PEER SPECIALISTS on MOBILE CRISIS UNITS

Mobile Crisis Units are teams that can include Peer Specialists, who are individuals with mental health lived experience. These units travel to locations where individuals are experiencing a crisis, offering immediate support. Peer specialists on these teams provide assistance, active listening, and connect individuals with appropriate resources, contributing to more understanding crisis intervention in community settings.

South Southwest (HHS Region 6) MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

The University of Texas at Austin
Texas Institute for Excellence in Mental Health
Steve Hicks School of Social Work

New England (HHS Region 1) MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

yale program for recovery and community health

SAMHSA
Substance Abuse and Mental Health Services Administration

Published in 2024 by the South Southwest Mental Health Technology Transfer Center (MHTTC)

Texas Institute for Excellence in Mental Health
1823 Red River St
Austin, TX 78701
United States

This publication was prepared by the South Southwest Mental Health Technology Transfer Center (TTC) Network under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA).

For more information on obtaining copies of this publication, email us at southsouthwest@mhttcnetwork.org or txinstitute4mh@austin.utexas.edu.

At the time of this publication, Dr. Miriam Delphin-Rittmon, served as Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration.

MOBILE CRISIS UNITS

Community-based Mobile Crisis Units use face-to-face intervention, deployed in real time to the location of the person in crisis in order to achieve the needed and best outcomes for that individual. These teams consist of mental health professionals and may include Peer Specialists.

"Crisis" in mental health systems is often the gateway to intensive (and sometimes unwanted) interventions that trend to reduction of personal rights and freedom – ie restrictive settings and treatment including seclusion and multiple types of restraint, etc. For these reason, and to emphasize the subjectivity of people at the center of this inquiry, I favor the use of 'person experiencing intensity 'people in distress', etc."

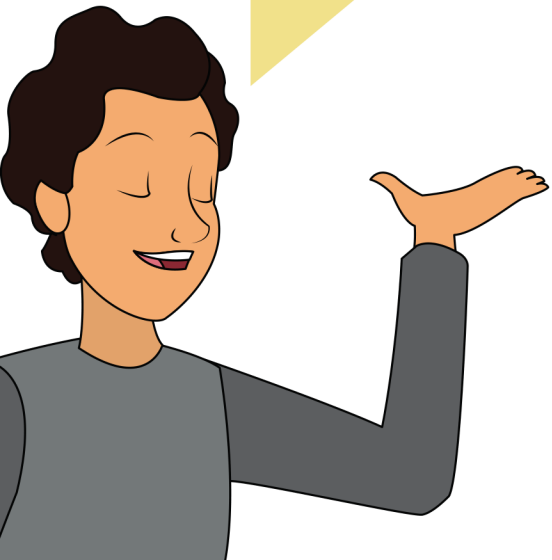
-Eduardo Vega

ADDITIONAL STAFF ON MOBILE CRISIS UNITES

Clinicians capable of assessing the needs of individuals and law enforcement may be on mobile crisis teams. Mobile Crisis Units that operate without law enforcement accompaniment are strongly preferred. There may be special circumstances that warrant law enforcement officers to be involved, though each unit will have different policies surrounding the role and involvement.

"Being recovery-oriented is at the core of our response. We approach all situations with the belief that people can and do recover from mental health crisis."

-Clay Robbins



PEER MOBILE CRISIS TEAMS TOOLS

"Being person-centered and strengths-based are principles that guide [peer interactions]. We approach every situation and every client as unique. We try to help a person plan their own crisis resolution by identifying the strengths they have and, in their situation, how to use those to their best advantage. The peer approach focuses on possibilities and options as opposed to consequences."

-Clay Robbins

Person-Centered Engagement practices, aiming to reduce power differentials.

Ask about the individual's experience and what happened, not what's wrong.

Collaborate with the individual to examine potential solutions, giving priority to autonomy and choice in referral options.

Share personal stories as needed, establishing common ground for swift engagement.

Ask the person what would be helpful for them – they are the expert of their experiences.

Engage in ways that are culturally relevant. Peer Specialists ideally share intersectional identities with the region served.

Communicate quickly, clearly, and effectively with all people involved.

Hold space for the individual to explore intense feelings including suicidal intensity and rage.

PEER SPECIALISTS on MOBILE CRISIS UNIT TEAMS

- Grasp the concept of trauma and provide support centered around healing.
- **Emphasize strengths and skills in interactions.**
- Reflect on the demographics of the area, considering both language and culture.
- **Engage with callers describing intense experiences, including suicidality or hallucinations, irrespective of whether the Peer Specialist has personal lived experience**.
- Participate in peer-led training explicitly tailored for Peer Specialists, aligning with peer values and practice principles. Standard crisis response training for general or clinical staff is not sufficient.
- **Express dissent with decisions regarding involuntary commitments made by others. Share personal stories when appropriate.**
- Advocate effectively for both themselves and the individuals they serve.

- Misrepresent as a clinician.
- **Try to solve callers' problems.**
- Keep personal information confidential.
- **Avoid directives on medication adherence.**
- Stick to the Peer Specialist role; avoid extra or non-role duties.
- **Do not take on clinical duties like assessments and diagnosis.**
- Do not take actions that are coercive, disempowering, or beyond the Peer Specialist's scope of responsibilities.
- **Avoid decisions leading to involuntary hospitalizations or jail, and don't endorse such decisions**.
- Are not involved in involuntary hospitalizations, including paperwork signing or acting as a witness.

SUCCESSFUL PEER SPECIALISTS

Clear roles and duties consistent with peer support.

Trust individual expertise regardless of distress; support to recall or uncover personal knowledge.

Avoid peer isolation; collaborate within a team to prevent peer drift and maintain fidelity to principles.

Effective supervision by experienced peers ensures fidelity and support within peer roles and principles.

Clinician co-workers/collaborators/colleagues who understand and respect the peer role.

An understanding of their own boundaries or triggers and how they might be impacted by the work.

Self-care strategies.

Provide thorough, ongoing training covering peer roles, ethics, boundaries, and crisis intervention for staff development.

Career opportunities for advancement.

Adequate and equitable pay.

ORGANIZATIONAL LEADERSHIP TIPS

"Peers have their own expertise that is not going to look like expertise in clinical work – that does not make it less valid, it does not mean we do not know what we are talking about. We are experts based on lived experience and our extensive training, not textbook material."
-Lauren Rosenzweig

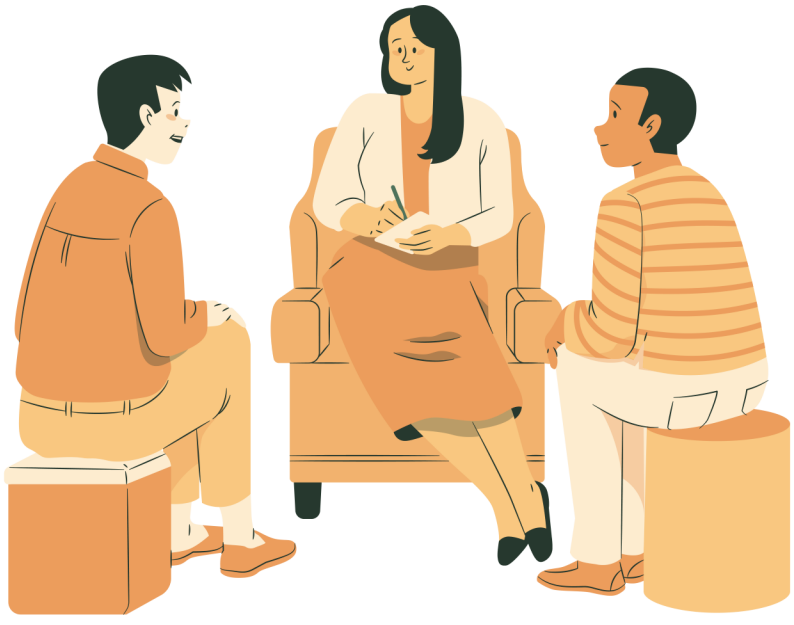
Hiring

Prioritize peer specialists based on skills, not diagnosis, to prevent tokenization as "consumers."

Hire peer supporters with diverse mental health challenges, including substance use and complex issues or experiences.

Ensure sufficient peer specialists are hired for meaningful impact, avoiding reliance on one.

Remove policies rejecting applicants with prior criminal justice involvement.



ORGANIZATIONAL LEADERSHIP TIPS

Peer specialists who are adhering to their role appropriately will not define what a desirable outcome or "recovery" looks like for a person seeking support.

- Kirill Staklo

Supervision

Train supervisors in peer support fundamentals to aid Peer Specialists in professional growth.

Educate supervisors on peer support nuances, guiding them in ethical support provision.

Prefer peer supervisors who are peer specialists or with lived experience for supervisory roles.

Establish peer-to-peer groups for mutual support and co-supervision from peer perspectives.

Maintain consistent expectations for all employees, including leave policies.

Integrate consciousness-raising sessions for all Mobile Crisis Unit Team members, addressing coercion and trauma-informed care.

Offer debriefing and additional support to Peer Specialists witnessing challenging incidents like restraint.

Leadership

“Organizations should also have policies in place to support peer support staff in maintaining their own wellbeing, such as clearly explaining that sick days can be used for mental health as well as physical health, having a leave policy that allows someone time away without risk of losing their job, and offering benefits so staff can take care of their needs and access services.”

- Morgan Pelot

Tips for Organizational Leaders

Respect peers; affirm equality; avoid superiority; appreciate their contributions and perspectives equally.

Value peers' unique skills; recognize Peer Specialists for their distinct contributions to the team.

Shift team focus to emotional support, empathy, and acceptance rather than risk assessment protocols.

Educate policymakers on peer services, evidence-based practices, roles, and funding requirements comprehensively.

Involve peers in leadership roles during program design, policy development, and procedure establishment.

Create formal documents outlining distinct peer roles, ensuring separation from other provider roles.

Provide peer-specific training facilitated by peer-led groups, aligning with peer values and principles.

Do not frame peer support as a cost-saving measure; prioritize its inherent value.

Overemphasis on cost savings may devalue peer support, leading to chronic underfunding and undervaluation.

POTENTIAL CONFLICTS FOR PEER MOBILE CRISIS

Like all professional disciplines, there is an ethical code for Peer Specialists. Some routine practices on Mobile Crisis Units might compromise ethics and values. Organizations need to consider these conflicts and design policies in ways that reduce or eliminate these conflicts for Peer Specialists.

Once a clinician determines a client needs to go to the hospital, we do our best to encourage them to go voluntarily. However, rather than persuading clients, we do our best to be open, honest, and matter of fact about the situation. If a client is willing, we try to support them through this difficult and traumatic process. This looks different at different times. Sometimes...peer specialists offer to go to the hospital with clients, ride in ambulances. and/or meet them there to support them through admission. Other times we lend our support to family or others that might be involved.

- Clay Robbins

Conflict & Remedies

Conflict	Remedies
Taking notes or maintaining documentation about individuals without involving them.	 • Discuss content of the note as it is being developed. • Organizations may opt to not require Peer Specialists to write treatment notes. • Allowing clients to read the note and suggest edits or additions.
Job expectations that do not fall within a peer support role.	 • Organizations can ensure that job descriptions include duties consistent with the peer support role. • Expect all staff to perform functions included in their job descriptions and not to go beyond these duties and functions.
Police dispatched with other members of the crisis team.	 • Allow Peer Specialists to discuss the situation with the individual before any force is considered. • If police are routinely dispatched, dispatch police in unmarked cars and plain clothes with weapons not visible.
Restraint might be used when behavior is assessed to be dangerous by clinician.	 • Organizations should not involve Peer Specialists in restraint situations. • Ensure restraints are the last option used to de-escalate a situation.
The individual might confide to peer specialist that they do not want to take their medication or participate in prescribed treatment	 • While Peer Specialist should not advise the person about program participation, they can support the person in speaking up about their concerns about prescribed treatment. • Peer Specialist may share personal stories that could help the person find a way out of their conflict about services.
Adjudicated treatment orders into peer services	 • In privately operated programs, the option to refuse court referrals exists, but this discretion may not apply if the program receives public funds. • Peer Specialists can empower individuals by offering choices beyond court-ordered activities, even though they cannot influence the court's decisions or details of treatment orders. • Organizational leadership has the responsibility to educate the court on the effectiveness of peer services when engagement is voluntary.

There was not a clear consensus on a few points. For example, all peer experts surveyed agreed that Peer Specialists should not be involved in coercive activities such as forced restraints, medications, and/or hospitalizations. However, some reported that Peer Specialists should not be affiliated with programs that allow these activities or any possibility of force or coercion (such as police presence). Some of the peer experts reported defining “firewalls” that allow peers to provide services outside of these sensitive areas.

All reported that supervision must be provided by someone who understands the peer role, and that a peer in a supervisor role would be preferable. There was not consensus among peer experts regarding whether or not a clinician trained to understand the peer role should provide supervision for this role.

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The content provided in this document is not exhaustive. Contributors provided expertise; their contribution does not imply endorsement nor does it imply opposition to the document.

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