Peer Support Integration Guidelines for Vermont's Enhanced Mobile Crisis Services

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Vermont's
PEER WORKFORCE
Development Initiative

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Contents

Introduction

The guidelines in this briefing are established by the **Peer Support Integration Fidelity Council**, which is a subcommittee of the Peer Workforce Development Initiative Steering Committee. This document provides guidance related to hiring and structural decisions around peer support roles in mobile crisis services to ensure they are in alignment with the best practices, ethics, values, and certification standards for peer support services in Vermont.

This guidance is based on our many years of experience integrating peer support services into community mental health agencies and multi-disciplinary teams; the body of knowledge and thought that has been developed collectively in Vermont, the United States, and beyond by peer support providers, as well as the experiences of peer supporters within and outside the PSIFC who are providing peer support services in mobile crisis currently. This is the second iteration of these guidelines, following an initial publication in July of 2024. The PSIFC thanks Leslie Nelson and Tara Miller, founding members of the PSIFC, for their contributions to the development of the initial guidelines upon which this version builds.

In the original set of guidelines from 2024, we referenced and relied on the following publications:

- Lyn Legere (n.d.). The Provider's Handbook on Developing & Implementing Peer Roles.
- National Association of Peer Supporters (2013). National Practice Guidelines for Peer Specialists. Washington, DC: N.A.P.S.
- National Association of Peer Supporters (2019). National Practice Guidelines for Peer Specialists and Supervisors. Washington, DC: N.A.P.S.
- Sera Davidow (n.d.). A Handbook for Individuals Working in Peer Roles.
- South Southwest Mental Health Technology Transfer Center (2024). Peer Specialists on Mobile Crisis Units. Austin, TX: Texas Institute for Excellence in Mental Health.
- Substance Abuse and Mental Health Services Administration (2015). Core Competencies for Peer Workers in Behavioral Health Services.

This updated set of guidelines does not contradict but further improves upon the guidance from 2024 based on collaboration with the Department of Mental Health and the integration of lessons from hands-on experiences in mobile crisis services. The intended audience is all people at a designated agency who are involved with mobile crisis services, including administrators, supervisors, crisis screeners, and, of course, peer support providers.

We have attempted to provide sufficient guidance to ensure that peer support roles can be integrated into mobile crisis teams in an effective and appropriate way without being overly prescriptive, understanding that teams operate differently. We strongly encourage agencies to have collaborative processes that include peer support providers and crisis screeners to develop agency-specific workflows and practices consistent with these guidelines. The PSIFC can be reached at psfidelity@pathwaysvermont.org with questions and consultation requests.

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Definitions of Terms Used

Co-optation: the process by which a dominant group assimilates dissenting individuals or ideas, often diluting their original intent or impact to maintain existing power structures.

Lived Experience: Life-changing and transformative experiences that someone has gone through personally and directly in areas that help them connect with, relate to, and advocate for the people that they will be supporting. For mobile crisis these include: Receiving crisis services, having been through crisis, trauma, addiction/substance use, suicide attempts/suicidality, severe emotional distress, receiving services in the mental health system, extreme states, and/or hospitalization.

Non-peer support roles, non-peer support staff: Any staff who are not in an explicit peer support role, whether or not they have relevant lived experience

Peer Support: Peer support is non-clinical and based on a genuine, mutual relationship between the peer support provider and another individual. Peer support emphasizes a non-judgmental, values-driven approach that promotes multiple perspectives, and advocates for human rights and dignity.

Terms Intentionally Not Used

Peer (as a label): It's not uncommon for peer support providers to be referred to as "peers," including some who refer to themselves that way, but we encourage avoiding this. People who receive services but don't work in peer support jobs are also sometimes referred to as "peers." People may say things like, "is so-and-so a peer?" The impact of this is that it conflates having lived experience in the mental health system with being a peer support provider, which leads to confusion and misunderstandings about peer support. Peer support is not simply the employment of people who have received services in the mental health system.

Mental illness, mentally ill: We do not describe people receiving services or people working in peer support roles as mentally ill due to the many people who do not agree with or accept that framing of the nature of their distress or difference, and to respect the many ways that people understand their experiences.

Areas of Guidance

1. Mobile crisis teams navigate consent in a way that preserves the voluntariness of peer support:

A. Peer support is well understood to be both voluntary and self-directed. As such, peer support fundamentally cannot take place without consent. If a person in crisis (or their guardian) gives informed consent for an Enhanced Mobile Crisis Response (EMCR) in general, peer support co-responds without additional consent needed for peer support. If the person in crisis does not consent to the EMCR (either because they cannot be reached or because they say "no"), peer support does not co-respond unless/until consent for the EMCR is given, or, if the intervention is against the person's wishes, there is specific consent for peer support to be present as an advocate/support during the non-consensual encounter. See flowchart on page 12.

B. When consent has not yet been given for an EMCR, mobile crisis teams will consider the following steps to try to obtain consent:

    a. If the person requesting a response is not the individual in crisis/self-referral, call and/or text the individual in crisis.

    b. Check to see if the individual has a crisis plan or advance directive on file.

    c. Provide reasonable time for the person to respond. Peer support providers should advocate for waiting for consent.

    d. Consider contacting providers or other supports who the person in crisis has an ongoing relationship with and that the person has clearly indicated should be contacted in a crisis or as a conduit for communication.

C. Crisis work is fast-paced and can be unpredictable. If the crisis screener determines that an EMCR needs to be dispatched prior to consent being obtained here are some things to consider:

    a. Ensure all crisis screeners are capable and confident in their ability to accurately describe what peer support is and how it could benefit the individual. (If the screener is not able to accurately describe this role, they can attend the Implementing Peer Roles training available through the PWDI, ask for help from the peer support providers on their team, or email psfidelity@pathwaysvermont.org for further guidance.)

    b. If the peer support provider has had prior encounters with the individual in crisis and believes the individual would welcome the support, the peer support provider may choose to co-respond.

    c. The peer support provider may either choose to drive separately and stage nearby or be ready to join on telehealth should the person welcome the support and/or want the addition of peer support/advocacy specifically, but will not initially

co-respond.

D. Peer support providers are included in decision making about who co-responds on an EMCR with a priority placed on who would best meet the needs of the person/family being supported

E. Peer support providers prioritize autonomy and self-determination and therefore do not coerce or pressure people they support to participate in any service, including peer support, to take or not to take psychiatric medications, or to make any other particular decision about their personal wellbeing.

F. When peer support providers observe coercion taking place they assume the role of an advocate and promote choice. They stay present with the person as long as possible and/or desired to help mitigate the risk of trauma, harm, and violation of their rights.

G. Peer support providers are not credentialed as Qualified Mental Health Providers (QMHP), though they may attend the QMHP training to become familiar with involuntary processes.

H. Peer support providers are not involved in any decisions leading to involuntary hospitalization or jail and do not endorse such decisions. Peer support providers do not participate in involuntary processes such as completing Witness Statement of Facts used in warrant applications.

2. Peer support has a distinct non-clinical role:

A. Peer support providers have expertise that is different from clinical staff and their perspectives are treated as equally important as clinical judgment, assessment, diagnosis, and recommendations.

B. While there is certainly overlap between the tasks and activities of peer support and other roles (such as crisis screeners, clinicians, case managers), their roles are not identical.

C. When creating peer support positions, organizational policies and procedures need to be reviewed to ensure that any inconsistencies with peer support roles are addressed.

D. Non-peer support staff who have relevant lived experience are not peer support providers. Having lived experience is considered a valuable addition for all roles, but it is not the same as being in a peer support role. Peer support providers may have former careers and credentials as clinicians, physicians, lawyers, etc., but they do not operate in those capacities when they are in a peer support role.

E. Non-peer support staff who have been trained in Intentional Peer Support or similar trainings may incorporate concepts and approaches rooted in peer support into their practice, but this does not make them a peer support provider unless they transition to a peer support role.

F. Peer support providers can support individuals who are in crisis without clinical triage, referral, or observation, including when the individual is experiencing extreme/altered states of consciousness, risk of harm to self, risk of harm to others, self-injury, intoxication, and things that get called psychosis.

G. Peer support providers receive peer support training provided by others with lived experience (e.g. Intentional Peer Support, Alternatives to Suicide, Hearing Voices, etc.), in addition to training that is necessary for all staff (e.g. mandated reporting, duty to warn, etc.)

H. Peer support providers do not administer screenings or assessments of any kind.

I. Peer support providers do not administer medications or monitor people's use of medications. However, peer support providers do have supportive, non-directive conversations about psychiatric drugs and other substances, consistent with peer support ethics and practices.

J. Peer support providers use the same language individuals use to describe their own experiences. Peer support providers do not refer to people they support using clinical or diagnostic language unless the person self-identifies or self-describes that way.

3. Peer support providers need guidance and support from others who do peer support work:

A. Peer support providers are supervised by a peer support manager or team leader within their organization who has experience in peer support.

B. Peer support providers who cannot be assigned an appropriate supervisor with peer support experience will receive organizational support to access coaching, mentoring, and/or technical assistance from other peer support providers outside of the organization.

C. Peer support providers need access to networking and continuing professional development within their field outside of the organization they work for.

4. Peer support providers have relevant lived experience:

A. Peer support providers in mobile crisis have personal, direct lived experience in one or more of the following areas at a minimum: Receiving crisis services, having been through crisis, suicide attempts/suicidality, severe emotional distress, extreme states, and/or hospitalization.

B. Lived experience as a family member or close friend to people going through the experiences described above are important and valuable perspectives, but do not satisfy

the requirement of direct lived experience.

C. While lived experience is a requirement for peer support, it is not sufficient by itself to prepare people to do peer support work successfully.

D. A peer support provider does not need to have the same lived experiences as someone they are supporting in order to be able to support them. E.g.: if a peer support provider has lived experiences with voice hearing but not self-injury, they can still support someone around their experience of self-injury.

E. When peer support providers do not have direct lived experience in a particular area, they learn from others who do. E.g.: If a peer support provider does have experience with coming off psych drugs but they haven't experienced hospitalization, they listen to and learn from others who have been hospitalized to better understand that experience.

F. Self-disclosure is done with intentionality, awareness of power dynamics, and to strengthen the connection.

5. Advocacy is an essential part of peer support:

A. Peer support providers advocate for the expressed interests of the people they support, within the boundaries of their professional ethics, rather than the peer support provider's or other's perception of their "best" interests.

B. Peer support providers do not give legal or medical advice.

C. Peer support providers learn about relevant resources and support people in accessing them, as desired by the person.

D. Peer support providers have an understanding of the system of care, involuntary processes, patient/client rights, grievance and appeals processes, etc.

E. People using mobile crisis services can, if desired, speak privately with the peer support provider.

6. Successful and safe integration of peer support providers into multi-disciplinary teams requires the intentional creation of time and space for processing and co-learning:

A. Peer support providers and their colleagues are given the time, resources, and support to understand their roles.

B. Peer support providers are fully integrated into the mobile crisis team.

C. All mobile crisis team members can initiate a debrief of an encounter to learn, share feedback, clarify roles, etc.

D. Mobile crisis teams have an intentionally developed structure to discuss their shared work.

E. Agencies ensure that non-peer support staff are educated about historical and current harms that occur in the mental health system.

F. Non-peer support staff are given opportunities to have people with lived experience be their teachers, facilitators, or mentors, such as by attending trainings facilitated by people with lived experience in a given topic.

G. Transparency and clarity about the range of settings and situations that a peer support provider will encounter is an important part of the recruitment and hiring process to ensure that the needs of the peer support providers and the operational needs of the program are a good match.

7. Peer support providers are supported and accommodated appropriately:

A. Leaders, administrators, human resources, and non-peer support staff have an understanding and appreciation of the unique challenges that peer support providers face.

B. Peer support providers are encouraged to name harm or discrimination when they encounter it in the workplace and will know at least one person to whom they can reach out within their organization who will respond with care and consideration.

C. Accommodation requests are not treated as performance-related concerns.

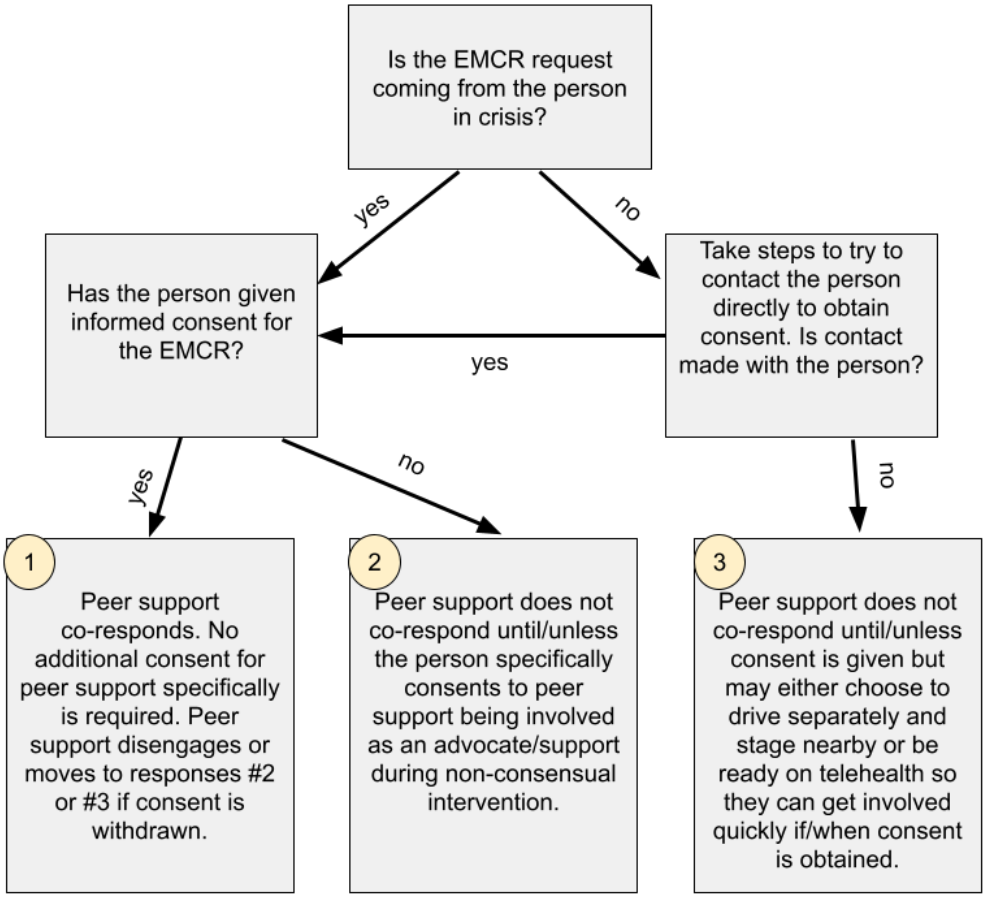
D. Performance-related concerns are addressed clearly, promptly, and respectfully, and not assumed to be due to the peer support provider’s lived experience.

E. Peer support providers are not excluded from conversations or parts of the work because of assumptions about their reactivity.

F. Peer support providers are not expected to accept hours, tasks, or working conditions that other non-peer support staff would not be expected to tolerate.

G. Peer support providers are afforded all the benefits and privileges that non-peer support staff have available to them.

Mobile Crisis Peer Support Consent Flowchart



Example Scenarios

1. Michael

Michael, a high school student who recently turned 18, shared with his social worker that he had been feeling the urge to “get violent” with his father lately, which led to a conversation about getting a crisis team involved. Michael agreed to this and so the social worker called and requested the crisis team respond. When the crisis team came to the school Michael shared that he was precariously housed, as he and his father had been homeless for a few years after moving to Brattleboro before finding an apartment. Micheal noted that their relationship is strained. Michael explained that he has been staying with some friends in a house due to his relationship with his father, and that moving in with him again would not be a good idea.

Michael opened up to the crisis team about feeling that he would be better off if his father was dead and he had been cutting to try and punish himself for feeling that way. With graduation only a few months away, and not having many natural supports due to moving constantly and strained familial relationships, Michael was feeling lost and like he had no control over what the rest of his life was going to look like. Lucia, the peer support advocate, connected with Michael due to closeness in age, and being a recent graduate of college. Lucia, using some self-disclosure about her own fears navigating post-grad life and the working world, engaged Michael in a conversation around hopes, dreams, and fears. Michael added how there’s no roadmap already defined for people and that uncertainty and chaos is destabilizing.

He was unsure how to create a path that felt meaningful to him despite real concerns of physical health, wellbeing, and financial stability, which Lucia validated and related to. Annalise, the screener on the crisis team, also validated how common these experiences are, especially when happening at such a transformative time in one’s life. Annalise offered some suggestions and resources through her and Lucia’s agency that Michael may feel better supported with. Through this conversation, Michael was able to express what he really wanted to do after graduation, and named some short-term goals like obtaining a license and getting a job so he could have some money to move. This led to a referral being made for outpatient services, and Michael wanting some check-ins with peer support.

2. Paul

The crisis team receives a call from Paul with concerns about his wife Katherine, a woman experiencing what Paul describes as her “first manic episode.” Paul is very concerned, as she is exhibiting behaviors he has never seen before in the last 20 years they have been together. Paul describes that her speech was quick and then slow

seconds after. She would be calm for a moment and then start shouting and cursing at Paul, then be tearful, and return to a state of being on guard and accusatory. Paul did not tell his wife that he had contacted a crisis team as he was afraid of how she would respond.

The crisis team determined that the concerns for Katherine were great enough that they would respond even without Katherine's consent. Tabitha, the Peer Support Provider, had met with Katherine before and thought that she may welcome peer support but the team decided it would be best for Tabitha and Carl (the Crisis Screener) to drive separately so Tabitha would be able to leave the situation in case Katherine did not want Tabitha present. Carl arrived at their home before the peer support co-responder did. During this time, Carl had a hard time engaging Katherine in a conversation surrounding how she was feeling and what she'd like to do. When peer support provider Tabitha came, Katherine immediately recognized Tabitha and expressed she wanted her to stay. Katherine commented about how there were "too many men around," so Tabitha asked what she'd like to do about it, offering to ask Carl and Paul to step into another room if that would make her feel more comfortable. Katherine responded that she wanted to talk to one of her friends about what was upsetting her, but asked if Tabitha could be that for her right now.

Tabitha expressed that she could listen without judgment, but that it wouldn't be the same as talking to a friend who knew her better. Katherine agreed to this and Tabitha confirmed this plan would work for Paul and Carl as well. Once Paul and Carl had stepped out, Tabitha let Katherine know that she could share anything she wanted, but because of her role,Tabitha did have some limitations to what she could keep just between them. Kathrine acknowledged this and began to share about a traumatic incident at work that she felt a lot of shame and guilt for, due to having to involve a supervisor and potentially police, which she felt broke her supervisor's trust in her.

The story was a heartbreaking one involving the prison system, one Tabitha had her own lived experience with. Katherine's experience and the way she was clearly impacted by it was so intense that Tabitha was moved to tears as she continued to hear the story Kathrine was sharing. This was a key point in the connection Tabitha and Katherine shared, as Katherine finally felt like someone was sharing the weight of the situation with her, and was reacting in a comparable way. Katherine continued to share her story uninterrupted with Tabitha as Paul spoke with Carl in the other room about some of his safety concerns for Katherine. Paul shared that she had been getting up at odd hours the previous night and was walking in the street. Paul was concerned she'd get hit by a car, but when he had asked Katherine if she was trying to get hit she had denied it. She had also been getting increasingly angrier toward Paul and was unable to not yell and curse at him for longer than a few minutes. Carl suggested the hospital due to the behaviors he described, especially since they were so out of the ordinary. While Paul and Carl were having this exchange, Tabitha and Katherine shared lots of tears

and validation of intense fear regarding systemic injustice and institutional control, even touching hands as they were sitting in front of each other. Tabitha asked if it was okay that Carl and Paul rejoined the conversation so they could figure out together where to go from here. When Katherine agreed, Paul and Carl rejoined and Paul expressed more explicitly his concerns to Katherine. Hearing this she decided to go to the ER with Paul accompanying her, and even gave Tabitha a hug as she left to show her appreciation.

3. Raya

The crisis team received a call from a middle school counselor for a kid who had disclosed some concerning thoughts around wanting to fall asleep and never wake up because of how overwhelmed she was feeling. Once Esther, a crisis screener, and Fern, a peer support advocate, confirmed that the kid, Raya, would be open to talking to the crisis team about these thoughts, the pair co-responded to a middle school.

The two met with Raya who asked if the counselor could step out of the room. She shared that she had been feeling intensely suicidal after just recently getting out of the hospital due to a pretty serious suicide attempt for which she had had to seek medical care. She shared that things at home had been rough, and that she essentially parents all five of her younger siblings who live in a small apartment with her and her mother.

Esther asked if she had a relationship with her father, interested to hear if this could be a possible escape from her home life. However, Raya expressed that her dad has been in and out of jail, she feels worse when she visits him and comes back home. Esther admitted that she had a lot of concerns hearing this, especially with how traumatic her recent attempt was, and the feeling that there was nowhere Raya felt safe to go. Fern asked about Raya's experience at the hospital, to which Raya replied that she didn't like it and didn't want to go back. Due to Esther's concerns, she was still suggesting a place other than home, but less restrictive than the place she was before. Esther explained to Raya that she would like to call the crisis team's supervisor to come up with other places Raya could go. Fern asked Raya if she would prefer to have some time alone or if she would prefer for Fern to remain in the room with her while Esther had this conversation. Raya asked Fern to remain in the room while Esther consulted her supervisor about other alternative placements for Raya. While Esther was, away Fern shared her own lived experience with her father being incarcerated, and validated how hard it must be on Raya. Raya opened up and shared that she felt she was seeing things a kid should never have to see. Fern admitted that was most likely true, and pointed out that she seems to be in a caretaker role for a lot of people in her life, and that must feel exhausting, to which Raya agreed.

Then Esther came back to talk to Raya about a hospital diversion program, which Raya said she still felt hesitant and fearful of. Esther asked Raya if she receives

outpatient services like therapy, which Raya denied but said she was open to exploring. With this new information, Fern asked Raya if she could advocate on her behalf with Esther when they consulted with a supervisor. Raya agreed to this. Fern advocated for the lowest level of care (outpatient services rather than a hospital or another facility), per Raya's wishes. Although there was hesitation at first due to the amount of safety concerns, the team agreed that getting in touch with outpatient services, as well as conducting daily check ins from crisis, was a good course of action. Fern and Esther came back to talk about these options with Raya, and she agreed that she wanted to try them. Esther made plans to talk to Raya's mother about setting up an intake, and Fern told her she would call tomorrow to check in with her.

4. Jeannette

The crisis team received a call from a nursing home staff member saying a resident kept shouting "I don't want to be here anymore!" and that staff worried this could be a suicidal statement. In addition this resident had been attempting to leave the facility. When asked about bringing in the crisis team to speak with her, the resident, a woman named Jeannette, said she was open to meeting in person. She agreed because she was hoping there was something they could do to get her back in the facility she was in previously.

Upon arrival, Jeannette seemed skeptical and closed off, saying that she doubted either Christa, the screener, or Brian, the Peer Support Provider, would actually understand what she was going through. Some of Jeannette's staff interjected that she had had to switch programs, as she needed access to a necessary medical device for her care that only this facility had, but that Jeanette was "always combative and rude" to staff because she "couldn't seem to understand" that this was the only place she could receive the care she needed. This caused Jeannette to react strongly saying "she didn't care about all that" because she was actually feeling a lot of loss after losing the community she had made at the previous home, as well as losing some privileges like frequent time outside. She expressed that was the reason she kept trying to get out, as she wanted to "go" and this is what she meant when she said she "doesn't want to be here anymore," not that she was suicidal.

Christa validated this and shifted the conversation slightly by asking what she did to fill her time at the home. Jeannette relaxed slightly and responded with a story of her time as a librarian. Jeanette began to smile a little as she shared her love of books and reading, but added that in this place she mainly kept to herself with these activities as she was the only one on her floor without dementia. She opened up about her struggles with meaningful connection and conversation when she felt like everyone would forget minutes later. Brian shared that he also had a love of books and was able to spark a little conversation with Jeanette about some shared book favorites. Both Brian and

Christa also validated the sense of loneliness in a nursing home being a very common, shared experience despite Jeanette's dismissal of their comments.

For the rest of the time, Brian and Christa talked with Jeannette about the various books she was reading and what she liked most. Jeannette expressed how she felt that this was turning out to be the most intellectual conversation she had been able to have in a while, and the three brainstormed some ideas for Jeannette to engage more with other residents through book exchanges or going to the library more often. Jeannette added that her daughter also brings her books and visits from time to time. She was looking forward to the next time she came, hoping she would bring a new one. Brian and Christa left Jeannette with the crisis number in case she ever wanted to talk in the moment again, and Brian made plans to follow up with her the next day to check in.

5. Kayden

The Crisis Team receives a call from Sharron, a mother concerned about her 22 year old "daughter" Rebecca, saying that she is ignoring all of her calls and that she isn't getting a response to any of her texts. Sharron was especially concerned because of Rebecca's history of serious suicide attempts in past. The crisis team took down Rebecca's number and told Sharron they would try to get in contact with Rebecca. The Crisis team called and as the team spoke on the phone the individual corrected the crisis screener that their preferred name was "Kayden," not "Rebecca," and that he actually identified as a trans man, and added that his devoutly religious mother refused to use his chosen name or pronouns. When asked if he would like to meet with the crisis team, he agreed just so he could "get Sharron off his back" despite repeatedly denying any thoughts or intention to end his life. The team made a plan for Miranda, the crisis screener and Nico, the peer support provider, to meet with Kayden in his dorm room.

As the crisis team met with Kayden, he reaffirmed that "nothing is wrong" and that he was "just stressed out" Nico, sensing that Kayden might not be comfortable with Miranda, a cisgender woman, chose to out themselves as trans, which seemed to make Kayden feel more comfortable. Eventually Kayden asked if he could just talk to Nico. Once Miranda left the room, however, Kayden opened a drawer in his desk and showed Nico the collection of prescription medications he had started collecting and storing. Kayden saidthat he feels that only Nico as another transgender person will understand that he's "dead anyway" but just needs "someone to know the truth", imploring him not to say anything to anyone so that he is able to go through with his plan without being stopped.

Nico responded with understanding and validation but explained that they were not able to keep this "secret" for Kayden because of their role in the crisis team. This upset Kayden who expressed that by telling anyone else, Nico would be betraying his

trust. Nico asked him to say more about what he was feeling and the conversation led to Kayden opening up about why he felt he couldn't tell anyone else about his plan. After a while, Nico was able to help Kayden come up with a way to feel more comfortable sharing his plan with other providers and gave Nico permission to bring Miranda back in the room. Eventually Miranda returned to the room and together they worked to make a plan;although Kaydemsaidhe didn't feel ready to go to any therapeutic programs, he said he will share how he is feeling with a close friend in the area and see if he can go over for the night. He said that he would call the crisis team again or have his friend take him up to the emergency room if he needed more support. Kayden agreed to call the Crisis team the next day to check in and see if there was any other support that he needed.

6. Astrid

The crisis team was contacted by the parent of a young adult, Astrid, requesting a mobile response to their home. Bethany, the crisis screener, talked with Astrid's mother and confirmed that Astrid knew about and consented to the EMCR. She then called the peer support advocate, Zara, to request co-response. Bethany and Zara met outside the family's apartment before entering together to meet with Astrid and her mother and father.

Astrid and her parents explained that Astrid was autistic, had recently moved back home after a period of living independently with supportive friends, and was having a hard time with the transition. Astrid was having what the family described as meltdowns and some passing suicidal thoughts. Astrid expressed feeling that she urgently needed to be somewhere other than her parents' house (although she acknowledged that they were very supportive). Bethany asked questions as part of her assessment and inquired if Astrid wanted to go to the hospital. Astrid expressed interest in this possibility as a quick way to get out of the house and as a way to get more psychiatric evaluation, but she also had some fears, saying that she hadn't been to a psychiatric hospital before and had significant sensory needs.

Zara hadn't said much besides introducing herself but at this point jumped in to say, "Part of the reason that we have teams of a clinician and a peer support person working together is that we have different kinds of experiences and information to bring, and one of the things that I bring is that I have been in the hospital before, quite a few times. It's been a while and every place is a little different so I couldn't tell you for sure exactly what it would be like, but I could probably give you a sense of what to expect, if that would be helpful."

Astrid said that would be helpful and Zara went on to describe what has been typical in her experience, including that often cell phones are not allowed, bras and belts and shoelaces may not be allowed, checks happen at least hourly during the night, that

the doors are locked, that sometimes restraints or crises with other patients happen, etc. Zara wasn't trying to dissuade Astrid from this option, as these conditions might have felt preferable to what she was currently experiencing at home, but Zara also knew that Astrid might not know these things and they might be important for making an informed decision. Astrid said, "Would I also get put in restraints? I can't have anyone putting their hands on me." Bethany responded with reassurance, saying, "No, they won't do that." Zara said, "Well, they could. That is something that can happen in the hospital if they perceive you as potentially harming someone else or yourself." Bethany said, "That's true - you're right. I guess I just meant that you don't seem like someone who is likely to do something that would cause that reaction. But, yes, it's possible."

Ultimately, Astrid decided that they did want to go to the hospital. The group spent some time discussing possibilities for longer-term options for when Astrid got out of the hospital that her parents could work on exploring in the meantime.

Bethany had to hurry away to the ER after the visit so did not have time to debrief immediately. Zara reached out later and they were able to reflect together about how the visit went. Both workers expressed appreciation to the other about various things that went well, and then Zara said, "I feel like maybe there could have been more exploration of whether a crisis bed or respite could have been an option for Astrid to consider before going to the level of hospitalization." Bethany said, "Well, maybe, but when I hear suicide I just feel like it's better to be safe." Zara made a mental note to bring this topic to supervision or team meeting to clarify whether crisis programs and peer respites would be an appropriate option to advocate for in the future in a similar situation.

7. Ilana

Francisco, a peer support worker, received a call from Ben, a crisis screener, about Ilana, a woman who frequently uses crisis services. Francisco had been on EMCRs to support Ilana in the past around self-injury and suicidality, and they had a good connection. Ben explained to Francisco that Ilana was having a particularly hard day and that they were in the process of securing a mental health warrant, but that Ilana didn't know this. He requested that Francisco provide some phone support to Ilana between now and when the warrant could be executed, but to not tell Ilana about the warrant out of concern that this could escalate the situation or cause her to try to evade. Francisco asked for a moment to consider this request. He then called Ben back and said, "I would very much like to support Ilana tonight but I'm not comfortable withholding information like that. I can come to that area so that once she knows what's happening she can have the option of my support, or I can support her now if I'm allowed to be transparent." Ben said he understood and this made sense given Francisco's role, and that he would get back to him soon about a plan.

A while later, Ben called back to say that Ilana was being transported to the ER and that he had told her that Francisco was available if she wanted his support during the EE, which she said yes to. Francisco drove to the ER and talked with Ilana for a while. She wanted him to be there during her conversation with the doctor but unfortunately this didn't happen before his shift ended. The two agreed that Francisco would check in on her the next day and made plans about how Ilana could feel as safe as possible while spending the night in the ER. Francisco left her a written note with the plan as a way to remember and feel connected.

Resource Guide

Web Resources:

- The Provider's Handbook on Developing & Implementing Peer Roles
- A Handbook for Individuals Working in Peer Roles
- Vermont's Peer Workforce Development Initiative
- Mad in America
- IDHA
- Madness Radio
- Wildflower Alliance
- Intentional Peer Support
- WHO Guidance on Community Mental Health Services
- Lived Experience Leadership
- Peer Support Integration Guidelines for Vermont's Enhanced Mobile Crisis Services
- Giving the (Young) People What They Want: A Policy Framework For Youth Peer Support

Books:

- Mad In America: Bad Science, Bad Medicine, and The Enduring Mistreatment of the Mentally Ill by Robert Whitaker
- Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America by Robert Whitaker
- Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies edited by Jasna Russo and Angela Sweeney
- On Our Own by Judi Chamberlin

PWDI Trainings:

- Intentional Peer Support Overview
- Implementing Peer Roles

Appendix I:
Sample Job Description for Mobile Crisis Peer Support Team Leader

Position Title: Mobile Crisis Peer Support Team Leader
Agency: HCRS
Division: Adult Mental Health
Department: Peer Support

The below duties or working procedures describe the chief functions of the job. They are not considered a detailed description of every duty of the job. The job description is intended to be dynamic in nature, subject to addition or deletion as required by programmatic changes and community needs.

Whenever the term "crisis" is used in this document it is meant as a shorthand way of referring to situations or experiences that are identified as such by the individual(s) experiencing it (though they may choose to use other language), and isn't meant to imply a universal concept of what crisis means or what it looks like.

Position Purpose:

Mobile crisis services give community members in Vermont the opportunity to access immediate voluntary support when they are in a crisis related to emotional distress or substance use. Mobile Crisis Peer Support Advocates will serve as part of the two-person team that responds to these requests for support, alongside an assessing provider on the HCRS urgent care team. Services will be provided in the community in a wide variety of settings as well as virtually. As this is a 24/7 program, evening and weekend shifts will be required. Peer support is included so that community members have the option of receiving support and advocacy that is informed by lived/living experience, and so that peer support can inform the approach and services of the team as a whole. The Mobile Crisis Peer Support Team Leader supervises and supports Mobile Crisis Peer Support Advocates to be successful, as well as participating in all of the same roles and responsibilities as Mobile Crisis Peer Support Advocates.

Principal Responsibilities and Duties:

- Provide supervision and support to Mobile Crisis Peer Support Advocates
- Lead the integration of peer support into mobile crisis services, collaborating closely with urgent care leadership, Peer Support Manager, Mobile Crisis Peer Support Advocates, and members of the urgent care team. .
- Connect with, listen to, believe, empathize, and co-strategize with community members experiencing crisis who request a mobile crisis response to support them in experiencing relief from distress
- Assist community members to identify and access needed resources
- Maintain awareness of and manage, as needed, the immediate environment around the person who requested services, such as by moving along bystanders, supporting concerned family members, interacting with law enforcement if present, etc.

- Support community members in understanding and exercising their rights while receiving mobile crisis services
- Participate in regularly scheduled meetings and ad-hoc debriefs with other mobile crisis team members to continuously improve and expand each other's skills, understanding, and approach to rights-centered, voluntary crisis support
- Make follow up connections with people who have received a mobile crisis response to check in, support connection to other resources, solicit feedback, develop plans for how to navigate future crises, etc.
- Provide phone support to people who call the HCRS crisis number looking for emotional support but don't want a mobile crisis response
- Support the development of mutual support networks and community connections where relevant
- Document services, practicing collaborative documentation where possible
- Participate in regularly scheduled meetings with the larger peer support team
- Assist with peer support tasks outside of mobile crisis services where possible

Key Knowledge, Skills and Abilities to successfully perform this job:

- Excellent relational skills
- Strong communication skills
- Ability to provide honest and compassionate feedback and accountability to people in a wide variety of roles
- Ability to see multiple perspectives and nuances
- Ability to participate in difficult or heavy conversations and be in proximity to people experiencing various kinds of distress
- Ability to be a supportive and collaborative team member

Relationships:

The Mobile Crisis Peer Support Team Leader is supervised by the Peer Support Manager and is part of the Peer Support Team. They supervise and work alongside the Mobile Crisis Peer Support Advocates, and work closely with the HCRS urgent care team.

Qualification Statements:

Minimum

- Commitment to the values of mutual support, community, justice, and choice.
- Lived experience of marginalization and/or trauma that supports the ability to connect and relate to people in crisis. This could include various kinds of trauma and marginalization, including madness, neurodivergence, institutionalization, homelessness, incarceration, family separation, loss, addiction, etc.
- Personal or professional experience supporting people in crisis.
- Experience in peer support, harm reduction, community organizing, or other related work
- Familiarity and experience with the psychiatric survivor, mad pride, neurodivergent, harm reduction, transformative justice, and/or disability justice movements
- Demonstrated leadership skills

Preferred

- Training in Intentional Peer Support (IPS), restorative/transformative justice, de-escalation, group facilitation, harm reduction, or other related areas
- Personal experience utilizing crisis services
- Supervisory/management experience

Working Conditions and Additional Information:

This position involves being in a wide variety of physical locations and stressful situations. A driver's license, the ability to drive regularly and for long distances (up to two hours at a time), and a reliable vehicle is required. Interactions with police and emergency responders will be necessary at times.

Appendix II:
Sample Job Description for Mobile Crisis Peer Support Advocate

Position Title: Mobile Crisis Peer Support Advocate
Agency: HCRS
Division: Adult Mental Health
Department: Peer Support

The below duties or working procedures describe the chief functions of the job. They are not considered a detailed description of every duty of the job. The job description is intended to be dynamic in nature, subject to addition or deletion as required by programmatic changes and community needs.

Whenever the term "crisis" is used in this document it is meant as a shorthand way of referring to situations or experiences that are identified as such by the individual(s) experiencing it (though they may choose to use other language), and isn't meant to imply a universal concept of what crisis means or what it looks like.

Position Purpose:

Mobile crisis services give community members in Vermont the opportunity to access immediate voluntary support when they are in a crisis related to emotional distress or substance use. Mobile Crisis Peer Support Advocates will serve as part of the two-person team that responds to these requests for support, alongside an assessing provider on the HCRS urgent care team. Services will be provided in the community in a wide variety of settings as well as virtually. As this is a 24/7 program, evening and weekend shifts will be required. Peer support is included so that community members have the option of receiving support and advocacy that is informed by lived/living experience, and so that peer support can inform the approach and services of the team as a whole.

Principal Responsibilities and Duties:

- Connect with, listen to, believe, empathize, and co-strategize with community members experiencing crisis who request a mobile crisis response to support them in experiencing relief from distress
- Assist community members to identify and access needed resources
- Maintain awareness of and manage, as needed, the immediate environment around the person who requested services, such as by moving along bystanders, supporting concerned family members, interacting with law enforcement if present, etc.
- Support community members in understanding and exercising their rights while receiving mobile crisis services
- Participate in regularly scheduled meetings and ad-hoc debriefs with other mobile crisis team members to continuously improve and expand each other's skills, understanding, and approach to rights-centered, voluntary crisis support
- Make follow up connections with people who have received a mobile crisis response to check in, support connection to other resources, solicit feedback, develop plans for how to navigate future crises, etc.

- Provide phone support to people who call the HCRS crisis number looking for emotional support but don't want a mobile crisis response
- Support the development of mutual support networks and community connections where relevant
- Document services, practicing collaborative documentation where possible
- Participate in regularly scheduled meetings with the larger peer support team
- Assist with peer support tasks outside of mobile crisis services where possible

Key Knowledge, Skills and Abilities to successfully perform this job:

- Excellent relational skills
- Strong communication skills
- Ability to provide honest and compassionate feedback and accountability to people in a wide variety of roles
- Ability to see multiple perspectives and nuances
- Ability to participate in difficult or heavy conversations and be in proximity to people experiencing various kinds of distress
- Ability to be a supportive and collaborative team member

Relationships:

Peer Support Advocates are supervised by the Mobile Crisis Peer Support Team Leader and are part of the Peer Support Team, and work closely with the HCRS urgent care team.

Qualification Statements:

Minimum

- Commitment to the values of mutual support, community, justice, and choice.
- Lived experience of marginalization and/or trauma that supports the ability to connect and relate to people in crisis. This could include various kinds of trauma and marginalization, including madness, neurodivergence, institutionalization, homelessness, incarceration, family separation, loss, addiction, etc.
- Personal or professional experience supporting people in crisis.
- Experience in peer support, harm reduction, community organizing, or other related work
- Familiarity and experience with the psychiatric survivor, mad pride, neurodivergent, harm reduction, transformative justice, and/or disability justice movements

Preferred

- Training in Intentional Peer Support (IPS), restorative/transformative justice, de-escalation, group facilitation, harm reduction, or other related areas
- Personal experience utilizing crisis services

Working Conditions and Additional Information:

This position involves being in a wide variety of physical locations and stressful situations. A driver's license, the ability to drive regularly and for long distances (up to two hours at a time),

and a reliable vehicle is required. Interactions with police and emergency responders will be necessary at times.