommodated without "undue burden." Still, this legal situation does not address the deeper ethical and political challenges involved in negotiating such situations, especially in the case of peer specialists who are hired precisely because of their experience of disability. Supervisors must strike a difficult balance between upholding conventional expectations for performance and professionalism and probing

the limits of disability-based accommodation, modification, and flexibility.

Stigma from providers: attitudinal and structural. In our case study, other clinicians' concerns also played a significant role in Shirley's termination. Many people, including providers, are likely to have internalized at least some negative stereotypes about individuals with serious mental illness—associations that are likely to be triggered by behavior perceived as aggressive or hostile (9). The low-wage, entry-level status of peer specialists may also reinforce power hierarchies in which the de facto value of lived experience is minimized relative to professional expertise. As such, norms of peer specialist compensation and status may exemplify structural stigma (10). As sociologists have long argued, attitudinal and structural stigma are reciprocally related, and their synergistic interactions in organizational settings can be difficult to analyze.

General best practices in peer specialist hiring and support—for instance, detailed policy regarding accommodations, protocols for peer provider wellness plans, and steps for supporting employees through relapses and symptom exacerbation—might circumvent some of the problems that arose in our case. However, situations occur where disruption and disability overlap in confusing and complex ways, and decisions are likely to be overshadowed by structural and attitudinal stigma from providers in community mental health settings. Further development of best practices requires that we grapple with truly complex ethical and legal challenges.

Conclusions and Recommendations

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

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