Underground Transmissions and Centering the Marginalized:

Collaborative Strategies For Re-Visioning the Public Mental Health System

Sascha Altman DuBrul – saschaoffthemap@gmail.com

Professional Seminar SSW790

Silberman School of Social Work at Hunter College

Table of Contents

Part I

Underground Transmissions and Centering the Marginalized:

Collaborative Strategies For Re-Visioning the Public Mental Health System

Abstract

The purpose of this paper is to lay the intellectual foundation for the development of a new generation of mental health support services. These services will both model cooperation between clinicians and the growing peer specialist workforce in the public mental health system, while actively encouraging the proliferation of a vibrant, independent peer movement that has the power to creatively influence the current culture of mental health services. This grassroots movement would express its influence *both within and outside* of the public mental health system with a common set of core principles based on self-determination and social justice. (WMRLC, 2016) (The Icarus Project, 2016), (Mead, 2003).

In this paper I argue that the current peer specialist movement struggles with the co-optation of its original principles that grew out of the Civil Rights inspired Psychiatric Survivors Movement of the 1970s (Penny, 2016). A particular challenge faced by members of this growing movement is the widespread assumption of incompetence by virtue of their diagnoses. I believe that for the growing peer recovery movement to be effective in changing the language and culture of mental health, it needs to put at the center of concern *those who most suffer from systemic oppression* and have a strong collective analysis reflected in its action. To do this we

have to align ourselves with the contemporary Movement for Black Lives and the growing North American social justice movements for human dignity. (The Movement For Black Lives, 2016) At the heart of this vision is the understanding that those labeled "mad," "traumatized," "disabled," or "addicted" do in fact, have the potential to be the most powerful leaders for profound social transformation, since they directly have experienced the very maladies that are affecting our society. I believe that by embracing this shifting power dynamic, and developing effective strategies for collaboration between clinicians and those most affected profound changes will be made in our mental health system, potentially paving the way for healing some of the critical wounds in our society.

Introduction – Statement of the Problem and its Significance:

For much of its history, mental health systems have been designed by experts in the field without the critical perspective of those who use the services themselves. It is not surprising therefore that today the dominant paradigm in the public mental health system is the *biopsychiatric model*. (Lewis, 2006) Biopsychiatry examines mental health solely through the lens of brain chemistry, excluding social, political, and economic factors of distress and disease. It rose to dominance in the 1980's during the Reagan era of neoliberal economic policy and incorporated the increasing use of the Diagnostic and Statistical Manual (DSM), a seemingly objective catalogue of mental pathologies that has grown to be hugely influential in the diagnosis and medication of vast numbers of North Americans today. (Moncrieff, 2008) Even the

current trends in psychiatry that focus on neuroscience, neuropsychotherapy and the plasticity of the brain, the focus remains on individual brain chemistry, with no attention or recognition given to the impact of socio-economic factors. (Lewis, 2016)

This biopsychiatric paradigm has left little room for alternate views of health and wellness. It privileges the knowledge of scientists and experts and belittles the resources of local communities, families and alternative healthcare practitioners. (Thomas, 2005) It reduces human emotions and behavior to chemicals and neurotransmitters (Horwitz, 2007), and reinforces the divide between the "consumers" and the "providers" of mental health services, further stripping agency from patients in taking leadership in their own healing. The role of trauma in patients' suffering is de-emphasized, perhaps because it would lead to too harsh an indictment of larger social factors. (Herman, 1997) Where to begin with addressing these issues in our field?

Key Terms

Dandelion Vision/Underground Transmission – With the understanding that lasting change happens from below, the dandelion vision uses the pioneer plant as a metaphor for describing the way ideas comes from the cultural "underground" and influence the dominant culture.

Dangerous Gifts/Mad Gifts – A potential re-visioning of the language of mental illness, the idea is that our differences might be seen as gifts rather than diseases. While some in the movement objected to the language of "danger" when describing mental illness, the language of "mad gifts" is a revision.

Dialogism – As opposed to Monologism. A term from Open Dialogue practice with its origins in the Russian philosopher Bakhtin. In a literary text it refers to different tones or viewpoints, whose interaction or contradiction is important to the text's interpretation. In family therapy practice it refers to the importance of different viewpoints coming together to help illuminate the whole.

Intentional Peer Support (IPS) – A training modality which grew from the informal practices of grassroots peer support, it is a theoretically based, manualised approach with clear goals and a fidelity tool for practitioners. This approach defines peer support as 'a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful' (Mead,

2003). Intentional peer support understands that trauma is central to the experience of emotional distress that often results in psychiatric labeling. It is an explicitly survivor-controlled, non-clinical intervention with primarily intrapersonal and social benefits.

Mad Maps/Transformative Mutual Aid Practices (T-MAPs) - Transformative Mutual Aid Practices (T-MAPs) is a set of community-developed workshops that provide tools and space for building a personal "map" of resilience practices and local cultural resources. Each participant collaborates with the group to complete a personalized booklet (or "T-MAP") of reminder documents that can be used as a guide for navigating challenging times and communicating with the important people in their lives. Through a mix of collective brainstorming, creative storytelling, theater games, art/collage making, and breath/mindfulness practices, the group is guided through a process to develop greater personal wellness and collective transformation.

Peer Specialist - 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. (Western Mass Peer Network, 2014) The peer specialist role initially developed out of the movement for human rights in the mental health system in the 1970s (Chamberlin, 1978) and grew in power with the rise of the Mental Health Recovery Movement. (Fisher, 1994)

Personal Journey: From Peer to Clinician Amidst the Recovery Movement

The context of this paper is the growing peer specialist movement in mental health (Salzer, 2010) and the understanding that, if given the right set of tools and circumstances, it has the potential to be a potent catalyst in creatively evolving the culture of the public mental health system. From my background as a mental health patient, beginning with my institutionalization as a teenager, to working for many years on creative peer support models outside the traditional mental health system, through my experience as a social work student at the Silberman School of Social Work, and now as a clinician on the Parachute Manhattan Mobile Treatment Team, I will attempt to reflect on the relationships between peers and clinicians and some strategies for growing a vibrant and more effective mental health system in New York City and beyond.

The Icarus Project

For more than a decade I co-developed and helped run an organization that was created to empower people, like myself, who had ended up in the mental health system and had been diagnosed with a "serious mental illness." The Icarus Project was created with the lofty mission of changing the language and culture of what is considered mental health and to empower those who saw themselves as "sick" by

appreciating the potential gifts they could offer to the larger society. (DuBrul, 2014) We began as a website community, published a handful of crowd-sourced books which were used as organizing and empowerment tools around the country, hosted art shows and workshops, and, with years of grassroots organizing and the help of some private funding, developed into an international network of peer-based support and activist groups. (Bossewitch, 2016) The Icarus Project proudly worked outside the traditional mental health system because all of us had directly experienced oppression at the hands of it, including forced treatment, belittling of our life experiences, and the existential sense of disempowerment that develops from being told repeatedly and condescendingly of our biologically based "dysfunction" and "disease".

The Icarus Project was determined to develop an alternative to the reductionist biopsychiatric model and traditional hospital based-care. Unlike earlier movements for change in the mental health system (Frese, 1997) we were inclusive and strategic in our organizing strategy: we opened up spaces for many different perspectives and embraced self-determination and harm reduction: everyone was welcome to participate whether they used diagnostic language to refer to themselves or rejected the mainstream language, whether they used psychiatric medications or chose not to take drugs. We also very much took advantage of internet technology and quickly became a magnet for creative people who were alienated by mainstream society. Our gatherings and publications were full of art celebrating our life experiences.

(Fletcher, 2016) *The key passion that brought us together was a desire to actually change the narratives we used to talk about ourselves and each other, and to envision a community where people's differences could not only be embraced but given space to shine.*

According to Bossewitch (2016) in his recent Columbia University dissertation "Dangerous Gifts: Towards a New Wave of Mad Resistance":

The Icarus Project represents a new wave of resistance, one that shifts from the ontological questions of the definition of disease and illness, to the epistemological questions of whose stories and voices are considered in the production of psychiatric knowledge*. This insistence on full-fledged participation in one's own healing, and more importantly, in healing by and through community, represents a new modality of protest that goes beyond the discourse of human rights and individual choice.* It is a modality of protest that meshes well with our "decentralized networked-era culture" and offers a path for taking direct action in the context of mental health." (*italics mine*.)

It was this sense of being actors in our lives, and creating new ways of living for ourselves and others, that propelled us forward and gave us a sense of purpose and community. It was a sense of outsiderness, a distrust of larger narratives about the

world, that allowed us to stay out of mainstream discourse and practice alternative ideas

Silberman School of Social Work

After twelve years of working outside the system as a peer, I made the fateful decision to go back to school and become a clinician. My personal journey led me back to my hometown of New York City as a student at Silberman School of Social Work. As a first year student in the One Year Residency (OYR) program, I found myself immersed in theories to help guide me in the process of thinking like a social worker.

In our Clinical Practice Lab class we were given the opportunity to think deeply about the process of direct service work from exploration to termination (Hepworth, 2009; Berzoff, 2011), had practice writing bio-psycho-social evaluations (Engel, 1980), engaged with contemporary systemic models like Ecological Systems Theory (Berkes, 2008). In my other clinical classes I absorbed the teachings of ego psychology (Goldstein, 1995), object relations (Fairbairn, 1952), self psychology (Kohut, 2009), and attachment theory (Bowlby, 2005).

In my first semester Human Behavior and the Social Environment (HBSE) course we were introduced to Pedagogy of the Oppressed by Pablo Freier (1970) in which he argues that knowledge isn't neutral, but the expression of historical moments where some groups exercise dominant power over others. This idea was further

elaborated in our Clinical Practice Lab with the study of Critical Race Theory (Ladson-Billings ,1998) which argues that liberalist claims of objectivity, neutrality, and color-blindedness actually normalize and perpetuate racism by ignoring the structural inequalities that permeate social institutions. These were ideas I had thought about but by reading and discussing them in school with others some alchemical process took place which gave me more personal power to articulate my understandings. Being part of a larger institution lent power to the theories.

While all of the social and clinical theories were very rich in ideas, my real learning happened with my fellow students. Every student in our program was required to take a two semester class called Clinical Practice Lab. Practice Lab was partly an attempt to create an environment where students could discuss issues of oppression openly - the intersections of race and class and gender and how they impact the clients who we work with as well as ourselves. Because the OYR program was designed for people already working full time in the profession, the majority of my fellow students were women of color, Black and Latina, all with full time jobs on the front lines at places like the Administration of Children's Services (ACS), Office of Alcohol and Substance Abuse Services (OASIS), homeless shelters and the juvenile justice system.

Many of my fellow students had children waiting for them at home after we finished our night classes. My real teachers at social work school were my fellow classmates, discussing institutional oppression. As a middle-class, white man whose experiences

in organizing have been in majority white spaces, those nights in Clinical Practice Lab class were critical to my social work education.

Our first year at Silberman coincided with the murders of Eric Garner and Michael Brown verdicts which catalyzed the Black Lives Matter movement with protests erupting in cities all over the country calling for the accountability of police.

Here was something I wrote on social media at the time:

Sascha Altman DuBrul
Just to be real: so many of my fellow students at social work school are mothers and tonight in class when we talked about the #EricGarner verdict and the #BlackLivesMatter movement three Black moms in a row started crying and talking about how terrified they are for their little boy's lives because of the police and this racist society we live in. These are women I've been learning and studying and writing papers and sharing stories with all semester and it was so painful to see their fear and rage and helplessness rise up, the looks of horror on their faces, so scared for their children's lives. Those of us who don't have to suffer this racist bullshit on a daily, those of us who don't have children of color who might just get picked up or shot by cops just for walking down the street, we need to educate ourselves and talk to other white folks to make sure they understand just how bad it is out there for so many of our fellow citizens. We need to put ourselves on the line and be in active solidarity with our brothers and sisters who suffer under the oppressive weight of this country's brutal and divisive history. This growing popular movement that's erupting in the streets is long overdue and I sure hope we can learn from the lessons of our past and do it better than our parents and take care of each other along the way. #collectiveliberation.

(Concluding paragraph here about how the deepening of my racial justice analysis and the awareness that so many front line social workers are poc and we need to build solidarity within .at the same time I saw a lot of sanism and fear of the mentally ill and othering in my classes)

The Need For Mentorship

One of the most important reasons I decided to go to social work school was that I desperately wanted mentorship -- supervision from people wiser and older than me. After many years of navigating roles of unofficial authority in The Icarus Project, without any kind of system of ethics holding myself and others accountable, I longed for clearer boundaries and the power and camaraderie of a professional group. I was grateful to find a profession, unlike other schools of therapy, where an analysis of oppression was incorporated into the healing practice and worldview. I also saw that if I wanted to have an effect on the larger culture I would need to be able to understand how people were being trained to be healers, I wanted to understand what it meant to play the role of a mental health "clinician".

My timing was fortuitous because just as I decided to work inside the system, the "peer specialist movement" has begun to grow and evolve in ways that are allowing me to bring my particular set of experiences to the table in a vocal and creative way.

What is a "peer specialist"?

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. (Western Mass Peer Network, 2014) The peer specialist

role initially developed out of the movement for human rights in the mental health system in the 1970s (Chamberlin, 1978) and grew in power with the rise of the Mental Health Recovery Movement. (Fisher, 1994)

The idea that someone who has been through their own mental health journey can help another person, potentially is revolutionary in a system that has always relied on the authority of doctors. The realization that "peers" who have struggled not only with mental divergence and stigma have the ability to help in ways that clinicians cannot creates a potential opening in a formally closed system: an opening which allows for a formally impossible shift in perspective. The peer role is the role of a change agent in a system needing change.

It is important to state that in the mental health context the term 'peer' does not simply refer to someone who has had a similar experience as another person. In practice, peer-to-peer support is primarily about *the nature of the relationship between two people*: a mutuality that isn't possible in a traditional clinician role because of built-in power imbalances.

Conflicting Forces

The "peer specialist" or "Certified Peer Specialist (CPS)" role in the North American mental health system is in the process of evolving, and there are many forces, some of them conflicting, which are attempting to shape its growth. It has been said (WMRLC citation) that the value system of the peer movement is at odds with the

medical model and there are strong forces of cooptation. (Penny, 2016) A compelling argument can be made that cutting costs lies at the heart of the mental health system's embrace of the Recovery movement. Some (Brawlow, 2013) compare the peer movement to Deinstitutionalization: a way to cut funding for mental health services by having lower skilled people paid lower salaries to do the same jobs. That said, the peer movement's growth around the country has paved the way for fundamental shifts in the way mental health not only is treated, but even the way it is socially conceived.

The Peer Specialists Movement or Peer Recovery Movement, holds all of these complexities as it develops and matures, and its history will naturally affect the dynamics between peers and clinicians in the mental health workforce.

Thrive NYC - An example of the use of Peer Specialists

Earlier this year the De Blasio administration announced a plan called "Thrive NYC", an effort to overhaul New York City's mental health care system with a package of 54 initiatives costing $850 million over four years. According to NY1: "[Thrive NYC] relies heavily on peer counselors, who are not mental health professionals but are already entrenched in underserved communities." (Billups, 2015) Peer Specialists play an important role in the vision of ThriveNYC:

"Peer Specialist Training—(DOHMH) Peers are a critical component of any plan to address the mental health challenges facing New Yorkers. Drawing from both lived experience and specialized training, *Peer Support Specialists have a unique ability to engage people whose needs might not be fully recognized and understood by the traditional health care workforce." (*Italics mine.) (Thrive NYC, P. 61)

According to the report, this change is beginning as early as next month:

"As of January 2016, New York State is providing coverage for peer support services delivered by professionally certified Peer Specialists to adults enrolled in Health and Recovery Plans. Coverage for these services is expanding to include children beginning in January 2017. *To facilitate the expansion of these pivotal services that is being driven by these changes in State payment practices, the City will invest in the training of additional peer specialists.* This training will equip individuals who have lived experience with mental illness and substance use to take on workforce positions in the health care system and obtain their NYS Peer Specialist Certification. *The City will graduate 200 peer specialists from this program per year beginning in Fiscal Year 2017.*" *(*Italics mine.) (Thrive NYC, P. 61)

Visionary Peer Leadership – Parachute NYC

In my second year of social work school I was given an internship at the Manhattan Mobile Treatment Team of Parachute NYC, a cutting edge project which has a staff

mix of peers and clinicians. In 2012 the Fund For Public Health in New York, Inc., in partnership with the NYC DOHMH Division of Mental Hygiene, launched Parachute NYC, a citywide approach to providing a "soft landing" for people experiencing a psychiatric crisis. It is an experimental model of family therapy influenced by the Needs Adapted Treatment Model (NATM)/Open Dialogue and Intentional Peer Support (IPS) with the aim of shifting the locus of care from hospitals to community integrated care. (Sadler, 2015)

The team I work on is a mix of peer specialists and clinicians (three social workers, three peer specialists, a family therapist, and a psychiatrist.) We work with people who've been diagnosed with psychotic disorders and have recently been in the psychiatric hospital. But unlike a traditional medical model, we are trained to allow unpredictability and an acceptance of multiple, potentially contradictory voices.

It is a working environment marked by creativity and a tolerance of uncertainty. The egalitarian and respectful relationship between the peers and clinicians on our team is striking considering how much the power differential exists between the two groups in traditional mental health contexts. While the culture at my internship definitely has something to do with to do with the particular individuals, I think the environment which has allowed these dynamics to flourish is created by the healing modalities and treatment models the staff have all been trained in. It gives us a common language to use, and a set of guidelines that lend themselves to open up

minds and inform actions. Parachute will be described in greater detail in Part III of this paper.

Part II

The Working Relationship of Peers and Clinicians – A Literature Review

Peer support 's current incarnation as the Mental Health Recovery Movement (Fisher, 2004) has its origins in the mental health liberation movement which grew up around deinstitutionalization in the late 1960s & 70s in North America. Former mental patients who felt oppressed by the traditional mental health system sought to establish alternatives to what was seen as a paternalistic and oppressive mental health care model (Chamberlin, 1978). It is important to note that this movement was contemporary with many other movements for democracy and social justice in Rights movements and those early longings for liberation still exist in the DNA of its makeup even as it has become more institutionalized

According to Davidson (2012), the first stage of national research related to Mental Health Peers involved feasibility studies, in which the main aim was to demonstrate that it was in fact possible to train and hire persons with histories of severe mental illness to serve as mental health staff (Davidson, 2000). The second stage of research involved studies comparing peer staff and non-peer staff, with both functioning in conventional roles such as case managers, rehabilitation staff, and outreach workers. (Rowe, 2007). According to Davidson (2012), it has thus required a third generation of studies to begin to answer questions regarding the type and quality of interventions in a mental health clinic: *Are there interventions that cannot*

be provided by people who do not have their own first-hand experience of mental illness? What are unique roles that Peers play as workers in the mental health system?

This study began with the assumption that peers play important and unique roles in the emerging 21st century mental health system. It focused on the relationship *between* peers and clinicians: how they optimally communicate, how their understandings are similar or different depending on their training and work environment, how is it possible to craft the best and most productive working environment for both peers and clinicians to be optimally supportive to the people receiving mental health services.

The study separately asked both peers and clinicians to define what a "successful intervention" in the field is or looks like. It compared perceived ideas of interventions and asked both peers and clinicians to talk about their relationship, and how they think their relationships effects the work that they do. The study asked about their own roles, as well as the roles of the others in the organization as well as about the dynamics of cooperation.

As the Mental Health Recovery Movement grows in influence and importance in North American mental health systems (Ostrow, 2012), there are documented struggles both integrating peers into clinical work environments and changes happening on the cultural level of workplaces (Walker, 2013). As of September 2012, 38 states had established programs that train and certify individuals with "lived experience" of mental health issues who have initiated their recovery journey

and are willing to assist others who are in earlier stages of the recovery process (Kaufman, 2014). Estimates place the number of peer support staff currently to be over ten thousand in the US alone (Davidson, 2012).

As changes in the mental health system shift power dynamics in workplaces across the country, the peer/clinician working dynamic is a wide-open new field of study. In recent years there have been dozens of academic articles describing both positive and negative peer support workers experiences, including: non-peer staff discrimination and prejudice, low pay and hours, and difficulty managing the transition from "patient" to peer support worker (Walker, 2013). At the same time, there has been a lot of pressure for peer workers to conform to a traditional mental health model (Gates, 2007). ****maybe talk of cooptation can go here?* The purpose of this research is to explore a growing movement in transition, and hopefully point to some best practices that can be useful to emerging collaborations in the field.

The Significance of Peers Working in the Mental Health System

To understand the significance of the modern peer support movement in the mental health system, it is critical to have a sense of the historical backdrop that has allowed it to grow, and the conflicting political forces that have had an influence on its development. Peer services in the mental health system can be traced back to the late 1960s and 1970s amidst the rise of deinstitutionalization and the Civil Rights Movement-inspired mental patient's liberation movement (Chamberlin, 1978). Deinstitutionalization was the movement to transfer people who were living or

receiving treatment in state mental institutions into the community. The mental patient's liberation movement was a movement of people who had been institutionalized and labeled as mentally ill who organized around their civil rights as people and as patients. They felt oppressed by the traditional mental health system, but also the power dynamic between many mental health professionals and themselves. The mental patients' liberation movement sought to establish alternatives to what was seen as a paternalistic and violent mental health system (Chamberlin, 1990).

During the same period of time, and also inspired by deinstitutionalization, was the Community Support Program (CSP), a project of the National Institute of Mental Health (NIMH), designed to improve services for adult psychiatric patients with disabilities who were living in the community. The CSP was the first government program to promote peer support and peer provided services and laid the institutional groundwork for the modern peer movement (Solomon, 2004).

The 1980s saw the rise of the biopsychiatric paradigm in mental health, with increasing numbers of people diagnosed with serious mental illness and given psychotropic medications (Whittaker, 2010). With this growth in diagnoses of mental illness and greater numbers of people integrated into the mental health system, the idea of peer support for addressing mental health issues grew alongside it.. (Bossewitch, 2015). The rise in popularity of self-help and 12-step programs such as Alcoholics Anonymous also influenced the emergence and acceptance of the peer movement.

Tensions

There has been a tension from the beginning of the Peer Movement, reflected in the language that is used by many to describe it: the "C/S/X" or "Consumer/Survivor/Ex-Patient Movement."

There have always been some that have been battling for better access to services (identifying as "consumers") along with those who have seen the services as harmful (identifying as "survivors" or "ex-patients"). The language of "recovery" from mental illness, popularized by groups such as the National Empowerment Center (Fisher, 2004) ended up in the highest levels of government when the President's New Freedom Commission on Mental Health (2003) called for a transformation of the mental health system based on principles of "recovery," as stated in its vision " To envision a future when everyone with mental illness will recover."

In a groundbreaking letter to Medicaid directors in 2007, Dennis G. Smith, director of the Center for Medicare and Medicaid Services, explained peer support as an "evidence based mental health model of care that consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders."

The Importance of Collaboration Between Peers and Clinicians: Recent Peer Integration Into Mental Health Agencies

The importance of this research is highlighted by the remarkable dearth of literature specifically regarding the working relationships between peers and clinicians in the

mental health system. While there have been many articles published about the effectiveness of peer support in mental health services (Walker, 2013) there have been very few articles about the working relationships between peers and clinicians. In 2007 an important study was published entitled "Developing Strategies to Integrate Peer Providers into the Staff of Mental Health Agencies" (Gates & Akabas, 2007) in which the authors analyze interviews with executive directors, human resource managers, supervisors and co-workers at 27 agencies in New York City using peer providers. They also interview peers who received pre-employment training through the Howie the Harp Peer Advocacy Center.

Specific problems they identified as interfering with peer integration in a clinical job site include:

- Persisting mental health stigma among many social service providers
- Role conflict and confusion: unclear boundaries for peers between being friends with clients or service providers or agency employees
- Lack of clarity around confidentiality related to disclosure of personal information
- Poorly defined peer jobs: lack of job descriptions, unequal wages and benefits, low pay, and lack of training or supervision
- Lack of opportunities for networking and support compared to clinical staff.

Gates & Akabas recommended policy strategies which could be enacted

> immediately, which include: agency adoption of a recovery orientation, minimization of peer vs. professional job distinctions, and peer provider job security, dignity, and control over disclosure of disabilities. Practice strategies, which they saw as requiring time to establish and become routine, include clear job tasks, sharing of client information, between peer and non peer staff, cooperative services planning, and supervision of peer providers by professionals. Ideally, they strategized, recovery oriented policies facilitate peer provider integration as they are realized through empowering agency practices.

A response article, "Integrating Peer Providers into Traditional Service Settings: The Jigsaw Strategy in Action" (Macias, 2007) put forth an interesting example of collaboration, based on a strategy designed to ease the tension of public school desegregation in the 1970s called "The Jigsaw Classroom." Unique to the Jigsaw Classroom is the explicit requirement that lower status individuals hold vital information needed by their higher status counterparts. The article relates examples of peer/clinician relations at a "start-up psychiatric rehabilitation program" in Massachusetts. The peers job descriptions included "helping to build a sense of community…by getting to know clients" Because of this, at a crucial point it became clear that peer staff had more personalized information about clients than anyone else on the staff. This was key in shifting the dynamics in a positive between peers and clinicians

All of the above examples have in common the power dynamic shifts between peers

and clinicians. By definition, a peer is someone who is coming from a lack of power, and the clinician, related to the peer, is someone who has historically held power. It stands to reason that any successful working relationship between peers and clinicians would acknowledge this power imbalance and work to overcome it.

The Importance of Studying the Collaboration of Peers and Clinicians

This research is grounded in an understanding that the mental health system has caused an enormous amount of harm to both individuals and society, and that ironically much of what gives peers their power is a shared understanding of ways they have been failed by the mental health system and society. This research is important, not just because the peer movement is growing, but because peers themselves have an opportunity to shift the culture of the mental health system in a positive direction. Whether they have the power to do this will depend on a number of factors, one of them being their healthy working relationships with clinicians.

Part III

Reflections on:

"Collaboration on the Parachute NYC Mobile Treatment Team:

How do Peer/Clinician Relations Affect Aligned Perceptions of Success within a Mental Health Organization?"

In my second year of social work school I was lucky enough to find an internship at the Parachute NYC Manhattan Mobile Treatment Team, a cutting edge project which employs a mix of peer specialists and clinicians to work with clients recently diagnosed with psychotic disorders and their families. I worked as a clinician alongside this mixed team clinicians (three social workers, three peer specialists, a family therapist, and a psychiatrist), visiting families, facilitating network meetings, and training in the Needs Adapted Treatment Model (NATM) based on Open Dialogue principles. Unlike a traditional medical model, we were trained to allow unpredictability and an acceptance of multiple, potentially contradictory voices. I decided to write a two-semester research paper for school about the working relationships of peers and clinicians on the Parachute team. I developed a series of questions that could be used for qualitative research, interviewed two peer specialists and two clinicians, and wrote up my findings. Below is an abridged version of the longer paper and in appendix A there are selections from the interview texts.

Parachute NYC

In 2012 the Fund For Public Health in New York, Inc., in partnership with the NYC DOHMH Division of Mental Hygiene, launched Parachute NYC, a citywide approach to providing a "soft landing" for people experiencing a psychiatric crisis. Funded by a $17.6M Health Care Innovation grant from the Federal Centers for Medicare and Medicaid Services (CMS), Parachute NYC has worked over the last three years to shift the locus of care from hospitals to community integrated care. Parachute NYC's continuum of services include four specially trained mobile crisis teams that are staffed by behavioral health professionals and peer specialists (individuals with their own experiences of being diagnosed with a mental illness who have been trained to support other) who provide long-term engagement (for up to two years) for individuals and their families in their home environment. (Alexander, 2015)

Parachute NYC is the single largest effort to date anywhere to integrate peers into the public mental health system. One of the key ways this integration has taken place is through extensive training for all staff in two modalities of practice: the Open Dialogue/Needs Adapted Treatment Model (NATM) from Northern Europe (Alanen, 2009) and Intentional Peer Support (IPS) from Vermont (Mead, 2003).

Need Adapted Treatment Model/ Open Dialogue (NATM/OD)

The Need Adapted Treatment Model/Open Dialogue (NATM), originally developed in Finland in the 1980s for working with people diagnosed with schizophrenia, is a method for multidisciplinary teams of professionals to work with individuals experiencing a mental health crisis in their own environments, mobilizing members of their own social network – family members, friends, professionals and supporters – in "network meetings" to foster positive, long-lasting change. (Seikkula, 2008) The person's social network is as critical as the treatment team in resolving the present crisis and seeking solutions for avoiding further crises in the future. Network meetings are forums in which the needs and concerns of all of the members of the social network are heard, and where all of the individuals work together to find resolutions to problems presented. These meetings occurring as frequently as needed and feasible and as long as they are needed within the year that the team engages with the person who had the crisis. The model has been replicated and modified for communities across Finland, Sweden, Germany (Alanen, 2009) and recently in the United Kingdom.

Intentional Peer Support (IPS)

Intentional Peer Support is a North American training model that has emerged amidst the growth of the peer recovery movement. IPS emphasizes social change and creating dialogues rather than what is considered traditionally clinically effective service. Founded in the 1990s by Shery Mead, a social worker and former

psychiatric patient, Intentional Peer Support is different from traditional service relationships because relationships are viewed as partnerships that invite and inspire both parties to learn and grow, rather than as one person needing to 'help' another. IPS doesn't start with the assumption of a problem and it promotes a trauma-informed way of relating. Instead of asking "What's wrong?" IPS practitioners are trained to ask "What happened?" IPS practitioners examine their lives in the context of mutually accountable relationships and communities — looking beyond the mere notion of individual responsibility for change. IPS encourages everyone involved to increasingly live and move towards what they want instead of focusing on what they need to stop or avoid doing.

Data Analysis and Discussion

This study began with the assumption that Peer Specialists play an important and unique role in the emerging 21st century mental health system. It focused on the relationship between peers and clinicians: how they optimally communicate, how their understandings are similar or different depending on their training and work environment, and how it is possible to craft the best and most productive working environment for members of both roles in order to best support recipients of mental health services.

While there are growing number of peers in the national workforce, it is clear that the Parachute NYC Mobile Treatment Team does not reflect the way that the majority of peer/clinician relations are set up in traditional social work agencies.

From the beginning, Parachute NYC was explicitly designed to foster a non-hierarchical and cooperative working environment that utilizes the unique strengths of its employees. It is, by many standards, an extraordinary and unusual program that has benefitted from the wisdom and experience of many gifted clinicians and researchers, international therapeutic training modalities, and generous funding from both the federal and state governments. Therefore, this research should be viewed less as capturing peer/clinician "business as usual" in North America and more as an example of how innovative dynamics have the potential to make significant changes to the current mental health system. Below are some reflections based on interviews with four team members (2 peer specialists and 2 clinicians) and the researcher's experience working as a clinical student intern on the team over a period of nine months between the Fall of 2015 and the Spring of 2016.

Findings

At the heart of the findings of this research is an awareness that the use of extensive training in Needs Adapted Treatment Model (NATM) and Intentional Peer Support (IPS) has significantly increased the level of creativity and collaborative ability for the Parachute NYC Mobile Treatment Team. With adequate resources devoted to training in these modalities it is possible to create a work culture that allows peer specialists not only to adapt to a clinical working environment, but to play a unique role in shifting some of the key dysfunctional elements of contemporary clinical

culture. This preliminary research points to an emerging collaborative process between peers and clinicians that might contribute to an effective and self-aware culture for a new model of social work practice.

The Role of Peers As Viewed by Peers

At its best, the presence of the peer specialist role allows the team to be able to share more of themselves, to create a more open environment. The presence of the peer, if given space, allows the team to engender a more participatory style where all the voices in the room are elicited, recognized, and heard. In fact, it could be stated that the peer role partially exists to provide a counterpoint to the more boundaried clinical role, and the synergy created between the two points to the potential for a new kind of model for healing practice.

According to one of the Peer Specialists on the team:

> "I think sometimes the peer in the room can do stuff that's a little different than the clinician because of the more constricting standards of being a doctor of social worker. I feel like one of the truly valuable things about being a peer specialist is that we have a more latitude to be ourselves."

With the decline in influence of psychodynamic models in social work and the rise of a more recipe-driven model of care, placing psychopharmacology and Cognitive Behavioral Therapy (CBT) in a central clinical role (Teghtsoonian, 2009), the use of dialogue and person-centered care is now being reintroduced in the form of the peer

specialist. This sense of being "oneself" in the helping roles is illustrated by the following reflection from a peer:

> "I think of peer work not really as a friendship with my people, because obviously there's a power differential between us, but more like a partnership we build together. I think of it as being an ally, as mutually sharing with each other. Their growth is something we experience together ".

At its most basic, one of the team's peers explained their primary role in providing experience-based perspective: "[We] try to utilize our personal experiences and/or share parts of our personal experiences, hopefully in a strategic way that might lend itself to connection and engagement, to understanding in a different way than in the clinical way".

"Useful Division of Labor"

The team psychiatrist also articulated his understanding of the peer specialist role and an acknowledgement that peers have the ability to do things that are not allowed to be done by clinicians. Within this idea is a deeper truth about how the roles compliment one another.

> "Functionally what tends to happen is the peer will help to be the voice of the client, especially when the client isn't able to express what they're going through. Having the peer in those meetings can really allow us to focus on our clinical role. So it's kind of a division of labor that becomes very useful."

Peers often have the ability to be more intimate with the clients and a peer/clinician division of labor allows a kind of synergy that is otherwise not possible. As will become clear later in this analysis, one of the keys to this synergistic relationship is the multiple perspectives of the peer and clinician existing simultaneously in the conversation.

Beyond the conversational dynamics, the peer role plays important functions in the relationship between team and family. Another Clinician respondent sees the peers playing a critical role in the shifting the perspective of parental figures:

> "[O]ften I think about the parents relationship with the peers more than the clients. I think of a bunch of parents in the past who would look at the peers on the team and say "you've been in the hospital like my son has? Do you have a partner? You're married? You *work*?" So there is a power in really giving hope back to the network that was supporting this person who they were getting ready to write off because of an illness and that's a key to why this model works in a family system.'

It must be noted how different this model is from the traditional mental health model. The ability for both the clinicians and the peers to be more person-centered is enabled by the presence of the peers and the training in NATM and IPS. This recipe creates a catalyst introduced into a new environment with the understanding they are actively fostering change in the system. This vision of this work can be summed up by the perspective of one of the peers: "I see myself as a change agent, I

see myself as a provocateur, being called upon to push boundaries, change boundaries if I can."

The Evolution of the Peer Specialist Role

The Parachute NYC Mobile Treatment Team began with a model informed by the work cited above in the literature review. Care was obviously taken not to repeat the mistakes of earlier projects. Specifically the policy recommendations of Gates & Akabas (2007): "agency adoption of a recovery orientation" (in the form of Intentional Peer Support training), "minimization of peer vs. professional job distinctions" (peer roles naturally evolving to become leads on cases*), and "peer provider job security, dignity, and control over disclosure of disabilities" (resources given to pay a living wage for peers on the team, a culture of respect, and the lack of need for peers to disclose.) Parachute stands as an example of how these recommendations can foster an effective program.

Polyphony and Engineering the Breakdown of Hierarchy

There is a concept in NATM/Open Dialogue practice called "Polyphony" – allowing all the different voices of participants to be present in a room at the same time. Polyphony, as practiced, doesn't strive for a consensus, but for the creative exchange of multiple viewpoints and voices, even if they disagree or are in tension. The aim is for a shared emotional experience, and the creation of a new, shared language which has the potential to move the participants to greater understanding and cooperation.

(Seukkula, 2008) On the Parachute NYC team this concept of "polyphony" applies not just to the family therapy practice engaged in by the team members with clients, but to the communication between the team members themselves

Acknowledgement of Power Imbalance

While there is a shared frame of reference for all participants (based on NATM and IPS frameworks), built into the design of the team are natural differences in perspectives of its members because of their varying roles. With a Needs Adapted Treatment Model these different perspectives become assets which ideally create a robust perspective and analysis which can then benefit the clients. That said, a peer specialist is, by definition, a person who is coming from a lack of power in the mental health system, and the clinician, in relation to the peer, is someone who has historically held power. It stands to reason that any successful working relationship between peers and clinicians would acknowledge this power imbalance and work to overcome it.

Even though the peers are given more freedoms and responsibilities on the Parachute NYC team, they still are paid less than their clinical counterparts. Unlike the clinical roles, there is no clearly defined career ladder for peers. Peer Specialists still face all the stigma that exists for someone who have ended up in the mental health system and been given a diagnostic label. All the correctives and attempt to create an egalitarian field have to acknowledge this.

Team Perspectives on Trainings

On the Parachute team the main strategy for overcoming power imbalances has been the requirement of all team members to participate in a series of comprehensive trainings (NATM and IPS) which provide the tools and common language for working through these issues. All four interviewees expressed a mix of opinions how power was shared on the team but all agreed the trainings were an enormously important part of the program.

> Peer1: "I think the NATM and IPS trainings definitely brought us closer together. I think it allowed us to share our (peers) feelings about clinicians but also for clinicians to show us how they really are. I think it helped us all not be so judgmental and understand our common humanity."

The manager of the program had this to say about the NATM trainings:

> "We are not a traditional program where (the manager) and the psychiatrist tell the social workers what to do and the peers do what the social workers tell them to do. We function with pushback and true transparent collaboration the majority of the time. I'm not gonna lie and say I don't put my foot down about things, particularly if I feel it is for the greater good. Hurt feelings and pushback, that's okay, that's how a team learns."

Another peer remarked on the challenge the whole team has struggled with, learning to work together. In this case her perceived sense of the challenge for clinicians:

> "I think it would be an okay thing for a non-peer to say "You know I'm having a hard time working with all these people who have lived experience all the time. Having to check my language and having to feel uptight about things." I think these are important conversations to have."

Intersectionality and Oppression

Analogous to other intersectional movements that attempt to create equitable relationships in diverse contexts (Tolliver, 2016) it is important that the peers themselves don't have to be the ones educating their clinician partners about all the ways they suffer oppression. To significantly change the culture of the mental health system the clinicians have to be just as educated as their peer specialist counterparts. In the words of one of the peers when asked about IPS trainings:

> "I would venture to guess that much of what we're suppose to be learning as peers are things that we already know and that it would be useful for our non-peer colleagues to be learning."

There is a tension here in that it is actually a part of the peer role to educate and advocate for the rights of diagnosed peoples, but having an educated population of

clinicians allows for a smoother systems change, it takes the pressure off of the ones with the least amount of power and gives them the opportunity to excel and be creative and useful in other ways.

Conclusion – Collaboration More Than Alligned Perceptions

The questions of this research project were initially designed to help understand how aligned the perceptions were between peers and clinicians on the Parachute NYC Mobile Treatment Team, in the hopes of providing a rough measurement of success related to peers and clinicians ability to work together. In the midst of the research it became clear that, while questions related to aligned perceptions were a good starting point for conversation, the ability for the two groups to see eye-to-eye was less important than their *ability to collaborate*. Put another way: it appears that peers and clinicians might not need to have the same perspective in order to provide good care to their clients. According to the polyphonic strategy of Open Dialogue practice, it is less important that a group of people agree with one another, and more important that they can have a shared emotional experience which allows for greater understanding and cooperation. In a well functioning working environment, peers and clinicians have the potential to help to define each other's roles, compliment each other's strengths, and potentially create a new collaborative paradigm for social work practice.

Part IV

Conclusion - Education and Evolutionary Relationships

Importance For Social Work Practice and Education

As seen from the literature, the Peer Recovery Movement on its own easily falls prey to the hierarchies of the mental health system. My exploratory research points in the direction that programs such as Parachute NYC hold out the hope for a socially just and effective mental health system, taking the best aspects of different worlds and adapting them to work in an evolving system. I also propose that the social work field because of its commitment to social justice is uniquely situated to growing this strategic development of the peer specialist and clinical roles.

Education and Evolutionary Relationships

It is clear that the Peer Recovery Movement is having an effect on the social work landscape economically. In order for this to be a positive effect there needs to be an embracing of what I refer to as peer/clinician evolutionary relationship. I propose the development of an explicit study of how social workers and peer specialists can collaborate. According to the literature cited above, there is a long way to go. Given the opportunity, the peer perspective has the ability to play a critically important role in making the social work profession more relevant and effective in mental health service provision.

Social Work Education

For the past two years the Silberman School of Social Work has offered year a course dedicated to giving social workers tools to examine intersecting oppressive dynamics about race, class, heterosexism and ableism. There is a striking lack of awareness in most social work curricula dedicated to issues of oppression that relates to mental health diagnosis. Poole et. al (2012) use the term "sanism" to talk about the ways the social work profession belittles the experience of people who have struggled with psychiatric diagnosis.

I propose that to stay relevant in a shifting and evolving mental health framework, that Silberman students are provided a curriculum which engages the possibility of peers and clinicians working together in egalitarian ways as has been addressed in this report. Initially this could take the form of guest speakers, readings and discussion in Practice Lab classes, to eventually an elective class in the Health and Mental Health Field of Practice.

This research is grounded in an understanding that the mental health system has caused an enormous amount of harm to both individuals and society, and that ironically much of what gives peers their power is a shared understanding of ways they have been failed by the mental health system and society. This research is important, not just because the peer movement is growing, but because peers themselves have an opportunity to shift the culture of the mental health system in a positive direction. Whether they have the power to do this will depend on a number of factors, one of them being their healthy working relationships with clinicians.

From the beginning, both liberatory and cooptive forces have been at play within the Peer movement, with the growth of peer specialists within the mental health system as well as alternative models of peer support outside of it. There are opportunities to change how mental health is addressed in our society: from an isolating, consumer-based biomedical model to one that is holistic, transformative, and socially contextualized. Transformation of the mental health system from within is dependent both on how clinicians are able to respect the expertise of peers and how peers and clinicians are able to form mutual, collaborative relationships. It is also dependent on the energy of a mental health movement outside the system that intersects with other liberation movements and brings transformative mental health praxis into all spaces of society.

References

Alanen, Y. O. (2009). Towards a more humanistic psychiatry: Development of need adapted treatment of schizophrenia group psychoses. *Psychosis*, *1*(2), 156-166.

Alexander, M. J. (2015, November). Crisis as Opportunity: The Parachute NYC-Approach and Participant Outcomes. In *143rd APHA Annual Meeting and Exposition (October 31-November 4, 2015)*. APHA.

Berzoff, J. (2011). Why we need a biopsychosocial perspective with vulnerable, oppressed, and at-risk clients. *Smith College Studies in Social Work*, *81*(2-3), 132-166.

Bowlby, J. (2005). *A secure base: Clinical applications of attachment theory*(Vol. 393). Taylor & Francis.

Billups, Erin (2015, November 23). Thrive NYC: An $850 Million Overhaul of the City's Mental Health Services. NY1.
Retrieved from:
http://www.ny1.com/nyc/all-boroughs/health-and-medicine/2015/11/23/thrive-nyc--an--850-million-overhaul-of-the-city-s-mental-health-services.html

Bossewitch, J. (2016). Dangerous Gifts: Towards a new wave of mad resistance. Columbia University, New York.

Braslow, J. T. (2013). The manufacture of recovery. *Annual review of clinical psychology*, *9*, 781-809.

Cain, N. R. (2000). Psychotherapists with personal histories of psychiatric hospitalization: Countertransference in wounded healers. *Psychiatric Rehabilitation Journal*, *24*(1), 22.

Chamberlin, J. (1978). *On our own: Patient-controlled alternatives to the mental health system*. McGraw-Hill.

Chamberlin, J. (1990). The ex-patients' movement: Where we've been and where we're going. *Journal of Mind and Behavior*, *11*(3), 323-336.

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*, *11*(2), 123-128.

DuBrul, S. A. (2014). The Icarus Project: A Counter Narrative for Psychic Diversity. *Journal of Medical Humanities*, *35*(3), 257-271.

Engel, G. L. (1980). The clinical application of the biopsychosocial model. *Am J Psychiatry*, *137*(5), 535-544.

Fisher, D. B. (1994). Health care reform based on an empowerment model of recovery by people with psychiatric disabilities. *Psychiatric Services*, *45*(9), 913-915.

Fisher, D. B., & Chamberlin, J. (2004). Consumer-directed transformation to a recovery-based mental health system. *Boston, MA: National Empowerment Center*.

Fleischer, D. Z., Zames, F. D., & Zames, F. (2012). *The disability rights movement: From charity to confrontation*. Temple University Press.

Fletcher, Erica. (2015). Mad Together in Technogenic Times: A Multi-Sited Ethnography of The Icarus Project (Unpublished doctoral dissertation). University of Texas Medical Branch, Galveston, TX.

Frese, F. J., & Davis, W. W. (1997). The consumer–survivor movement, recovery, and consumer professionals. *Professional Psychology: Research and Practice*, *28*(3), 243.

Gates, L. B., & Akabas, S. H. (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. *Administration and Policy in Mental Health and Mental Health Services Research*, *34*(3), 293-306.

J Dean. (2008, May 7). When the self emerges: Is that me in the mirror? [Web log comment]. Retrieved from http://www.spring.org.uk/the1sttransport

Kaufman L, Brooks W, Bellinger J, Steinley-Bumgarner M, Stevens-Manser S (2014). Peer Specialist Training and Certification Programs: a national overview – 2014 update. Austin, Texas: Texas Institute for Excellence in Mental Health, University of Texas at Austin.

Kohut, H. (2009). *How does analysis cure?*. University of Chicago Press.

Ladson-Billings, G. (1998). Just what is critical race theory and what's it doing in a nice field like education?. *International journal of qualitative studies in education*, *11*(1), 7-24.

Lewis, B. (2010). *Moving beyond Prozac, DSM, and the new psychiatry: The birth of postpsychiatry*. University of Michigan Press.

Lindy, D. C. (2014, November). Parachute NYC: An innovative approach to serving people with psychosis in New York City. In *142nd APHA Annual Meeting and Exposition (November 15-November 19, 2014)*. APHA.

Macias, C., Aronson, E., Barreira, P. J., Rodican, C. F., & Gold, P. B. (2007). Integrating peer providers into traditional service settings: the Jigsaw strategy in action. *Administration and Policy in Mental Health and Mental Health Services Research*, *34*(5), 494-496.

Mead, S. (2003). Intentional Peer Support. *Bristol, Vermont*.

Mead, S. (2003). Defining peer support. *Available from: parecovery. org/documents/DefiningPeerSupport_Mead. pdf*.

Moncrieff, J. (2008). Neoliberalism and biopsychiatry: A marriage of convenience. *Liberatory psychiatry: Philosophy, politics and mental health*, *9*, 235-256.

National Institute of Mental Health. (1990). *Clinical training in serious mental illness* (DHHS Publication No. ADM 90-1679). Washington, DC: U.S. Government Printing Office.

Nevo, I., & Slonim-Nevo, V. (2011). The myth of evidence-based practice: Towards evidence-informed practice. *British Journal of Social Work*, *41*(6), 1176-1197.

Poole, J., Jivraj, T., Arslanian, A., Bellows, K., Chiasson, S., Hakimy, H., ... & Reid, J. (2012). Sanism,'mental health'and social work/education: A review and call to action. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*, *1*(1), 20-36.

Sadler, P. (2015, November). Systems Implications of Parachute NYC-Back to the future: Moving to Home and Community Based Services. In *143rd APHA Annual Meeting and Exposition (October 31-November 4, 2015)*. APHA.

Salzer, M. S., Schwenk, E., & Brusilovskiy, E. (2010). Certified peer specialist roles and activities: Results from a national survey. *Psychiatric Services*,*61*(5), 520-523.

Seikkula, J. (2008). Inner and outer voices in the present moment of family and network therapy. *Journal of Family Therapy*, *30*(4), 478-491.

Solis, R., & Union, S. P. W. (1997). Jemez Principles for democratic organizing. *SouthWest Organizing Project. April*.

Teghtsoonian, K. (2009). Depression and mental health in neoliberal times: A critical analysis of policy and discourse. *Social Science & Medicine*, *69*(1), 28-35.

The City of New York. (2015). ThriveNYC: A Mental Health Roadmap for All. New York. nyc.govthriveNYC

Tolliver, W. F., Hadden, B. R., Snowden, F., & Brown-Manning, R. (2016). Police killings of unarmed Black people: Centering race and racism in human behavior and the social environment content. *Journal of Human Behavior in the Social Environment*, *26*(3-4), 279-286.

The Icarus Project . (2016, August, 6) Mission, Vision and Principles
http://theicarusproject.net/about-us/icarus-project-mission-statement

The Movement For Black Lives (2016, Aug 6) A Vision For Black Lives: Policy Demands For Black Freedom, Power and Justice. Retrieved from: https://policy.m4bl.org/

Thomas, P., Bracken, P., Cutler, P., Hayward, R., May, R., & Yasmeen, S. (2005). Challenging the globalisation of biomedical psychiatry. *Journal of Public Mental Health*, *4*(3), 23-32.

Herman, J. L. (1997). *Trauma and recovery* (Vol. 551). Basic books.

Horwitz, A. V., & Wakefield, J. C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. Oxford University Press.

Ostrow, L., & Adams, N. (2012). Recovery in the USA: From politics to peer support. *International Review of Psychiatry*, *24*(1), 70-78.

Pernice-Duca, F. M. (2010). Staff and Member Perceptions of the Clubhouse Environment. *Administration and Policy in Mental Health and Mental Health Services Research*, *37*(4), 345-356.

Seikkula (2008). Inner and Outer: Family and Network Therapy. Journal of Family Therapy, 30: 478–491

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric rehabilitation journal*,*27*(4), 392.

The City of New York. (2015). ThriveNYC: A Mental Health Roadmap for All. New York. nyc.govthriveNYC

Turner, J. C., & TenHoor, W. J. (1978). The NIMH Community Support Program: Pilot Approach to a Needed Social Reform*. *Schizophrenia Bulletin*, *4*(3), 319-349.

Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: A metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal*, *36*(1), 28.

Western Mass Peer Network, 2014. Declaration of Peer Roles.
Retrieved from:
http://www.westernmassrlc.org/images/stories/Declaration_of_Peer_Roles_2014.pdf

Western Mass Recovery Learning Community. (2016, August, 6). Our defining principles. Retrieved from**: http://www.westernmassrlc.org/defining-principles**

Whitaker, R. (2010). *Anatomy of an epidemic*. New York.

Appendix A: Voices from the Parachute Manhattan Mobile Treatment Team

Appendix A Instrument

Interview questions:

1. What is the role of the Parachute Mobile Treatment Team? What does the team do?

2. What's your role on the team?

3. How would you define a "successful intervention" in the field? Can you share an example of a successful intervention you've participated in as part of this team?

4. What are the roles of a peer on the team?

5. What are the roles of a clinician on the team?

(Are their interventions that can't be provided by people who don't have lived experience of mental health issues?)

(Do peers and clinicians have different boundaries in their roles related to personal disclosure and confidentiality?)

6. Please share an example about when the collaboration between peers and clinicians has worked really well.

7. Please share an example about when the collaboration between peers and clinicians hasn't worked as well as it could.

8. How do you feel the Needs Adapted Treatment Model training has affected the relationship between peers and clinicians on this team?

9. How do you feel the Intentional Peer Support training has affected the relationship between peers and clinicians on this team?

11/23/15

Visiting Nurse Service of New York
Community Mental Health Services
1250 Broadway
New York, NY 10001
www.vnsny.org
212.609.7799

To Whom It May Concern:

I am aware that Sascha Altman DuBrul is conducting a research study for his MSW class at Hunter College. Sascha Altman DuBrul is working as an intern at VNSNY on the Parachute Mobile Treatment Team. This study focuses specifically on the relationships between peers and clinicians on the Parachute Treatment Team and how they view success in a clinical context. Sascha has shared with me the details of his project. Sascha will be interviewing four members of the team and writing up a qualitative analysis for his school report.

I give him permission to conduct his study at our agency. VNSNY requests the agency name and identifiers of its clients be kept completely confidential in the research results.

Sincerely,

James Mills, LCSW

Program Manager

Parachute Treatment Team

Visiting Nurse Service of New York

148 West 125th Street, 4th Floor

T: 212-609-1843

Voices From the Team

What's the Parachute Manhattan Mobile Treatment Team?

Clinician1:
The Parachute Mobile Treatment Team provides psychiatric care to people in the community utilizing the NATM also known as Open Dialogue, a dialogical practice that involves at least two staff members being assigned to each case and that staff can be either a social worker and a peer, we have social workers, peers, and a psychiatrist and a family therapist. We try to provide treatment to people to keep them in the community.

Peer1:
I really think of the team as a communication tool for families when they're talking over each other and at each other. I think the team allows families to slow down, hear each other, give voice t those who don't normally get to voice their opinion, to give voice to our participants and allow them to hear each other in a different way for the first time.

Clinician2:
We're a mobile team, in that we go to people's homes, or they come to us, and it's a family, or network intervention for people who are experiencing psychosis. The linchpin of the work is something called Network Meetings where we meet with at least two people from our team and the identified person experiencing psychosis, and their network. We meet with them and in a particular style of working and we try to have a conversation about what the person's going through. We come in without an agenda or a set of idea of what needs to happen and with the perspective that by facilitating dialogue the network itself will find its own answers to the problems they are encountering.

Peer2:
Our role is to be with people while they are experiencing emotional or other types of crises. We work in a way called Needs Adapted Treatment and that's infused in our way of thinking and training with Open Dialogue work. It's not so much a model as a way of being. So the mental health/behavioral health intervention is dialogue. It's not a particular service plan or a number of sessions or a goal or an achievement of a goal or a medication. It can be all of those things but our main intervention is talking.

What's your role on the team?

Peer1:
Peer1: I don't have a degree or a license but I have my NATM and IPS training and I think I use my personal experience and my history. I have a brother whose been

diagnosed with all kinds of things from schizophrenia to schizoaffective to bipolar…psychosis with bipolar disorder, all types of stuff. Plus I have my own stuff and I see the dynamics lingering in my own family, I'm able to bring that with me and relate to people in a different way.

I think of my work not really as a friendship with my people, because there's a power differential there, but I think of it as a partnership with our participants, I think of it as therapeutic, I think of it as being an ally, I think of it as mutually sharing with each other. I grow with them. They don't grow alone in it. It's something we experience together.

Peer2: Some would feel like our role is to do specifically peer work, like Intentional Peer Support on a one-on-one way. Others might see us as full clinical elements of the team, our expertise being lived experience. So I see myself as a change agent, I see myself as a provocateur, being called upon to push boundaries, change boundaries if I can.

Clinician1: I am the manager of the program so I am a social worker by training and a manger by…default? (laughs) No, by experience.

Clinician2: I'm the psychiatrist on the team so I kind of represent the medical perspective. I think of it as in additional to the responsibilities of all the team members when we have a network meeting or any interaction with the client, those responsibilities of expanding the dialogue and exploring what's going on and what someone's experience is, I have this additional responsibility to address medical needs, consider the impact of medical issues on the person, and then to prescribe medications if they are seen as something useful. And to facilitate conversations about medications.

What does a successful intervention look like?

Peer1: I think a successful intervention is best done when it's a collaboration. Not only with the team but with the family. You know, sometimes the team ends up reflecting the family dynamic: when the family is disorganized sometimes the team ends up split and disorganized.

Our model is really good for working with people having their first break of psychosis because we give a lot of space for interpretation - we don't rush in with a diagnosis.

Peer2: Success is about the team coming together and knowing our different roles and collaborating together to get things right.

Clinician1: Sure. Um, a successful intervention would be, it really varies. It could be taking someone who is unstable in the community, stabilizing them through

network meetings, probably medication, and direct care with a social worker and a peer on a one on one in addition to network meetings in a way that prevents that person from a. going to the hospital or b. having a long painful episode of illness for lack of a better term. The last piece is to help people return to the life that they've had. And the other idea would be for people coming off of an inpatient admission to maintain stability, to transition back to the community and back to their life through the same means. We only offer what we offer: network meetings, dialogicial practice is the network meeting, direct peer support, direct social work support, and psychiatry.

It will be part of the learning process for her. Or she'll be fine and either way it's a win. It's not a win of she gets readmitted but if she comes back out with a better understanding of what's happening.

The Longer Vision – Clinician 2
I think this work takes into account the potential for short sightedness. For example a hospitalization can leave you feeling like a failure and I think this work tries to take into account the longer vision that an experience at the hospital might open up opportunities for further movement and more difficult discussion to happen. Maybe the network will mobilize for them coming out of the hospital will create something different than what was there before they landed in the hospital. So it might seem like a 'ding' on our numbers in the short term but in the long term it might be the turning point, we don't know. So there's a little bit of "faith in the model" (smiles) that's required on our team but the model pushes for the idea that if we're invited back (to meet with the client and the family) that's a success. And on the more micro level saying that if our utterances and comments open the space for new things being said, that's also on the micro level a success.

So on that micro level one example that comes to mind is with a client who's mother does a lot of the talking and the client has an experience of hearing voices so we check in with the client and ask the mother to hold back for a second and we ask the client what is it that you're hearing and he went into talking about it. And then it came up that he had never talked about it with his mother, he's never shared what he hears or what it's like for him to hear voices. She had the sense that something was wrong and he was struggling but their dynamic was such that she didn't do a lot of listening and he didn't do a lot of talking. So we facilitated that new thing being said and heard.

What are the roles of a peer on the team?

We're Experts by Experience - Peer1:
I think the peers are allowed to get a little more personal because we're able to disclose in a different way. But really in a meaningful way, not like: "You think that's fucked up? THIS is fucked up! It's not a contest." (laughs) It's more like: " I don't know if it's like this for you but I had a similar thing where this happened to me…" I

can share a little bit of myself and maybe they'll be like: "I never thought about that." or "That's it!"
So we're experts by experience and it's different, right? I myself am going to school right now to be a clinician so I can sit there and be like this is the theory of it all and blah blah but when you lives this, when you think you're gonna tell me about me? But I know it, I get it, I go to therapy, I take medication, I think it's just a different way to relate, they're like my peer!

Peer2: As I understand it we are supposed to express what might be thought of as the personal experience perspective. To try to utilize our personal experiences and/or share parts of our personal experiences, hopefully in a strategic way that might lend itself to connection and engagement, to understanding in a different way than in the clinical way.

Clinician1: Peers on the team are fully integrated members of the team. The only thing I don't expect from them is to write descriptions: participate in network meetings, to give direct care to clients, like it does to social workers, in all levels of program…Well it's funny because I know there's such a stigma against escorting peers to appointments. It's 1 on 1, the idea of Intentional Peer Support, I think of A meeting individually with a few of his people – ranging from art therapy for going out to a bite to eat, to kind of chasing often people, to sitting and listening, and S taking people to kickboxing classes, to Zumba classes, to poetry readings, but also they get their blood drawn if needed or just to sit and talk to them, much as I would expect any of the social workers on the team to do as well.

Useful Division of Labor - Clinician2
Functionally what tends to happen is the peer will help to be the voices of the client, especially when the client isn't able to express what they're going through for whatever reason. And so by being very attuned to what the client is saying or their behavior they can introduce what it might be like to be in the client's position, which really shakes things up…the other clinicians on the team have a fundamental belief in empathy and putting ourselves in the other person's shoes and considering what they're going through, but I think that practically speaking the other constraints or responsibilities pull on our attention and whatever our training is, it only allows us to be able to do so much, whereas the peer being there in those meetings can really allow us to focus on that role. So a division of labor that becomes very useful. We want that client's perspective voiced and oftentimes a peer will play a role in the network meeting to give a voice to a client. Outside of network meetings a peer will sometimes meet with the client - if someone's reluctant to meet with a psychiatrist or a social worker. Often it happens that the peer interaction is something that the client is more open to. Sometimes it's the reverse so its very versatile to have clinicians and peers on the same team because sometimes people don't think of themselves as being in the same position as a peer so they don't want to meet someone with "lived experience" they want to meet with "a doctor" or a social worker.

And to speak from their own experience adds this thing that nobody else could really be as validating what the client might be going through, it just has a different effect and than even a clinician disclosure. It's just a different thing.

What are the roles of a clinician on the team?
Peer1: When I think about clinicians I think about them having that therapeutic space to be able to talk at them and they can reflect back to you and help you sort out stuff. In this model it even allows the clinicians to be even more, like IPS and NATM, it allows them to be more personal, it changes them because usually they have to be much more guarded but here it's okay for a clinician to disclose a little bit, a little piece. I think clinicians offer so much knowledge and information, the theory that they study in school to prepare them to do the work and facilitate and do those different things. There certain things they can do that I can't do, and I really acknowledge that piece.
Sometimes I think the clinicians don't get to go as deep as they want to. Something that they could share is not going to be as profound as something that a peer could share – they don't get to have that opportunity to share. And they could be peers from lived experience but their role doesn't allow them to use that experience as much as they might want to. Because once you go in there to meet it's like "that's the clinician", "they have the power". But it's alright cause it allows the peer to come in and be like: I got this. In this model it allows the peer to be able to share more and go deeper because it's actually our job to utilize that personal space.

(Do peers and clinicians have different boundaries in their roles related to personal disclosure and confidentiality?)

I think so. Even for me there's a level I don't cross. I only use my story or different pieces of my life when it's necessary for them. There's a lot of stuff I don't share but I'll do it to empathize, to connect with them. It might be different experiences but similar feelings, or similiar experiences but different feelings and then we can ask "well why did you feel that way?" Peers have to be willing to share, we can't not disclose. If you're sitting there not disclosing then how effective are you at being a peer, what are siting there doing? When we're there the clinicians have the safe space in a sense to be able to I have my partner here to share, and we can facilitate the conversation together 13:46 When I'm meeting with a participant and a clinician it's hard for me to do peer work. It has to be like one I one, I can't do it with a clinician in the room with me. So usually when there's a clinician and a peer it's more oriented to the clinician doing the work and maybe me sharing a little, but that one on one peer work, when they want to get into stuff, they do act differently when they're alone with me, they do share differently, more openly, more trustingly. I'll let the team know: they were having these feelings, I'm honest with them.

Clinician1: Same thing. Participate in network meetings, meet directly one on one, manage the case, I guess for the clinicians on the case I do have a higher expectation

of someone being accountable for all aspects of the care, which is nonsense truthfully because I don't even do that. I expect the psychiatrist to be up on the psychiatric piece, I expect the social workers to know the case and if they have a case…If I have a case, I'm a social worker, I'm a clinician and S sees my woman "J" and I pretty much turned her over to her and I check in with S and periodically ask: "Hey, how's she doing? Does she need to see me? Alright I'll go see her. Does she need to see (the psychiatrist)? Okay, lets set up an appointment. And there's not any real heavy lifting on that case, it's a shared process.

S: Okay, the follow up up question is: "Are there interventions that can't be provided by people who don't have lived experience of mental health issues."

J: Hmm…A transport to the hospital. I wouldn't ask someone to do that. That's a pretty drastic step. They can certainly provide 1 one 1 therapy with air quotes up on "therapy." What is therapy? What is counseling? What is psychodynamic? What is person centered? What is psychoanalytic? I've taken the Intentional Peer Support (IPS) training, that's the peers framework, and there's a little more self-disclosure than there would be in therapy from a social work school framework, but at the same time it's about connection, engagement, and moving the person forward with conversation whatever that means.

S: It's interesting because I think you heard the question inverted. What I read to you was: Are there interventions that **can't** be provided by people who don't have lived experience of mental health issues? In other words: are there hings that peers can do which non-peers cannot?

Clinician: It really depends on the specific clinicians or the specific peer. "Neither A (a social worker) nor B (a peer) can say that they've heard voices. C can. I can't. A (a social worker) and D (a peer) can't say they're alcoholics, B (a peer) and I (a social worker) can. So where we use our personal experience and lived experience if you will and how we disclose that is really person dependent."

Clinician1: Depends who you ask. Some peers have very poor boundaries, this is something that's come up but hasn't on our team. And to be truthful some social workers have very poor boundaries, some peers have too rigid boundaries, and some clinicians and specifically psychiatrists have too rigid boundaries. So, no, I think it's always an issue of supervision and training and that can be by your collegues if you're a peer, and of course peers can be just as aware if poor boundaries are coming up as I would be if one of my clients are having poor boundaries.

All of this is in flux , we're still figuring out how we do this and what the differences and expectations are because it had been the case that the clinician's responsibilities were to kind of be the "captain" or the "quarterback" of the case and the peer would be a player who would get pulled in or out. I think as things have evolved, and this is

also representative of how we do the board (explain) and represent which clinician or peer is most responsible on a given case, now the peers who have certain clients for whom they are the most active contact person from the team. **And I think that's in line with this model where we all have different things to bring to the table between clinicians and peers but that there's not a hierarchy, that someone has something that's more important.** We're individuals who bring different strengths and then it sort of shakes out with different clients.

Clinician2: So there is this issue in terms of styles and boundaries and I think the clinicians have some training and maybe liability issues, a different approach than some of the peers. For instance, I'm never really going to go to a kickboxing class with a client (laughs.) That would never happen except by coincidence that we both ended up at the same class. And that's in the range of possibility for a peer on our team, which has turned out to be a really positive experience for the client. This is uncharted territory for us.

In terms of liability, from my training I'm taught: if you're the MD and someone files a lawsuit yours is the degree that's going to get targeted for anything that goes wrong. That's our litigious society, that's not anyone on the team's responsibility or fault. I see it as a fact to weigh and consider and it shapes my view.

Clinician2:Just to reiterate: even if I've had experiences, even if I've been in deep depression, even if I've had a manic or psychotic experience, my title is psychiatrist so my sense is that my title is going to trump anything I disclose, or if I do disclose that might really tarnish the relationship between the client and me.
For me being a patient, I want to be able to see my psychiatrist or therapist as someone who I don't have to take care of, and something happens differently with a peer. It's not that I think the client has a feeling that they need to take care of a peer, but it's the peers job to have had the lived experience – they're actually performing their job when they disclose: "yeah, when EMS picked me up and I was totally off the wall…" that's totally part and parcel of the work. And even if I had experienced the same thing it's going to be more of an obstacle for the work we need to do to together, kind of a boundary violation for me to say it as opposed to a peer, by virtue of our titles.

When the collaboration is working well.

Peer1: There was a point where we had a woman who had mobility issues and the family had their own home and was living in her one bedroom apartment and they wouldn't leave and because they'd say "she's gonna have a psychiatric meltdown" and she said she'd be fine. I remember saying "It hurts to hear her being spoken about like that. I wonder how it feels for her to hear you talking about her like this." We were having networking meetings every week and the parents were there and even the home health aid was there and then a year after working with her she's been living on her own for a year.

Peer2: There have been so many of those moments where we walked out of a network meeting saying to ourselves: "Wow that was so amazing!" But it's hard to think of one, I'll go with the most recent one. Three of us on the team and one of us as an individual. Person seemingly angry, very concerned about the side effects of medication they were prescribed in the hospital, had done a lot of research on the medications and the side effects and was pretty focused on the fact that he could die from taking them. And basically the person came in with an overall uncooperative hostile feel and after we had been meeting for maybe about an hour I just finally took over so I was facing the gentleman. I said, listen: "I don't always want to put on clothing to go out of the house but it's sort of something I have to do to get through the day, those are the rules expected of me. Sometimes medications are the same way, sometimes they're not. But what I can tell you is that this: (Clinician2 the psychiatrist) is a doctor right here that does not overprescribe medications and I can tell you for a fact that this is a doctor that prefers to see people on the lowest amount of medication possible and I have been present first hand when I have watched him lower medications for people and that is generally always his goal. I really took a borderline aggressive stance that "you're not going to mess with our psychiatrist, this guy is one of the good ones." And I think it was interesting because it was a very intense meeting, very sort of "who knows how this is going to go? I don't even know I this person is going to be able to sit through a meeting." We all tolerated 90 minutes of everything you can think of and that's when I think it works really well. **I think sometimes the peer in the room can do stuff that's a little different than the clinician because of the standards of being a doctor. There are just standards and accepted behaviors, I feel like one of the truly valuable things about being a peer specialist, up until this point, is that we have a more latitude.**

Clinician1: Collaboration with peers when it goes well, it's funny but I think about the parents more than the clients. I think clients are usually suspicious, at least the experiences I've had, the people are more suspicious who identify as peers. These are people who feel resistant. "Oh you're the peer, you're the person I'm supposed to connect with. I get it. Beat it." But I think of "A"'s parents,
I think of a bunch of parents in the past who would look at the peers on the team and say "you've been in the hospital like my son has? Do you have a partner? You're married? You work?" So the power was really giving hope back to the network that was supporting this person who they were getting ready to write off or who they were in their own way grieving a son or daughter they'd lost to an illness.

Please share an example about when the collaboration between peers and clinicians hasn't worked as well as it could.

Peer1: Sometimes there's miscommunication. Sometimes there's a sense of hierarchy. Sometimes there are blurred lines. There could be two clinicians on a case and one person's asking me to make clinical decisions and I don't want that

responsibility – that's not what I come in here for. You're the clinician don't put that on me! Another clinician they want to make all those decisions. People have different ways of working on the team. Part of my job is to remember: you provide a service, I provide a service. 18:30 We're all pieces of the meal, you know? You need the starch, the protein, and you need the vegetables. It's not like you're the dessert and you're better or I'm the appetizer and you're the main course, we're all part of the main course and it gets messed up when someone says "well I'm the most important part of the meal, not you. Or deciding who's going to get peer support when the person is clear that they want peer support "I'll talk to them about it if they want peer support or not" but they already told me they wanted peer support. I should be able to come in independently and be like "You want peer support? Alright I got you, lets make this work…" It really creates strife sometimes because the team will be so pulled apart and we can't collaborate. Sometimes the family is reflecting the teams work. The family's not getting along and the participant is here and the family's over here and the therapist might be with the family member and the peer might be with the participant and we're reflecting the same thing and it's like "oh shit! Are we not aware that we're reflecting the family turmoil? Lets pull our shit together. It's all about talking about it and this work is all about us talking about it and having the space to talk about it. I'm able to say: "No I don't like that this is happening and I need us to be together"

Peer2: And the point that was made to me afterwards by people working on the mobile crisis teams was that you have to have some kind of working relationship with the police. And I feel like I totally understand that but I also understand that there's more of us, mentally ill people, being killed by police then we are killing police officers.

Clinician1: Frankly, peers have the power to call bullshit in a way that wouldn't be appropriate for a social workers. As a peer they can push more and saying things to clients about taking responsibility for themselves. If it's done at the right time it's great, if done at the wrong time you lose the person. How do you know when it's the wrong time? When to use the velvet touch and when to use the hammer? It's an experiential thing and you get better at it over time.

The way people end up being serviced by the Parachute team are not folks who were compliant with treatment, they're people who ran in the opposite in direction.

I think it brought up a lot for team and there was a bit of a split along the lines between the clinicians and the peers. The peers feeling that the team had sort of neglected the client. The clinicians seeing that the mom, who was very reactive to the client, needed support, and the family therapist was the right person to provide that support in the moment. So I think it was meaning that the peers were seeing it one way and the clinicians were seeing it the other way. Because I think the peers could relate to the client and the idea of being neglected by the family and the treatment team. And you know, I'm on one side

of it and at the time I thought that the peers critique didn't actually describe the client's experience as much as what the peers were bringing to it. I've got my blind spots too so this is fair game for discussion with the team but how we deploy our resources with a family and how that shakes out sometimes looks different depending on our perspectives.

How do you feel the Needs Adapted Treatment Model training has affected the relationship between peers and clinicians on this team?

Peer1: I think the NATM and IPS trainings definitely brought us closer together. So many days of training! At some point I was so tired of going to DOHMH! This room gives me a headache I hate it! But I always looked forward to seeing the other peers and the other clinicians, to be with a bunch of other people who get it! There was something really special about being with people who understood and appreciated the importance of peers. Yeah they do this overseas too but we're gonna bring peers into it here. In NYC this is the standard: we have peers on our team. And I think it allowed us to share our feelings about clinicians but also for clinicians to show us how they really are and for us to not be so judgmental to them and under stand they we're all human. So I think it allowed us to be human and relate to each other differently and understand we all have a piece here. Peers and clinicians can work together.

Peer2: I think it would be an okay thing for a non-peer to say "You know I'm having a hard time working with all these people who have lived experience all the time. Having to check my language and having to feel uptight about things." I think these are important conversations to have. I came to this team knowing this was a mixed team. It was only later that I realized this was a group of people that were just told they were going to be doing this. That made a big difference to me, it helped me understand them in a different way. Gosh they didn't really sign up for this either, we're all making the best of it .
:Well I do think we've been building a momentum and a respect for one another and a respect for ourselves where we're getting to the point where we say things like: "That's amazing you did that, I never would have thought of it. But there's also a lot of working collaboratively and three of us or two of us going into somebody's home and doing a meeting with them and we feel like we're being watched because working collaboratively we are all watching each other. That doesn't mean it's a bad thing, but it's a different way of working for all of us. I think it has made us all more self conscious and a less self reflexive in our work, but as I think we're getting better and mode comfortable that's gelling. I've seen Collaborating not just with colleagues but with the people we're working with. Asking the clients what they need. Starting to think someone doesn't need to go to the hospital immediately. For some of us that's always going to be a reflex: increase of symptoms – this person needs to go to the hospital, but more and more people saying: maybe not, maybe the respite,

maybe we can visit more frequently, that's very big. We all want shift and change faster but those are.

Clinician1: It's hugely important because it really models the goal of this project which is peer/clinician collaboration. Non-hierarchical work. We are not Jay and the psychiatrist and the social workers where the peers do what the social workers say which is how a traditional program would function. We function with pushback and true transparent collaboration the majority of the time. I'm not gonna lie and say I don't put my foot down about things, particularly if I feel it is for the greater good. Hurt feelings and pushback, that's okay, that's how a team learns. I have to be able to take feedback. In the meeting today there was a good example: There was a question of whether our Nurse Practitioner student could go see a client and (one of the peers) wanted to ask the client beforehand. The idea was to call to see if it would be okay and (the peer) said "Well of course he's gonna say yes. He's a patient. He's got no choices, the psychiatrist calls to ask him a question of course he wouldn't feel comfortable saying no. There was eye-rolling but she had a good point. I don't know if we decided which way to go. (A clinician) agreed with her and I agreed with her but I also know that if I didn't bring students on visits they would never happen. But the decision making process is much more horizontal. I feel that way. I tell everyone: you let me know if I'm doing a bad job, alright? And they say: "no, we won't tell you." But they tell me in non-verbal ways – the wacky expressions and the body language, or the general avoidance! There's space in this program to talk it through.

Clinicians2: I think this idea of being non-hierarchical even though these titles and positions and pay grades these things are all realities we are aware of
I think there is a reality to some things: I have an office, other people have cubicles. There are those factors that play out in our dynamics that I'm aware of and not aware of at times I'm sure. But I think, and this is thanks to the kind of leadership and culture that's been maintained on the team, is that I think all the clinicians and peers feel empowered if they feel something or see something that's not right on a case, or even in terms of our internal dynamics on the team those things can be heard if someone feels like their voice wasn't listened to

How do you feel the Intentional Peer Support training has affected the relationship between peers and clinicians on this team?

Peer1: We get to have the clinicians do their piece and be really strong in their areas and then the IPS part allows the clinicians to appreciate what peers do and maybe take pieces of the principles and apply it to their own work. No one's better in the other and we can come together. It leveled the playing field and that is really important. And I think a lot of the work that I do is really important to the people we work with.

Peer2:I would venture to guess that much of what we're suppose to be learning as peers are things that we already know and that it would be useful for our non-peer colleagues to be learning.

Clinician1: It was initially very hard because it made us feel like the enemies of the peers, it definitely felt like an "us and them" kind of thing, that there was a benefit of being peers that clinicians couldn't have or ever understand. And it was hard. But as that has all faded and people can objectively look at the principles of IPS - the four: World View, Mutuality, Connection…and some other that I can't… Togetherness? I don't remember. But it's all consistent with what we do so there wasn't…we thought it was good. I think it was good because it gives a framework. For example, I went to the Gestalt Institute, you go to an institute, you're going to get that framework to work from. If you go to Freudian, or Family Therapy, you'll get that framework. Just language. The concepts are often so similar that it's just different language for the same concepts because the goal is always to connect with the person, understand their world view, and help them move through it.

SO I think it was good to know there was a systematic training and framework for peers to work under and for clinicians to go there and see that it was demystifying. I know what a WRAP plan is in theory but I don't know if I've ever seem one done or enacted well. And that is not the model we chose to follow, we chose to follow Intentional Peer Support.

even just it's presence is powerful…Even just having that acronym as something that gets thrown around I think it gives additional weight to the presence of the role of the peers as a unique intervention and that's part of how this team operates. I was at another clinic where they had a peer around but it wasn't actually clear what that meant as an approach. To link it to a tangible approach and have our interventions grounded in NATM and IPS it gives us a power as a team that we surely wouldn't have otherwise.

It is interesting to note that by all accounts including his own, the manager of the Manhattan Mobile Treatment Team was incredibly skeptical and even by some descriptions combative when originally introduced to the NATM/Open Dialogue and IPS practices and language because it so went against his training as the head of a mobile crisis team. That he has become the head of arguably the most effective and well functioning Parachute team might say something not just about his character but of the potential for other's to change and evolve.

Appendix B

This is a working draft of a grant proposal new program I am helping to develop with a creative group of peers and clinicians in New York City

Proposal: Seed Grant for the Institute for the Human Arts

Who We Are:
We are mental health professionals, psychiatric survivors, ex-patients, and members of some of the communities most in need of transformative models of mental health recovery.

What We Propose:
We propose the formation of an institute through which these ideas may be developed, practiced, and spread. The Institute for Human Arts will be a space bringing together experienced and aspiring practitioners of transformative mental health care, both within and outside of the mental health system. Many of these practitioners will themselves be members of highly impacted communities, psychiatric survivors, ex-patients, and others with direct experience of the struggles we are working to address. These in-person courses taking place in New York City will model the principals described above, breaking down hierarchies and valuing lived experience as highly as professional training. These courses will equip participants to deepen and create their own communities of practice around transformative mental heath care wherever they may be.

Our Principals:

Center the Most Marginalized: By centering the most marginalized, we begin to craft antidotes to all the forms of ill-health made manifest in a society based on war, impoverishment, exploitation, racism, hetero-sexism, and colonialism. By supporting those most impacted in their healing process, their pain can be transformed into a powerful force for transforming our entire society.

Holistic Transformation: We believe in the human ability to transform and heal through self-awareness, supportive communities, holistic care, and reclamation of personal and collective agency. We also believe that lasting healing and transformation happens simultaneously at all levels: in our selves, our communities, and our society at large.

Intersectionality: We strive to illuminate the connections between oppressions along the lines of race, gender, class, sexuality, ability, nationality, and others, and individual experiences of mental health. We believe that these connections must be unraveled and understood in order for healing to occur at the deepest levels.

Nothing About Us Without Us: Each individual is an expert in their own experience and must have the agency to represent themselves in their mental health care and in general.

Self-Determination: Each individual, to the extent possible, must have agency in the ways in which their experience is described, understood, and addressed. People may or may not subscribe to diagnostic categories and may or may not take pharmaceuticals. It is up to them.

Health is A Continuum: We do not see mental health care as a stigmatized practice to be undertaken only among those labeled "extreme". Rather, we recognize that in a fundamentally unhealthy society, transformative recovery and mental health care must be practiced in all communities among all people, in all ways, as a part of daily life.

Healing is a Creative Act: There is no need for mental health care to be sterile, punitive, or oppressive in any way. Rather, caring for ourselves and one another is a deeply creative practice which affords us the opportunity to reinvent our relationships to our experiences, our bodies, our past, present, and future, and one another.

Equalizing Access: We recognize that access to quality mental health care is not equal across society. Therefore we work to promote access to our offerings through financial scholarships, access for people with disabilities, and through our outreach methods.

Internal Principals:

Transparency: We share all necessary information with one another regarding our work through the Institute. Decision-making processes are clear and designed to maximize democratic participation.

Equalizing Power and Resources: We share our access to different forms of power for the benefit of the project, and leverage resources to promote leadership of those with least access to institutional power.

Building Trust and Cultivating Healthy Relationships: This is a long term project we all have reasons to be deeply invested in, and we know that it's imperative to build trust and camaraderie as members of a core collective incubating the Institute.

Commitment to Self-Care and Personal Transformation: Our work to promote transformative care for others can only be as successful as the care we can provide for ourselves. We are all continually learning and growing as we bring our full selves to this work.

Modeling Our Values: Our work will only embody our values to the extent that we are able to model them on a daily basis. Therefore working to combat all oppressions and inequities is a daily practice for us and not mere words on paper.

Our Method:

Phase One: Research and Organizational Development

Phase One of incubating the Institute for Human Arts involves research. Through a series of 20 one-on-one interviews with key stakeholders in our wider community, we will gather input on the best possible ways to organize the Institute. This is essential in order to enact our principals of *Center the Most Marginalized, Nothing About us Without Us,* and *Healing Is a Creative Act.* We do not presume to have all the answers, but rather seek to find wisdom by speaking with people representing various communities and practices we center in our work. Through Fall and Winter 2016, we will gather, code, and interpret input from key stakeholders, using this information to expand our vision and shape our work. We will also be doing grantwriting and fundraising at this time.

Phase Two: Faculty Recruitment and Curriculum Development

Phase Two will entail reaching out to and hiring faculty members based on the themes and priorities uncovered during Phase One. We will then work with this faculty to develop their unique curricula to be taught at the Institute. Also during this phase, we will secure physical space and other necessary resources for our launch. We plan to organize a few small cultural and educational events at this time to generate interest in the Institute. This phase will span Spring and Summer 2017.

Phase Three: Launching the Institute

Phase Three will be the launch of the Institute in Fall 2017. The beginning of our courses will be welcomed with a special celebratory event.