Hotline Peer Specialist Integration

Preliminary considerations for equity and sustainability

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PeerPride, Inc. is a consulting and direct service organization run by a team of diverse peer support, equity and crisis services specialists. The team specializes in assisting with the establishment of remote crisis and peer support services, as well as advancing the cultural competency, accessibility and equity goals of clients providing direct services. Our key areas of expertise are informed consent in crisis work, LGBTQIA+ competency and racial equity. PeerPride's Connecticut-based direct service community program, Trans Haven, offers peer support, educational resources, advocacy and healthcare navigation by and for trans individuals in the state. PeerPride is also building new open-source peer support software focused on accessibility, adaptability and privacy. It will be available for free access in 2023.

Kirill Ivan Staklo (he/him) is a suicidologist and crisis services expert who is passionate about empowering vulnerable communities to build their own crisis and peer support programming that serves their unique needs. He specializes in the creation and management of both multi-purpose and specially focused support lines, highlighting data privacy, informed consent, accessibility and harm reduction as cornerstones of his programming. Before co-founding PeerPride, he directed the largest international transgender support hotline and was part of the administration of Trans Lifeline's Trans Mental Health Survey. He holds a bachelor's degree in forensic psychology and frequently works with mental health providers and advocates providing care to people who have experienced incarceration. Kirill has been a featured speaker at the National Association of Peer Support conference, the International Roma LGBTIQ Conference, CrisisCon and others.

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Intro to the peer role

As a field, peer support has a unique foundation. The role of a peer specialist is rooted in shared lived experience. Both historically and today, that lived experience extends past similar diagnoses and struggles with mental health or substance use, and into **common trauma and harms experienced within and by proxy of clinical systems**. Survivors of invasive, non-consensual and often discriminatory treatment in psychiatric settings – most commonly people of color, LGBTQIA+ people, women, disabled people and poor people – benefit enormously from the emotional support and advocacy offered by individuals who understand the impact of those experiences.

These systems of community care have always existed organically in every environment where people experience medical trauma, and significantly predate the more formalized introduction of "peer support" as a field in the 1970s. Peer support was born from the urgency for people to be able to navigate both the challenges presented by their mental health and/or substance use struggles and the trauma that comes inherently with clinical interventions.

Today, "lived experience" as a bona fide requirement for professional work in the peer support field is often erroneously reduced exclusively to lived experience with a diagnosis. However, peer support service leaders who highlight the fundamental community-care roots of peer support, and who work within the realm of crisis support in particular, often observe: even with the most minimal integration of peer support specialists into clinical environments, the level of **cultural relatability and trauma informedness** can make the difference between a successful peer support service and an unclear new role indistinguishable from the rest of the clinical apparatus.

Simply put, the more a peer specialist and the person they support relate to one another, and the more the peer supporter is empowered to defer to the needs of the person they support, the better the outcome tends to be, especially for marginalized communities.

The role of a peer is always, and must remain, enormously distinct from that of any other individual providing services in the realm of mental health, substance use or crisis support. Clinicians and most crisis hotline volunteers and staff are actively trained to abstain from sharing any information about their own lived experience. Individuals working within a specific clinical setting are expected to function as representatives of that agency foremost, and to uncritically provide the clinical services that are "on the menu" at that agency. People receiving services at a clinic or through a crisis support service are often expected to **follow a specific trajectory** of "compliant" behavior in order to receive support and treatment without hindrance or coercive intervention. For a peer specialist who is true to the fundamental ethic of their role, what is "on the menu" is, first and foremost, **determined by the needs and boundaries of the peer they are supporting**.

In tandem with that, each peer specialist brings with them their own unique combination of lived experiences and boundaries that they may highlight, utilize and administer within the scope of their role. Agency with self-disclosure and determining boundaries on part of both the peer specialist and the person they are supporting is essential for the peer role to function correctly. Anyone who is not a peer specialist, of course, also has lived experiences and boundaries. However, the nature of those non-peer roles does not enable providers to engage their lived experiences, and unfortunately, often results in providers disregarding their own boundaries, trauma and implicit bias when providing care.

1. Jorge calls a crisis hotline that is staffed by clinicians. He is grateful that someone picked up the phone quickly and shares that he is struggling with flashbacks, hopelessness and suicidality after experiencing sexual assault. Enrique, who answers the phone, is also a survivor, but has been trained to refrain from talking about his own life when answering calls. Frustrated with what feels like a neutral response and assuming that the hotline operator does not know what it's like to experience assault, Jorge begins to describe what happened to him in detail in hopes of showing how much it impacts him. Enrique feels sick when he is reminded of his own experience, and struggles to stay grounded in the conversation, but acknowledges generally that "it sounds really painful" and continues to ask risk assessment questions. He does not tell Jorge that he is a survivor and does not redirect the conversation when Jorge goes into detail. He unconsciously avoids talking about Jorge's trauma, but focuses on completing the risk assessment and figuring out whether or not Jorge has a plan to end his life.

2. Jamilah calls a crisis hotline that is run on a peer support model. She shares that she is an alcoholic, recently began drinking again after experiencing a hate crime, and feels like a failure. She asks Adrian, the operator, if they drink, and they reply that they currently do in moderation, and have also struggled with being reliant on substances when bad things have happened. Jamilah is glad to speak to someone who relates to her. She begins to feel more grounded after sharing about the trauma that led to her drinking, being reminded that she's not a failure for having an adverse response to it, and asking and hearing about some of Adrian's experiences coping with trauma. However, she believes very strongly in full abstinence as the only way to manage substance use, and insists that Adrian has to try AA. Adrian has had bad experiences with AA. They let Jamilah know that while they personally haven't found the AA structure helpful, they are happy to brainstorm together with her about what works best for her. When Jamilah continues to

try to convince Adrian that abstinence is the only way for everyone, Adrian redirects the
conversation, then gently reminds Jamilah of their boundaries and finally checks in about
whether she would prefer to speak to someone who shares her experience and abstains
from drinking fully.

Providers who do not use a peer support model are expected to abstain from sharing lived experiences for a number of reasons. First, many agencies see this policy as a way of focusing on the client. Second, the role of clinicians and many hotline workers is typically framed as the role of a neutral party with authority on assessing or treating mental health or substance use, and/or addressing crisis. **The role of a peer support provider is different.** The expertise and value of peer support as a practice is centered in the ability to support people based on shared lived experience and respect for the autonomy of the person seeking support. Peer specialists must listen actively and defer to the needs of the person seeking support both on their lived experiences and on the best ways to meet their needs and respect their boundaries. In supporting individuals experiencing crisis, the peer role necessitates for the provider to be even *more* aware of the importance of autonomy for the person they are supporting.

Medical trauma & minority stress

Structurally acknowledging and building resources to address minority stress is an essential component in building crisis services that are effective for the most vulnerable communities. So, what is minority stress?

Minority stress is created by ongoing experiences of social inequity, exclusion, disparate treatment, as well as exposure to and risk of danger due to belonging to a "minority" or marginalized group. Specifically, mental health symptoms – trauma, acute stress, depression, anxiety, suicidality, substance use as a coping mechanism and more – frequently originate from adverse experiences related to marginalization. When providing crisis and peer support services, it is essential to account for the fact that **what constitutes the norm and what constitutes an emergency varies from person to person based on the circumstances of their life.**

It's important to know that the mental health impact of minority stress comes from **how individuals and systems treat a marginalized person,** not the fact of **holding a specific identity** in and of itself. This is a crucial aspect of cultural humility that must show up in peer support models for a service to work effectively. To illustrate this distinction:

Examples

  1. *Ellen is a peer supporter and hotline worker. In a training, her supervisor reminds her that trans individuals are at a statistically higher risk of experiencing suicidal ideation. When Ellen speaks to a trans person on the hotline and they share an experience of transphobia at work, she feels hyper-alert and expects there to be a higher likelihood of*

suicidality as a topic because they are trans. She asks more questions about the caller's safety and whether the caller is experiencing ideation, subconsciously centering the conversation on that topic more than she would with other callers.

2. Franky is a peer supporter and hotline worker. In a training, his supervisor reminds him that trans individuals often experience violence, rejection, isolation and lack of access to safe resources, which can have a detrimental impact on their physical and mental health, including risk of suicidal ideation. When Franky speaks to a trans person on the hotline and they share an experience of transphobia at work, he remembers the barriers and struggles the caller might be facing. He affirms that what happened to them was unjust and not their fault, checks in about whether they are in a safe place now, whether they have access to community and support, and whether there are resources he could help them find.

In psychiatry and clinical psychology, there is a lengthy history of disproportionate amounts of harmful pseudo-science, misdiagnoses and pathologization impacting the most marginalized populations in unique ways.

While "hysteria" may have been removed as a diagnosis from the DSM in 1980, patients who are or are assumed to be women continue to report symptom misattribution, diminishing dismissals and difficulty finding mental health providers that believe them. While "drapetomania" may no longer be considered a valid condition, people of color are 5 times more likely than white people to be imprisoned, and are more likely to experience solitary confinement, but are less likely to have access to mental health resources. 80.3% of mental health providers are white, while only 6.7% are Black. One study revealed that at least half of medical school residents and students surveyed held one or more false beliefs about biological differences between Black and white people,

including supposed differences in pain tolerance. While "gender identity disorder" is no longer a diagnosis, "gender dysphoria" remains one, and is a requirement for most trans people in the US to access gender-affirming care. Hospitals continue to be one of the locations with the highest risk of sexual assault for trans people. In the United States, the professional field of mental health care has shifted significantly throughout history similarly to all other forms of healthcare. These disproportionate impacts continue in today's mental health systems and are important to highlight when building new services.

Medical trauma is understood to be a complex and traumatic response rooted in experiencing harm as a result of seeking medical and/or therapeutic wellness services.

As a result, lived experience of medical trauma often leads to marginalized people refraining from seeking out healthcare or crisis services. The impact of medical trauma in clinical services and other service delivery can be further illustrated in the following excerpt from *When Treatment Becomes Trauma* by Michelle Flaum Hall and Scott E. Hall:

> *"While the knowledge of having certain life-threatening diagnoses can activate traumatic stress reactions or other mental health crises for patients and/or their families, the processes required for treating such diagnoses can contribute to this reaction. From procedural elements (e.g., the timing of informed consent) to treatment elements (e.g., medication used), factors within the treatment approach are certainly worthy of examination as we strive to understand the risk factors for experiencing medical trauma."*

Globally, racial and ethnic minorities and migrants have a higher risk of nonconsensual institutionalization than the population of the dominant ethnicity or race. In a survey

conducted by a peer support hotline, approximately 800 trans people with lived experience were asked about their experiences seeking out mental health and crisis services. **70% of the respondents stated that they had never called a crisis line.** The majority of those who had not specified that while they had experienced crisis, they did not feel safe calling a hotline due to fear of nonconsensual intervention and/or discriminatory treatment. Approximately ¼ of the respondents stated that they had called hotlines and had been forced to interact with law enforcement as a result, and one in five had been placed on an involuntary psychiatric hold. Offering competent support to the most vulnerable communities in crisis and peer support work means understanding that clinical options may not be safe or competent for people of color, immigrants, LGBTQIA+ people (especially trans people). Adverse experiences with law enforcement, discriminatory treatment by first responder and mental health providers, misdiagnosis, placement in incorrect facilities and more risks have long-term effects on people's mental health, safety and material stability.

This is where the unique role of a peer specialist continues to be essential. When correctly trained and integrated into a hotline system, a peer specialist is able to hear, trust and appropriately respond to the needs of marginalized people – including adhering to their code of ethics by respecting the principle of self-determination above all. The callers that peer specialists serve should have consistent certainty that their needs, lived experiences and personal boundaries will determine the type of care they receive. This guarantee is essential for services to be safe and trustworthy for marginalized people to contact.

Providing support over the phone requires specialized training, even for peer specialists who are already certified and experienced in their role.
There are several key distinctions that peer specialists should make when providing remote services. First, the nature of telephonic work itself. Second, the spectrum of anonymity and lack of continuity. Third, the absence of a clinical environment. Last, security and quality assurance considerations.

Who is calling?

Adapting to text or phone based support means adjusting for possible bias, assumptions and miscommunication, as well as being highly aware of one's own emotional capacity and ability to listen deeply with intention.

In an in-person environment, peer specialists and other providers have access to a great deal of interpersonally disclosed and observable information about the person they are supporting. These settings may also have access to data and other pertinent specifics such as:

- Demographics
- Health information
- Legal history

This information may have been volunteered by the person directly, collected for reporting purposes, or shared from another party without the individual's consent. Peer supporters accustomed to working in in-person settings, or even telehealth settings

where most can still visually identify the people they are supporting, will need to adapt to a fast-paced work environment where support is provided exclusively via voice or text. Operators on the line will not have access to cues that would typically be observable by sight such as facial expressions, body language or, often, any preliminary information or context about the caller. It is impossible to have full anonymity in an in-person environment. However, when creating a hotline service, there are far more options to protect the anonymity and confidentiality of callers and texters.

One of the main sources of burnout for peer and crisis support line operators is abuse of the resource by people calling to prank or harass operators, often including explicit hate speech and sexual harassment. It is essential for hotline policy and practices to simultaneously protect the privacy of the people it supports and the well-being of the people answering calls and texts. With or without anonymity and confidentiality protections in place, hotline work often means not knowing anything about who is reaching out. Additionally, hotline workers may or will not know:

- What the caller's environment contains and this may present barriers and challenges in supporting an effective interchange.
- Knowledge or understanding of what the individual might need.
- Whether a caller is using the line for its intended purpose.

If constructed with those features in mind, hotline software can bar operators from seeing any identifying information about a caller or texter that is not shared by the caller or texter themself, while still preserving the operator's ability to make notes, set alerts for line abuse and restrict a number's access to the line.

Another common challenge and source of burnout for people new to remote hotline work is not having relational continuity in the peer support relationship with the people

they are supporting. When engaging in face-to-face peer support work, peer specialists are typically able to check in with peer participants and follow up on how they are doing. On a hotline, this is largely impossible without having access to personal information and contacting the caller or texter non-consensually (outside and away from the hotline service). Peer specialists working on a hotline may also experience a perceived lack of clarity if a call does not end with a clear resolution. Examples of this include:

- A caller's phone dying.
- A caller requesting to end the call, or a call being abruptly ended for unknown reasons.
- A frequent caller suddenly ceasing accessing services.

Even with a conversation being fully completed, a hotline worker may feel a sense of curiosity or worry about the caller's wellbeing if they do not speak to that person again. In order to reduce burnout related to not knowing the outcome of a conversation, it is crucial for operators to have both training and ongoing programmatic orientation that highlights the peer support ethics of mutuality, dignity and self-determination. Individuals already in a peer support role are an excellent fit for operator training specifically. This is because peers' ability to trust people seeking support in navigating their own lives creates healthy boundaries and resilience that operators coming from other professional backgrounds may find more challenging to develop.

The presence of a clinical environment carries a culture of assessment and liability. The absence of a clinical environment permits a hotline to create a unique and innovative structure. In this peer specialists are beholden only to the ethics and culture of peer support, and the needs of the caller or texter. By contrast, in clinical settings, peer specialists typically operate as a supplementary resource that is secondary to the

overarching authority of their organization or agency's clinical providers and policies which uphold medical models of treatment and care. Within the structure of a support hotline, a peer specialist answering the phone is the first and typically the only point of contact for the person seeking support. By contrast, in clinical settings, a healthcare worker answering the phone is the first of often many points of contact for the person seeking support within a triage-style system that seeks to assign degrees of urgency. Peer specialists are empowered to support individuals as they see fit, and, per the ethics of peer support, as the individual receiving support determines most helpful. The hotline setting allows program leadership to implement policies and practices that actively uphold this autonomy.

Quality assurance, management and security that is involved, culturally competent and respectful is one of the most impactful factors in hotline worker and volunteer retention and well-being. Direct supervision and other forms of organizational oversight in phone-based peer and crisis support work are unique. Many peer specialists are not supervised by other certified peer specialists, which, because of the singularity of the peer role, can often create a disconnect between the peer specialist and their supervisor. A new hotline setting is a unique opportunity to ensure that peer specialists are supervised by people with ongoing experience doing the same work. Phone-based work allows for discreet, accessible, and adaptable hands-on training. If the hotline has a call and text recording retention period, it also allows for accountability and in-depth call review.

Quality assurance will require more assessment of operators' ability to respect callers' privacy If software used automatically reveals callers' identifying information. Leadership will need to monitor data privacy policies closely and preempt potential threats. Peer specialists and other providers used to in-person work should be aware of

the higher risk of their own personal information and that of the people they support being compromised in the event of a data leak, and should receive cybersecurity orientations as well as have access to ongoing support from a trauma-informed and privacy-oriented technologist on the hotline.

Technology is key and often dictates whether or not a hotline operates in a manner consistent with the ethics of sustainable peer support.

> *For example, if the software used for the hotline does not allow for an operator to flag abusive behavior on the line or temporarily block a spam caller, retention and capacity will be compromised.*

The impact of safety being compromised on the hotline is often far reaching; extending to both the peer specialists taking calls and individuals calling in for the first time who are unaware of the harm these workers have faced. Risk of mutual harm on the hotline often extends farther into the community, especially amongst marginalized groups, which rely on word of mouth and direct feedback from trusted associations. Poor feedback related to harmful hotline experiences can result in a compromise of accessibility for groups deemed most vulnerable. This risk of mutual harm is greatly increased when peer specialists are not buttressed with appropriate technological safeguarding.

Informed consent and harm reduction

Implementing informed consent practices is foundational in reducing harm and preventing further medical trauma in mental health and crisis service access among marginalized communities. An informed consent model and practice is vitally important in ensuring that individuals are supported and empowered in making autonomous decisions surrounding their care. Obtaining fully informed consent is procured by a two-fold process that must include continuously seeking consent and exploring ambivalence with the person involved. Informed consent can be further expanded on in the following quote from Hall:

> *"More than simply information, informed consent is a process and an opportunity for healthcare providers—to strengthen the relationship through effective and compassionate communication. A primary goal of informed consent is to increase understanding of a procedure by ensuring that patients know risks inherent in the treatment, probabilities of success, frequencies of risks, alternative treatments, and any other information pertinent to making an informed decision."*

Informed consent and autonomy throughout all crisis and peer support care work is fundamental to expression and fidelity of the peer support ethic. As such, a hotline employing certified peer specialists and other people with lived experience can only utilize their expertise adequately if its own policies and practices hinge on consent and autonomy. Essential features of an informed consent based, trauma informed crisis service that is consistent with the peer support ethic include:

- **Right to specific information.** Informing callers and texters fully and clearly regarding the line's policies and the level of privacy and autonomy they can expect, especially if there is any situation in which a caller's anonymity and confidentiality may be compromised, such as with a non-consensual intervention.
- **Adherence to a harm reduction model.** Hotline operators must have a clear understanding of the broad spectrum of coping mechanisms callers and texters may employ. Hotline operators must be able to support the exploration of multiple pathways, which includes safe use of those coping mechanisms if that is what the person they are supporting elects.
- **Commitment to and protection of personhood.** Policies protecting operators, callers, and texters alike from avoidable trauma (inappropriate comments, culturally incompetent treatment etc). This also extends to policies protecting the ability of operators and callers and texters alike to redirect a conversation or end a call if needed at any time. This will keep peer specialists' work on the line consistent with their training and ethics.

Non-consensual interventions (calling law enforcement or emergency services on a person seeking support) are omnipresent within crisis work and have some of the largest impact on the trustworthiness of a line for vulnerable communities.

In Texas, mental health services are currently exceptionally difficult to access, and access to clinical mental health services is typically preceded by interaction with law enforcement. To better inform these recommendations, PeerPride interviewed providers of peer support services to marginalized communities in Texas, and the most consistent feedback we received was that **the people they support avoid seeking out support services if there is a chance they will have to interact with police,** and that **if there was a crisis resource that guaranteed autonomy and informed consent for people**

experiencing crisis, it would be a game changer. Across the board, it is known that statistically individuals of all demographics tend to experience a **higher rate of suicidal ideation** following a non-consensual hospital stay. Additional considerations for risk surrounding non-consensual interventions include:

- **Increased risk of harm.** Non-consensual intervention could result in immediate or long-term abuse for individuals calling or texting from an unsafe environment.
  For example, if an LGBTQ+ minor who is in an unsupportive home environment contacts a crisis line to receive confidential emotional support, and experiences non-consensual intervention, the likelihood of their family or caregivers escalating to abuse following the intervention is high.

- **Long-term implications of a medical history containing psychiatric hospitalization.**
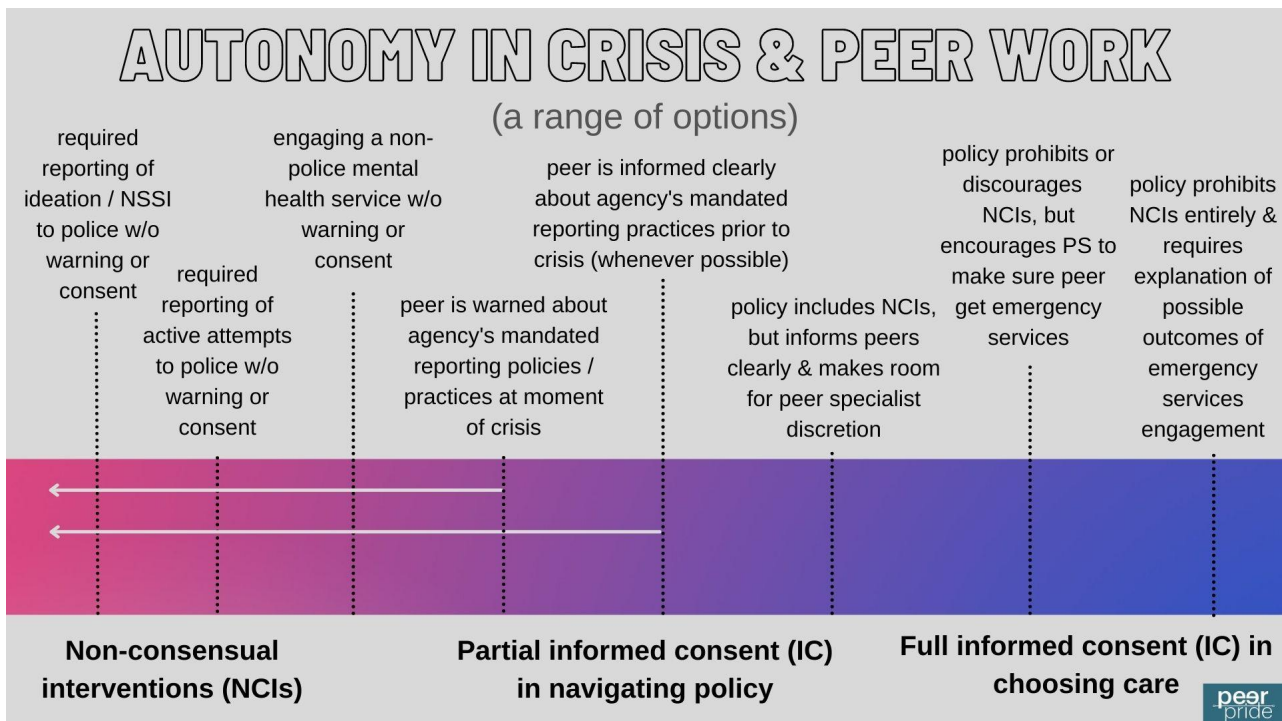 *For example, in some geographical locations, transgender people are denied access to medically necessary treatment due to psychiatric hospitalization history.*

- **Material detriment.** Many low-income and even middle-class individuals report an additional desire to avoid calling support lines in fear of facing financial consequences.
  For example, a caller may need to avoid being charged for an ambulance and hospital visit or stay if they say "the wrong thing" and have emergency services called on them.

- **Subpar hotline performance.** Crisis hotlines that employ a step-by-step risk assessment protocol for the purpose of determining the need for non-consensual intervention typically do so at the expense of organic rapport between the caller / texter and operator. *For example, protocols that mandate responses to specific questions also create a structure that is not guided by the caller / texter and that precludes informed consent, which is inconsistent with how peer specialists do support work.*

The most key element to highlight on this topic is that if a peer specialist has received information that the person they are supporting does not feel safe interacting with law enforcement or first responders, and the policies of the hotline do not permit them to respect that boundary, **they will be operating in contrast with the ethics of peer support.**

The most equitable option is always the option where the caller / texter has the most autonomy with regard to the care they receive, and is presented with alternatives which allow them to self-define what supports feel most beneficial in that moment.

Operating within the code of ethics for peer support specialists, it is possible to create a remote crisis service that operates on the basis of informed consent. In order to do this, it is important to clearly identify the current (or planned) policies of the hotline and

determine the manner in which the hotline will enable informed consent within its framework.

With the exception of some state laws that apply to all state residents in specific circumstances, it is **not** within the obligations of certified peer support specialists to report individuals in crisis to emergency services. However, in the event that a hotline absolutely cannot avoid non-consensual reporting under specific circumstances, policies can reduce harm and safeguard consent for callers and texters by informing them clearly, specifically, and accessibly what could precipitate and come after such a report.

Any hotline policies surrounding callers' privacy and confidentiality should be clearly, prominently and understandably displayed and communicated. This policy should be concisely communicated on the website, and to callers early on in the conversation, either by the operator or in an automatic greeting message. Additionally, any caller or texter who is likely to experience non-consensual *or consensual* intervention as a result of their call must be made aware of what could happen as part of the intervention. Even if the person receiving support requests an ambulance, the operator should inform them of what will or may happen when emergency services arrive, and what will or may follow.

Additional considerations may involve the peer specialist hotline operator facilitating an open discussion about supports after the event. This may include a straightforward conversation about the caller's feelings of trust and safety related to the hotline itself, with the understanding this could be subject to change based on their experience with consent and the events that may follow any style of intervention, consensual or not.

In order to comply with both the law and with the ethics of peer support, it is essential to establish services that maximize anonymity. Because the ethics of peer support work necessitate maximum autonomy, personal sovereignty, and highlighting lived experience, any hotline employing certified peer specialists and other providers with lived experience should use those standards as the baseline for all practices it employs.

Even the strictest laws around mandated reporting do not typically necessitate the gathering of any specific personal information on an individual receiving services. As such, hotline policy may require the hotline to make reports to comply with the law, but it may not have to include compulsory gathering of identifying information. Hotline leadership should obtain legal counsel and gain a complete understanding of the actual scope of the legal requirements in the state in which the hotline will operate. While mandated reporting is a factor the hotline will likely have to consider for child and vulnerable adult abuse and neglect, peer support and mental health services often erroneously treat crisis and suicidality in adults as if it falls under the same mandated reporting category. **It typically does not.**

A needs assessment and focus group work conducted prior to service establishment helps a peer support and crisis hotline avoid trial and error during the first two to three years of its operation. This preliminary work should include:
- Identifying the populations currently likely to use the hotline
- Identifying the populations the hotline would like to reach

- Identifying and addressing potential barriers to accessibility, including language and disability accommodations
- Creating a plan for programming that utilizes lived experience most effectively and ensures ample representation of the lived experiences held by target reach populations among direct service staff and program leadership
- Soliciting feedback from the public, particularly vulnerable populations with higher risks of traumatic experiences and crisis, regarding their needs
- With the help of peer specialists and a focus group, creating a list of local community-based resources serving diverse populations
  (ex.: Black-run programs, veterans' services, LGBTQIA+ and trans-specific programs, domestic violence resources, resources by and for autistic and disabled people, immigrant community resources, etc.)

When establishing programming based on peer support ethics, peer support specialists should be involved in every step of the work. Noting, however, that most peer support specialists **and** other providers do not have hotline-specific experience, the integration of peers and non-peers alike into a new hotline program should occur under the guidance of peer support leaders with experience in remote crisis work.

Training for remote work should involve ample amounts of remote training. In order for a peer support program to train its providers on phone-based peer support practices, phone-based assessment of prospective providers and remote (online and phone-based) training will provide the closest possible experience to the actual work. For specialists providing services based on lived experience, it is crucial to experience the medium they will be using extensively prior to using it. Additionally, a peer support specialist who is comfortable and skilled in building rapport and providing support to an individual in person may find that those skills do not translate as easily into phone-based communication. Preliminary assessment of peer support providers for a

hotline should gauge "soft skills" and natural comfort with the medium. Training should allocate ample time to the specificities of phone-based dynamics (such as comfort with silence, assessing whether a provider is oversharing or taking up too much airtime, gauging consent without body language or facial cues, etc.).

Equity-oriented training in peer support entails a training program that is adaptable to the lived experiences and areas of opportunity each individual peer supporter has. We recommend a hybrid program containing multiple types of instruction styles (live interactive instruction, online self-study with asynchronous instructor support, group learning, recorded webinars, hands-on practice, one-on-one mentoring, etc.) with a broad range of modules on different topics, including special topics that may be made required for individual peer specialists to complete before being done with training.

Conclusion

Considering the ever-evolving landscape of hotline and crisis services and current crisis redesign efforts, the successful integration of peers with lived experience is critical.

Historically, attempts have been made to create a host of alternatives to traditional and clinically based mental health, substance use, and overall wellness supports. These supports have proven to be largely ineffective in reducing systemic harm and have substantially failed marginalized communities.

We strongly recommend that hotlines looking to engage peer specialists in their programming go beyond integration of individuals, and commit to full structural integration of the peer support ethic into their crisis work. Due to its unique adaptability and priority of staying true to the needs and self-determined goals of the people it serves, peer support practices can be a powerful agent of change in crisis work and can bring about the shifts that mental health systems need to continue undergoing in order to decrease harm to vulnerable communities. Due to clinical mental health options being historically unsafe and unprepared to care for poor people, people of color, immigrants, LGBTQIA+ people and disabled people, it is essential that new programs look to new models of care to safeguard service recipients from harm and peer support workers from moral injury.

PeerPride is honored to be a voice for change and support the design of safer systems.

The authors of this document believe strongly in the ethics, principles, culture and ethos of peer support. Much of this work has been made possible by those who have lost their dignity, personhood, and lives, in the process of seeking safe and humane care and shelter from harm and injustice.

- https://www.nami.org/Blogs/NAMI-Blog/July-2019/Racial-Disparities-in-Mental-Health-and-Criminal-Justice

- https://www.counseling.org/docs/default-source/vistas/when-treatment-becomes-trauma-defining-preventing-.pdf

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- https://www.peersupportworks.org/

- https://www.ustranssurvey.org/