The Role of Peer Support & Harm Reduction in Integrated Care

Disclaimer:

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Learning Objectives:

LO1: *Identify three ways that systemic injustices impede mental health and wellness*

LO2: *Describe the role of harm reduction in peer support*

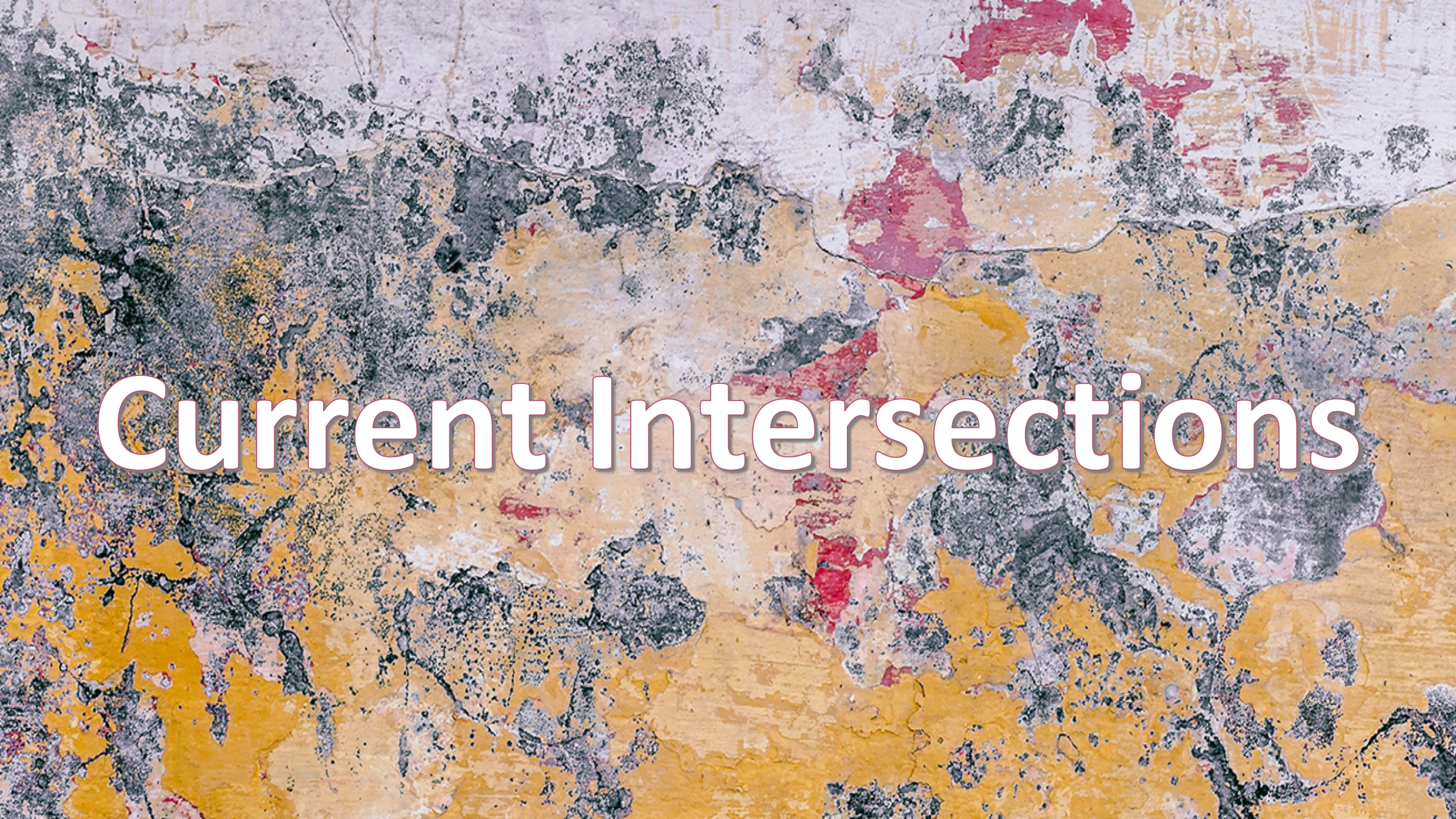
LO3: *Apply strategies for collaborating with peer supporters as an integrated behavioral health provider*

1. I am generally in charge of who I live with/sleep around	2. No one is routinely taking notes about what I do during my day and sharing them freely with others	3. I can get out in the sun or breathe fresh air pretty much whenever I want.
4. If I have a concern or complaint, I can typically expect that people will believe what I say and/or take me seriously	5. If I have a strong emotion, it's usually seen as valid (and not spoken of as a symptom or risk factor that is solved just by getting rid of the feeling)	6. I can reasonably expect that there aren't formal meetings that take place to discuss the details of my existence, especially without me present
7. I am consistently seen as a credible source for information about my own needs and wants	8. If I have a 'bad habit' (smoking, diet, etc.), it's unlikely that anyone's going to try to force me to stop it abruptly	9. When I tell people about my past, present, and future I generally get to tell it through my eyes and in my words
10. I have regular access to my cell phone, social media, and other ways to connect with people and learn about what's going on for my friends and family, or in the world	11. If I don't want to do something someone else thinks I should do, I can usually avoid doing it without them having power to force me or convince others I am bad or sick for not listening	12. I can reasonably expect that most important decisions will be mine to make, and that if others are involved it will usually be because I've chosen them to play a primary role (spouse, good friend, etc.

How did that make you feel?

A Sampling of Historical Intersections Between the Mental Health System & Systemic Injustice

- **Drapetomania**: In 1849, the Louisiana State Medical Convention selected Samuel Cartwright to chair a committee examining diseases in black people. On March 17, 1851, he reported back that he'd discovered Drapetomania, a disease in enslaved peoples that led to them running away. Amputation of toes was one of the 'treatments.' Dysaethesia Aethiopica appeared around the same time.
- **Homosexuality in the DSM**: Homosexuality appeared as a mental disorder in the Diagnostic and Statistical Manual in the second edition published in 1968. In 1972, it was removed based on a vote of 5,854 (for removal) to 3,810 (for retaining it). However, it was then replaced with 'sexual orientation disturbance' which was not removed until 1987. (It was not removed from the World Health Organizations International Classification of Disease until 1992.)
- **Psychiatry and the Holocaust**: During the Holocaust, the T4 program was established to eradicate disabled people, including those labeled with schizophrenia and other psychiatric disorders that were believed to be chronic. Up to 275,000 people with psychiatric diagnoses were believed to be murdered.
- **Trans People in the DSM**: In 1968, trans identities showed up as 'sexual deviations' in the Diagnostic and Statistical Manual. In 1980, it became a 'psychosexual disorder,' and in 1994 it was changed to 'sexual and gender identity disorders.' In what many see as a positive move, in 2013, the diagnosis was shifted to 'gender dysphoria.' Though many find this less stigmatizing, it remains the case that being trans remains connected to having a psychiatric diagnosis.
- **Women & Schizophrenia**: Before the 1960's, the group most commonly given the diagnosis of schizophrenia were white, middle class women who were not fulfilling their expected societal role. Their hospital charts commonly cited 'symptoms' such as not taking care of children or household chores as expected, embarrassing their husbands, and reading too much. This was a continuation of the reality that for many years, men were able to commit their wives to psychiatric facilities without question for a range of offenses including disagreeing about religious beliefs to wives' objections to their husbands' affairs with other women.
- **Black People & Schizophrenia**: In the 1960's, black men became most likely in the US to be given the diagnosis of schizophrenia, and it remains true that black and brown people are far more likely to be given what are seen as the most severe psychiatric diagnoses. This is also true in other countries. For example, a black man in England is 18 times more likely to be given a diagnosis of schizophrenia than a white man.


Current Intersections

HEARING VOICES

Beyond the Medical Model, featuring Mark Jones, Wildflower Alliance, 2012

Self-Injury

Honor Indigenous Cultures and Histories, TEDxMinneapolis, Featuring: Jill Fish

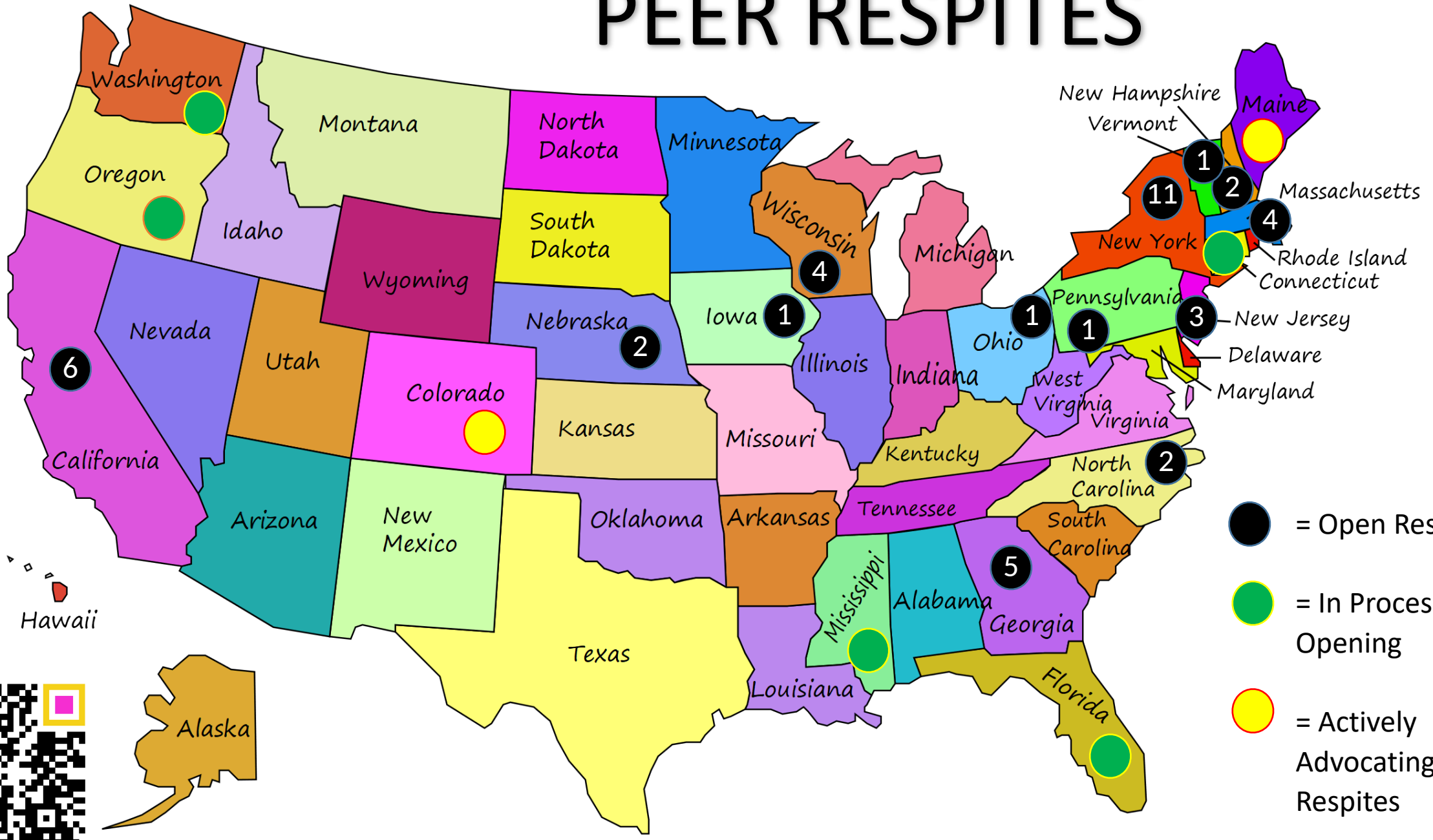
Lack of Self-Care (showering, etc.)

No You Cannot Touch My Hair, TEDxBristol, Featuring: Mena Fombo

Violence & Anger

And the Psych Ward Says, Anita Dias

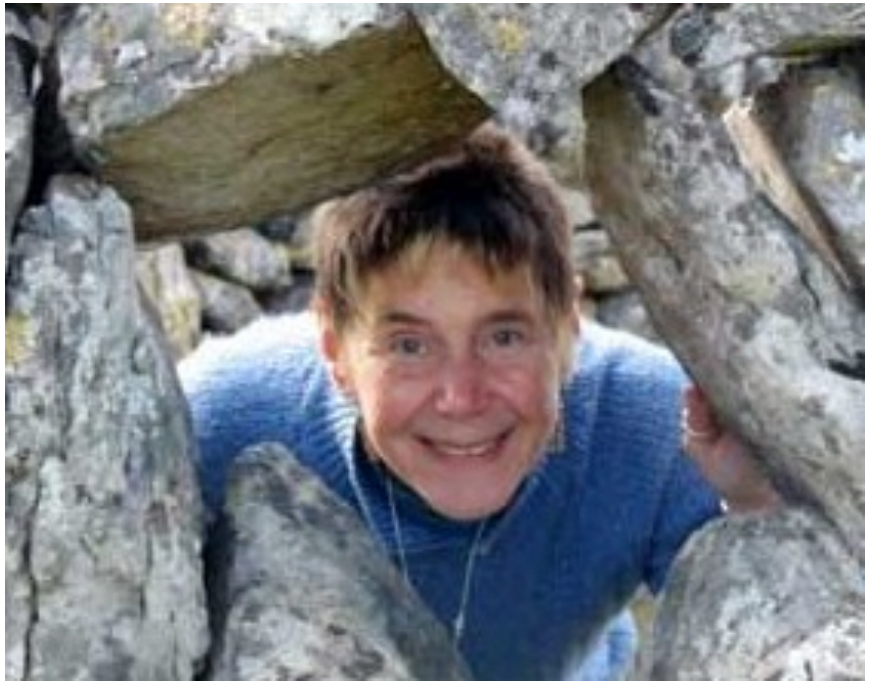
PEER RESPITES



Stepping Stone Peer Respite

“First” Peer Respite

New Hampshire, 1995



Shery Mead

The Unwritten History

- **Jennie was hospitalized in Central State Hospital in 1947**
- **She created the Zuni Federation for Mental Health in 1978**
- **It served as a ‘retreat’ for people with psychiatric histories**

Harm Reduction

The evolution of harm reduction can be traced back to various roots, including the AIDS crisis in the 1980s.

No matter what starting point we use, it's always been about Black, Brown, queer and other communities (sex workers, drug users, etc.) who have been treated by society as invisible or as scapegoats (including in their greatest moments of crisis) coming together to support one another to survive.

Harm Reduction V. *harm reduction*

A philosophy rooted in values and principles that focuses on supporting someone to reduce barriers to living their best life as they are rather than changing something about them.

Any effort to help reduce the harms of a particular system or situation; Most commonly used when it is not possible to create a sustainable shift to a different approach

For example…

Marcel has been hospitalized three times because his family gets scared that he's trying to kill himself whenever they catch him cutting. A peer supporter brainstorms with him about who he can talk to who won't be so reactive when he wants to talk about self-injury.

Marcel's family convinced crisis clinicians that he is a "danger to self" and needs to be hospitalized. A peer supporter goes to visit him right after he's admitted to the hospital to bring him some of his own clothes to wear because having to wear hospital clothing makes him feel vulnerable and increases his distress about being stuck there.

Harm Reduction

Harm reduction is the radical acceptance that someone doing or experiencing something **you perceive** as risky may choose to continue living in that way indefinitely (and even forever), while still supporting them to live a full life.

Even More Importantly…

It means letting go of the **power** to identify **WHAT** the problem is, **HOW** someone should respond to it, and **WHEN** or **IF** they should be working toward change while still being willing to walk alongside them as they figure things out, and helping them to clear their path of dangers along the way.

Harm Reduction Principles

1. **Acceptance rather than judgement & condemnation** *(Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them)*
2. **Includes whole spectrum of experiences & actions** *(Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others)*
3. **Prioritizes quality of life over stopping targeted action or experience** *(Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies)*
4. **Non-judgmental, non-coercive supports** *(Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm)*
5. **Centers voice of people who've lived it** *(Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them)*
6. **Uplifts personal agency & peer support** *(Affirms people who use drugs (PWUD) themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use)*
7. **Impact of social inequities & systemic oppression consistently recognized** *(Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm)*
8. **Doesn't ignore potential risks & losses** *(Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use)*

National Harm Reduction Coalition, harmreduction.org/about-us/principles-of-harm-reduction/

A Harm Reduction Approach…

EXPERIENCE	APPROACH
Hearing Voices	• Goal isn't necessarily to stop hearing voices • Open to exploring/mapping and similar experiences • Learn strategies like making appointment with voices, talking back to voices, etc.
Self-Injury	• Not seen as an emergency or 'crisis' unless truly life threatening (which is unusual) • Willing to explore resources on safer self-injury strategies • Explore whether or not the person wants to stop
Suicide	• Not seen as a medical emergency unless person has done something to put themself at medical risk • Explore reasons why someone wants to die • Use validation, curiosity, vulnerability, and community as primary approach • Aim is to support person to feel more power of/understanding of their suicidal thoughts, not to necessarily get them to go away • Understands that loss of power is often at the root of suicidal thoughts

But What is ‘Peer Support’?

Formal peer support is support offered by someone who’s ‘been there’ and who has been trained to use the wisdom gained from surviving to support others traveling a similar path. Focus on connection and minimization of power imbalances are primary.

PEER SUPPORT IS NOT…:	PEER SUPPORT IS…:
Advice giving	Sharing common experiences (including of loss of power and control at the hands of our systems)
Assessment	Exploring meaning
Treatment planning	Exploring resources
Carrying out a provider’s agenda	Supporting person to get heard/advocating with
Observing	Partnering to identify choices and possibilities
Diagnosing	Validating, connecting

A Peer Supporter Can Use a Harm Reduction Approach to…

EXPERIENCE	Interventions
Hearing Voices	• Ask questions like “Where have you heard that message before?”; “Does the voice sound like anyone in your life, past or present?”; Did something happen right before you started hearing that voice? • Explore strategies like pretending to talk to someone on your cell phone when responding to a voice; Setting an appointment with a voice for a later time • Advocate for deeper understanding with provider, family, etc.; Interrupt bias/assumptions
Self-Injury	• Ask questions like “When self-injury is working for you, what does working mean?”; “Is this something you want to stop or change?”; “Did something happen right before you started self-injuring?”; “How does it make you feel when you self-injure?” • Explore strategies like using tattooing or piercing; Share books with safer self-injury strategies; Brainstorm ways to avoid negative responses from family, employers, providers, etc. • Advocate for deeper understanding with provider, family, etc. .; Interrupt bias/assumptions
Suicide	• Ask questions like “Is there something in your life you want to die?”; “Did something happen right before you started feeling this way?”; “How long have you been feeling this way?”; “What do you wish people understood about you/this?” • Explore things the person wants to do before they die; Explore places the person still finds some peace, strength, etc.; Explore things they might miss if no longer here; Be willing to sit in silence, cry together, etc. • Advocate for deeper understanding with provider, family, etc.; Interrupt bias/assumptions

To Support Systemically:

- Advocate for peer support roles to be independent whenever possible and for the independent orgs to be supported in truly sustainable ways
- Where an independent peer-run org isn't available, advocate for the work to be done to develop such an org and take over peer support roles once ready
- Where roles are integrated, advocate for an independent peer-run group to handle the hiring, training, ongoing supervision, development roles and standards for practice, etc through a sub-contract.
- Where none of those options are possible, advocate for senior leadership 'peer' roles within the organization to be responsible for these tasks
- Where there are no senior leadership 'peer' roles advocate for them to be created while also learning everything you can about what peer roles should look like from peer-run orgs in other parts of the country

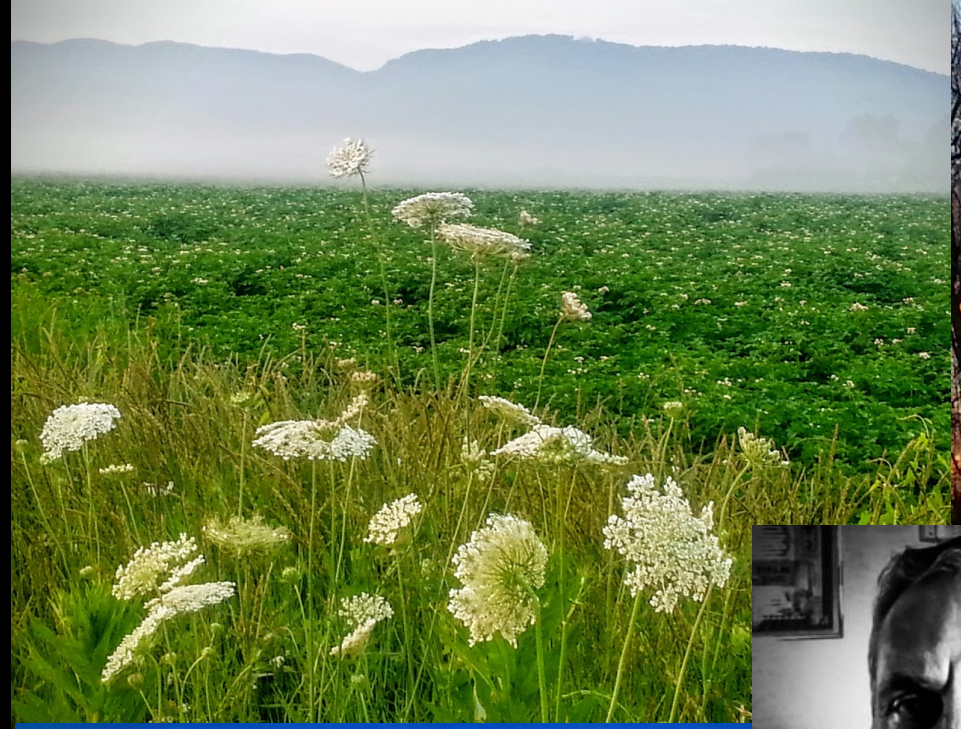
Where most peer roles exist

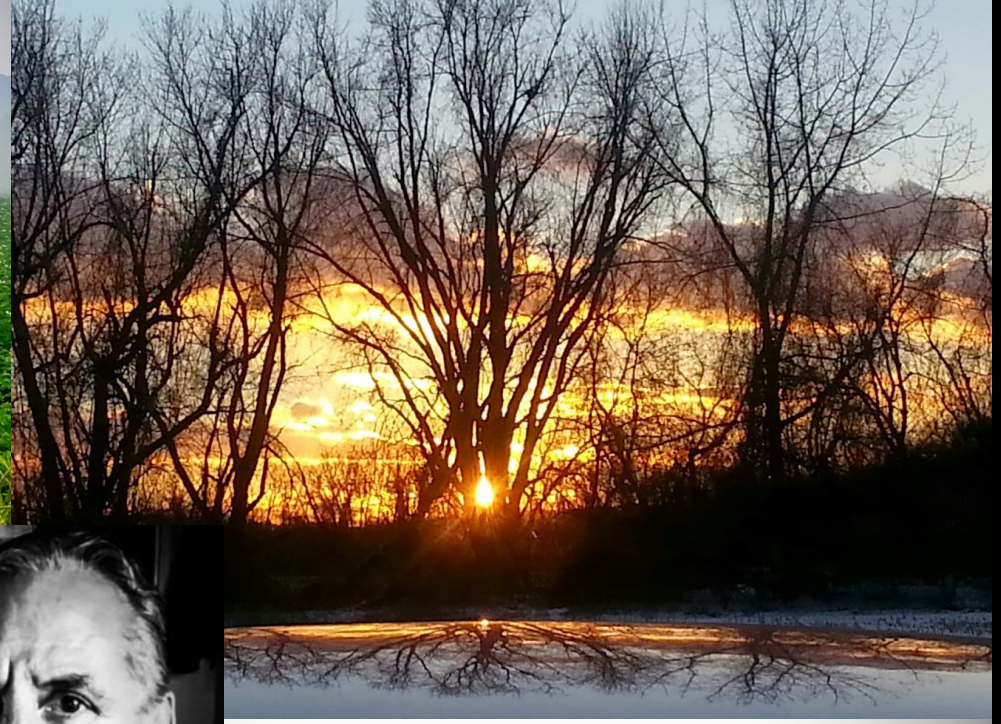
To Support Individually:

- Support peer supporters to not have to go to meetings where people are being discussed without them present
- Support peer supporters to not have to make routine notes in individual people's permanent records
- Support peer supporters to access trainings specific to their field of practice
- Anticipate, tolerate and coach others on how to effectively navigate some tension between peer support and other roles
- Interrupt psychiatric oppression when you see it
- Stay humble and keep deepening your own learning

As Partners:

- Get really good at explaining what each other's roles are and the strengths and limitations of each one
- Establish ways to check in and make sure that roles are holding integrity/not drifting
- Establish tools that help invite opportunities to talk through conflicts between the roles (that go beyond the tensions that should exist)
- Collaborate on efforts to bring other co-workers up to speed on peer supports, harm reduction, etc.





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