



The Pillars of Peer Support Services Summit

The Carter Center

Atlanta, GA

September, 2013

Pillars of Peer Support Services Summit 5 - The Role of Peers in Building Self-Management within Mental Health, Addiction and Family/Child Health Settings.

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Background and Introduction

The Pillars of Peer Support summits have been held on an annual basis in Atlanta, GA at the Carter Center. The first summit was held in November 2009 to examine and promote Peer Support Services (PSS) in state funded Medicaid plans. The goal of this and subsequent summits has been to provide technical support to states in the development and deployment of the peer workforce. Originally the focus was on the behavioral health field, but later summits have sought to include perspectives from the Addictions field, Parent Support Providers, and others. Throughout this series of summits a leadership team has worked with sponsoring organizations and state behavioral health authorities to provide an ongoing forum on Peer Support Services.

The Pillars of Peer Support Services Summit V was held at The Carter Center in Atlanta, GA on September 25 and 26, 2013. The title of this summit was: “The Role of Peers in Building Self-Management within Mental Health, Addiction and Family/Child Health Settings.” A central goal of this summit was to expand the inclusive range of Peer Support Services and include Recovery Coaching and Family Support Services. A primary focus was also to examine how self-management can be promoted through these services in health settings. This report includes an overview of key findings with supporting references, including the Power Point slides for the presentations made at the summit.

Pillars of Peer Support V (2013)

The design and format for the 2013 Pillars of Peer Support Summit was similar to past sessions. It included a combination of keynote presentations, panel discussions, and facilitated participant groups. Participants were again nominated by state behavioral health authorities, and included representatives from a wide range of peer services. Two keynote sessions were provided at the 2013 summit. Larry Davidson, Ph.D., Professor of Psychiatry and Director, Program for Recovery and Community Health at Yale University School of Medicine presented: The Role of Peers in Building Self Engagement among Consumers of Services. Larry Fricks, Deputy Director, SAMHSA-HRSA Center for Integrated Health Solutions presented: The Role of Peers in Building Whole Health Self-Management Outcomes.

Three panel discussions were presented at the Pillars of Peer Support Services Summit V. The first panel examined the issues of “Family Self-Management Innovations and Outcomes within the Family/Child Community.” The participants for this panel included Sue Smith, CEO of the Georgia Parent Support Network, and Frances Purdy, Director, Certification Commission for Family Support. The second panel focused on Peer Self-Management Innovations and Outcomes within the Addiction Recovery Community. The participants included Neil Kaltenecker, Executive Director, Georgia Council on Substance Abuse; Charryse Copper, Consultant, SAMSHA National Center for Trauma Informed Care; and James Guffey, Director, Community Recovery Supports for the Georgia Mental Health Consumer Network. The third panel considered Peer Self-Management Innovations and Outcomes within the Mental Health Recovery Community. This was led by James Sawyer, Youth Engagement Content Specialist at the TA Partnership for Child and Family Mental Health; and Beth Filson, a Certified Peer Specialist and Independent Consultant for Trauma Informed Care.

Two workgroup sessions of facilitated discussions were included in the summit, and all attendees participated. Participants self-selected into three groups of Mental Health, Addictions, and Family Support. Each of the discussions included a focus question, and group reports were provided to the full group of summit participants. For the first work group the focus question was: What skills and/or abilities do family support peers, addiction recovery peers and mental health peer support specialists bring to the workplace that make them effective in teaching and supporting self-management/self-care? For the second work group the focus question was: What can agencies do to position and

support Family Support Peers, Addiction Recovery Peers, and Mental Health Peer Support Specialists to insure that they are effective in teaching and supporting self-management/self-care?

Keynote presentations

Dr. Larry Davidson

Dr. Davidson began his presentation noting that engagement in care historically has meant connecting persons with mental illnesses and/or addictions to needed behavioral health services and supports (i.e., getting people ‘into treatment’). This contrasts with self-engagement, which means engaging persons with behavioral health conditions in managing their own conditions and their own care. *Self*-engagement was then the focus for his presentation.

He noted that currently we are moving away from a care model of *symptom management*, which has always (falsely) accepted long-term disability as an inevitable outcome for those with mental illnesses. We are now moving towards promoting the recovery, social inclusion, and citizenship of persons with mental health conditions (and addictions) through the use of community-based supports, including those that are peer-based. Additionally, the Affordable Care Act (ACA) and Centers for Medicare and Medicaid Services (CMS) are likewise shifting foci to self-management of health care conditions, including in behavioral health. Dr Davidson noted that, as this happens, who is better positioned to promote self-management than peers?

This is leading to a paradigm shift. Traditionally, we (professionals) have treated mental illnesses with the hope that the illness would go away. Yet unfortunately too often it was the person who was sent away. Now we are focusing on preparing and equipping people to take care of their mental illnesses and themselves while remaining in the community. In order to adopt this approach, what do people need to engage in self-care? People need to have available and consistent social support; accurate and accessible information (and, if needed, health education and modeling); an internal locus of control; and a personal sense of efficacy.

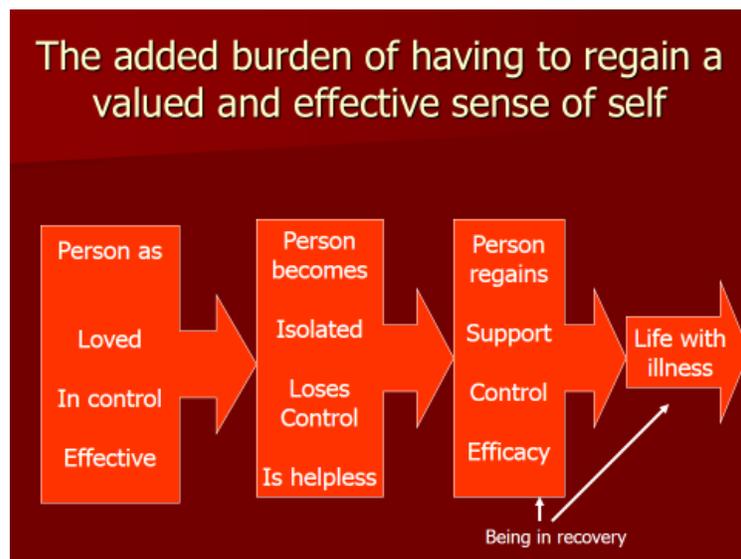
Dr. Davidson identified key factors for self-care that commonly are detrimentally affected by having a serious mental illness. These include: The availability and consistency of social support (through stigma, rejection, and alienation); accurate and accessible information (and, if needed, health education and modeling); an internal locus of control (through illness/symptoms); and personal sense of efficacy (through illness, repetitive failures, demoralization, and discrimination).

Before people with serious mental illnesses can exercise self-care, they will need to: Acquire or have social supports; be provided with accurate and useful information about “self-care”; re-establish an internal locus of control; and regain a personal sense of efficacy. The added burden of having to regain a valued and effective sense of self challenges self-care outcomes.

Dr. Davidson provided a framework that outlines the challenges of having to regain a valued and effective sense of self.

This is illustrated in figure 1.

Figure 1.



As a result of these challenges there are three implications for practice and care. These include 1) Most people with serious mental illnesses will be able to figure out how to take care of themselves while living a meaningful and gratifying life. 2) In order to do so, they may first have to regain a sense of being loved and accepted as a worthwhile person who can have some control over his or her life, and be somewhat effective in the world. 3) This may represent a first and essential step toward recovery, and a first focus of efforts of peer staff to engage people in self-care.

A clear role for peers in this process was also identified by Dr. Davidson. He noted that in order to lay this essential foundation, peer staff need to pay particular attention to the micro-processes and micro-decisions of everyday life. This is because the process of recovery from mental illness is made up of the same innumerable small acts of living in which we all engage, such as walking a dog, playing with a child, sharing a meal with a friend, listening to music, or washing dishes. Recovery is nothing more, but also nothing less. Recovery must be strengths-based. It is these activities that form the focus of recovery-oriented clinical and rehabilitative interventions. As a result, interventions must focus on enhancing pleasure and competence as much as, if not more than, treating illness and remediating deficits. This is both more gratifying and more fun, as well as more effective. In promoting recovery, the role for peers is clear and important. Their role is to help by focusing on eliciting and enhancing the person's own sense of control and efficacy, as only the person him or herself can enter into, pursue, and maintain his or her own recovery. The goal is to focus on identifying and building upon each person's assets, strengths, and areas of health and competence to support the person's efforts to manage his or her condition—all while establishing or re-gaining a whole life and a meaningful sense of belonging in and to the community. In order to achieve this, Dr. Davidson notes that we must 'invite' people to take an active role in their own care (i.e., self-care). This includes exploring a person and family's own understanding of the situation, and providing information, education, and role modeling related to self-care. This is achieved by connecting self-care to personally relevant goals, aspirations, and understanding "activation."

Patient (behavioral) Activation includes helping people: Prepare for health care visits and ask questions; identify and set health-related goals; plan specific action steps to achieve goals; encourage exercise and good nutrition; assist in daily management tasks; assist in problem solving; provide social and emotional support and feedback; and follow up with people over time. Behavioral health symptom management goes beyond medication adherence. Experiences and symptoms can be discussed, explored, and monitored with trusted others, and rendered less disruptive. There is an important and key role for trusted others, and recovery cannot be simply the latest thing we do to people with mental illnesses.

In conclusion, Dr. Davidson identified that there is an important role for peers in building self-engagement among consumers of services. This is achieved through four key activities and resources and includes the principles of: 1. Support: Having people believe in and support me (i.e., not having to do things alone). 2. Hope: Tangible and living proof of the possibility of recovery (i.e., peer role modeling, mentoring, and support). 3. Opportunity: Clear directions, instructions, and expectations. Having the opportunity to take initial steps and to ask others for clarification. 4. Tools: Memory aids and other devices to assist the person in structuring his or her time. We cannot assume that people either already have, or will think of, such simple tools of everyday life on their own. Due to learned non-use, they often don't.

Dr. Davidson's presentation was well received by the attendees and it stimulated several questions from the audience. Key among these was the notion that there is a role for peers in helping those with behavioral health conditions to build and sustain a strength based recovery.

Larry Fricks

In his keynote address Larry Fricks presented "The Role of Peers in Building Whole Health Self-Management Outcomes." He noted that the power of a Peer Provider is that he or she understands and can support three important issues. These include: 1) The human need for connection; 2) The disabling power of a mental illness; and 3) The shift currently happening in the public behavioral health system. Illustrating the power of a peer provider, he cited a study by Rush University Medical Center in Chicago, which found that "social ties could play a more important role in determining longevity than even smoking, lack of exercise, or obesity," and can also "help you live longer and better" (AARP Bulletin: February 2013).

Peer providers bring lived recovery experiences that include addressing whole health, both mind and body. They are hired because of their whole health recovery experiences and not their clinical education. This means they can focus on the impact of the illness rather than the symptoms of the illness.

Larry Fricks cited six key attributes of Peer Support Specialists that promote recovery. These include: 1) Insight into the experience of internalized stigma; 2) a sense of gratitude that is manifested in compassion and commitment; 3) Peer

Specialists take away the “you do not know what it’s like” excuse; 4) they have had the experience of moving from hopelessness to hope; 5) they are in unique positions to develop relationships of trust with their peers; and 6) they have developed the gift of monitoring their illness and managing their lives holistically, including both mind and body.

The Affordable Care Act (ACA) and health care reform promote prevention, whole health and self-management. Larry Fricks noted that there are critical roles for peers trained as whole health coaches. A second critical role for peers is to be trained as healthcare navigators/coaches, as is being piloted at two Federally Qualified Healthcare Centers (FQHCs) in Michigan.

Mr. Fricks also cited whole health and resiliency as the new frontier in recovery. Up to 80% of health care visits are stress related, and prolonged stress can lead to physical illness and trigger relapses of mental illness and addiction. In addition, trauma, stigma, discrimination and poverty are common stressors for peers. Quoting Rosalyn Carter in her 2010 book *Within Our Reach – Ending the Mental Health Crisis* “When a person is under severe stress, the brain has to work very hard to maintain normal blood pressure, heart rate, and temperature, among other things. If a person experiences multiple, continuous stressors, he starts losing the battle.” Fricks also noted that according to Dr. Gregory Frichione, Director of the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital, “The key to managing stress is resiliency.”

Mr. Fricks spoke about the Whole Health Action Management (WHAM) training, and that it contains ten key factors. These are: Stress management; healthy eating; physical activity; restful sleep; optimism based on positive expectations; cognitive skills to avoid negative thinking; service to others; support network; meaning and purpose; and spirituality.

Larry Fricks also reported on the role of Peer Health Navigators/Coaches in the Michigan FQHC pilots. In these programs Peer Support Specialists provide: Appointment assistance, follow up with specialty services and managing complex health/service systems; help identifying community resources, benefits and referral to outside agencies; linking to community based formal and informal supports for whole health self-management; developing Wellness

Recovery Action Plans (WRAPs) and facilitating classes and groups in WHAM, diabetes, pain management, increasing physical activity, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and dual recovery; and providing individual support related to self-management of two or more chronic conditions.

In closing, Larry Fricks quoted Dr. Martin Luther King, Jr. - “We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.”

Panel Presentations

Panel # 1 - Family Self-Management Innovations and Outcomes within the Family/Child Community

Panelists:

Sue Smith – CEO, Georgia Parent Support Network

Frances Purdy - Director, Certification Commission for Family Support

The first panel discussion in the Pillars of Peer Support Summit V addressed the role of Family Self-Management within the family and child community. Brief presentations were provided by Sue Smith, CEO of the Georgia Parent Support Network and Francis Purdy, Director of the Certification Commission for Family Support. Both presentations laid out the framework for the role of family support services within the continuum of care for youth. Personal stories and journeys were used as part of the presentations to illustrate key points for this panel.

The role of the family support services to provide advocacy was noted as a key resource for parents and families who are struggling to build recovery based goals and outcomes. Empowering parents and families to better understand, access, negotiate, and engage in recovery-based services promotes enhanced self-management. Parent Support Providers can be a valuable component of the overall services available to foster recovery and promote resiliency.

The credentialing process for Certified Parent Support Providers (CPSP) was described by Francis Purdy. She noted that CPSPs use their lived experiences and specialized training to assist and empower families raising children and

youth who experience emotional, developmental, behavioral, substance use, or mental health concerns. Partnering with service systems, they can help families overcome stigma and discrimination, and can improve family outcomes. Seven key CPSP roles were identified and include: Leadership development and systems advocacy; child/youth skills building; parent/adult skills building; support, connecting, and mentoring; goal setting and information sharing; information and referral, intake or initial engagement; outreach, awareness, and stigma reduction.

Ms. Purdy also reported in this session that it is important for family and peer service providers to have a clear understanding of the different levels of professional designation, and presented five different categories and definitions. These include:

CERTIFICATE – The recognition of completion of a training or educational program (which may be based on reaching a certain level of proficiency or just “seat hours”)

CREDENTIAL – The recognition of successful completion of a training, educational program, and/or documented experience that adheres to established professional standards set by an Institution of Higher Education or a professional group / organization, eg. MSW, JD, RN, etc.

CERTIFICATION/CERTIFYING– The process of voluntary recognition of an individual who meets specific established knowledge, skills and attitudes/dispositions for initial and continuing practice as set by a standardized process in accordance with an appropriately accredited organization

LICENSURE – Mandatory regulatory structure for authorizing or permitting a specific scope of practice of an individual professional. This may include specific endorsements that define the population served or topic content allowed within the license.

ORGANIZATIONAL ACCREDITATION – Voluntary recognition of an organization that meets specific established standards or criteria, eg: JCHO, COA, CARF, CHEA, ANSI/IEC

Differentiating between these categories will support greater professionalism and clarity within the field.

The first panel stimulated broad discussion among the summit participants. There was interest in the certification process and the role of different programs, providers, and services offered. It was noted by several participants that the role of family supports in the continuum of services is a key to promoting self-management and recovery.

Panel 2 - Peer Self-Management Innovations and Outcomes within the Addiction Recovery Community

Panelists: Neil Kaltenecker – Executive Director, Georgia Council on Substance Abuse

Charryse Copper – Consultant, SAMSHA – National Center for Trauma Informed Care

James Guffey – Director, Community Recovery Supports for the Georgia Mental Health Consumer Network

This panel provided an overview of key components of self-management for those receiving services the addictions recovery community and the roles that peers serve in this process. Personal stories and journeys were used as part of the presentations to illustrate key points for this panel. Overviews of different programs were also used to illustrate the range of services available in this community. The workforce roles of Recovery Coaches and Certified Recovery Empowerment Specialists were described.

Peer self-management was described as a process of helping others to recognize the challenges of addiction recovery and providing the necessary supports for positive outcomes. The process of recovery is aided by the support of someone with lived experiences to promote engagement and overcome the grasp of addictions. Personal stories were used to describe how trauma and other life events challenge the recovery process. In each case the role of peer and community supports were noted as key elements in recovery.

This panel generated lively discussion of the different roles that peer-based services can provide in the systems of care for people with substance use conditions. Additionally, there were questions for the panelists about how they have been able to use their own personal recovery journeys to help others and promote improved outcomes of care.

Panel # 3 - Peer Self-Management Innovations and Outcomes within The Mental Health Recovery Community

Panelists:

James Sawyer – Youth Engagement Content Specialist, TA Partnership for Child and Family Mental Health

Beth Filson – Certified Peer Specialist, Independent Consultant for Trauma Informed Care

A central focus of this panel was the role of peers in supporting the development of individuals' self-management and recovery. A focus on the role of peer supports for youth was presented by James Sawyer. Beth Filson discussed the influence of trauma in mental health recovery and the important role that peers can have in fostering recovery and promoting resiliency.

Both panelists used personal stories and experiences in describing the role of peer supports, and how these influence their own work as peer and youth support specialists. James Sawyer discussed how technical assistance is being provided to those who are developing systems of care resources for youth and families in the Children's Mental Health Initiative (CMHI). Issues around the training, supervision, certification, funding, hiring and retention of youth peer staff were noted as key challenges.

Beth Filson described the role of trauma as a key element in understanding both the need for services and the role of the peer specialist in promoting self-management and recovery. Personal stories were used to illustrate her key points that trauma must not be overlooked or ignored as a powerful influence in the recovery process.

There was active discussion about the role of peer support services in the spectrum of mental health services. It was also noted that the experiences of those with lived experiences can have a significant and powerful role in promoting empowerment and fostering resiliency. Several summit participants were able to use their own stories as well to discuss and illustrate these points.

Working Groups

Working Groups Session One: (Note: for the work groups participants were asked to self-select into three groups – Family Supports, Addictions, and Mental Health)

For each of the breakout sessions the summit provided a focus question to begin conversations. For the first working group session this question was: ‘What skills and/or abilities do family support peers, addiction recovery peers and mental health peer support specialists bring to the workplace that make them effective in teaching and supporting self-management/self-care?’

In the *Family Support Work Group* there was active discussion about what roles this workforce has in promoting and supporting self-management and self-care outcomes. Their overall conclusion was that because of their lived experiences Family Support Peers have the ability to:

- 1) Make connections that support confidentiality and trust. Their self-disclosure helps promote hope and self-determination.
- 2) They are able to create supportive relationships. These help families to better understand their own experiences and validate both the traumatic experiences they have been through, and also celebrate victories in the recovery process.
- 3) Share experiences and describe what has been helpful to them. By helping to define their experiences for others, family support peers are able to both understand and explain the challenges that families experience.
- 4) Being strong promotes understanding and supports advocacy. Family support peers are able to demonstrate resiliency and promote advocacy and a sense that recovery is possible.
- 5) Family support peers are able to

translate the complex language of the care systems into human experience language. They are able to simplify and clarify all information and reframe information into useful messages and directions.

The *Addiction Recovery Peer Workgroup* also had active discussions about the role of this workforce in promoting self-management and self-care skills. They determined that there are a number of key factors that support their ability to foster recovery and promote favorable outcomes. These include: 1) Addiction recovery peers have the ability to instill hope and inspiration by being living examples of recovery, and allowing others to build and strengthen their own hope for recovery. 2) By telling their own stories without shame or judgment, recovery peers are able to give others new and/or different perspectives, and explore the many pathways to recovery. 3) Recovery peers are able to make connections and work to create a recovery culture. 4) Through the establishment of healthy boundaries, recovery peers are able to promote self-care goals and collaborative supports that model recovery for others. 5) Recovery peers are able to maintain mutuality as a hallmark of peer support, foster empowerment, and promote self-advocacy. 6) Through the sharing of community knowledge, recovery peers are able to provide information on how to address basic social and healthcare needs. 7) By engaging in advocacy, recovery peers are able to use person centered language and share experiences with others.

The *Mental Health Peer Work Group* found that lived experiences promote recovery and are key to having effective service systems. They noted that because of their lived experiences peer specialists are able to: 1) Make meaningful connections with others that role model equality and shared meaningful conversations. 2) They can use their recovery experiences to teach recovery skills. 3) Peers are able to see strengths in others and promote individual potentials that others may fail to recognize. 4) Peer specialists can use non-judgmental listening skills to promote strength-based approaches to recovery. 5) They support communications that demonstrate that recovery is possible and model personal responsibility. 6) Peers are able to “go the extra mile” for those they support through compassion and advocacy. 7) By providing practical survival skills, peers are able to help others navigate and negotiate complex service and care systems. 8) When peers model recovery and personal responsibility they are able to fight stigma in a respectful way. 9)

Peers are able to help normalize the experiences of others by validating symptoms that others may dismiss. 10)
Through their lived experiences peers are able to recognize barriers to recovery and help others to overcome them.

Working Groups Session Two

The working groups remained the same for the second session. Their task was to address the focus question: ‘What can agencies do to position and support Family Support Peers, Addiction Recovery Peers, and Mental Health Peer Support Specialists to insure that they are effective in teaching and supporting self-management/self-care?’ Each group discussed this and presented their findings to the larger group. Following these presentations there was an opportunity for the groups to discuss and develop a consensus of their findings. The facilitated discussion resulted in a consensus of five key elements that agencies can do to promote the role of peers in promoting self-care management. These included: 1) Training and education; 2) Supervision and staff support; 3) Equitable wages and support; 4) Agency inclusion at all levels; and 5) Building agency cultures that promote recovery

1) Training and education – Summit participants noted that the professional roles of Peer Specialists require both core and continuing education supports. This includes the training that is necessary to receive certification and the ongoing training that would be expected of any professional. Concern was expressed that agencies are cutting back training and education resources due to tight budgets, and this is impacting peer staff. There was also a concern that this could become disproportionate with other staff, and limit the professional development of peers. Additional issues were raised that as systems move to more chronic illness management that the peer workforce will need new training and exposure to self-care and self-management resources.

2) Supervision and staff support – The issue of supervision for Peer Specialists was identified by summit attendees as a particularly crucial issue for how agencies can promote the use of peer services. It was noted that there are a range of requirements for how Peer Specialists are supervised for billing and reimbursement. In some cases clinical professionals are required to provide this supervision, and there was concern expressed that frequently there is a lack of understanding of the roles of peers and how to effectively supervise their work. The summit participants noted that the

supervision of the peer workforce is an issue that requires attention and could be an important topic for future Pillars of Peer Support Summits.

3) Equitable wages and support – The summit participants recognized that there is a broad range of compensation for Peer Specialists. In some cases their value is recognized and wages are commensurate with the work they produce, and in others they are viewed as low wage alternatives for providing clinical services. In order for agencies to embrace and promote the role of peer services, peer providers will need to be paid appropriate living wages. This will provide respect and recognition that they are valuable contributors to care-providing teams.

4) Agency inclusion at all levels – The role of peer staff varies across different agencies. In some organizations they are recognized as full equals among the professional staff. In others they are seen as resources to support clinical staff and sometimes called upon to provide services that are not respectful of their roles. In order for agencies to build a culture of recovery, it is important to recognize and embrace appropriate roles for peer professionals.

5) Building agency cultures that promote recovery. There was extensive discussion about how agencies are able to build cultures that promote recovery. Peer services are seen as a core element of this approach, and there is an essential need for organizations to recognize and embrace this. This approach is only achieved when leadership is at the forefront promoting this, and there is an expectation that all members of the organization--from the board to all other staff-- must buy into it.

Next Steps and Conclusions

The summary feedback and evaluations support that this was another favorable and successful summit. Participants recognized that the concepts of self-management are central to recovery, and that as health systems expand their focus on chronic illnesses there is a distinct role for peer support. This includes all of the disciplines of family, addictions and mental health peer support services.

The presentations in this summit provided an effective base for the work that was done in the panel and breakout sessions. The work groups produced actionable information and a framework for how agencies can promote these services and build recover cultures. The participants also recognized the favorable role that the Pillars of Peer Support Services Summits have had in the evolving development and promotion of peer services.

Appendix

The Role of Peers in Building Self Engagement Among Consumers of Services

Larry Davidson, Ph.D.

Professor of Psychiatry and Director
Program for Recovery and Community Health
Yale University School of Medicine

Project Director, Recovery to Practice
SAMHSA

Two Types of Engagement

- Engagement in care historically has meant connecting persons with mental illnesses and/or addictions to needed behavioral health services and supports (i.e., getting people 'into treatment')
- **Self** engagement means engaging persons with behavioral health conditions in managing their own conditions and their own care (and is the topic for this session)

Current Situation

- Moving away from symptom management that has (falsely) accepted long-term disability as inevitable
- Moving toward promoting the recovery, social inclusion, and citizenship of persons with mental health conditions (and addictions) through the use of community-based supports, including peer-based
- ACA and CMS shifting to self-management of health care conditions, including behavioral health
- Who better to promote self-management than peers?

Paradigm Shift

- Traditionally, we (professionals) have treated mental illnesses with the hope that the illness would go away (but often it was the person who was sent away)
- Now, we are focusing on preparing and equipping people to take care of their mental illnesses and themselves while remaining in the community

What do people need in order to engage in self-care?

- Available and consistent social support
- Accurate and accessible information (and, if needed, health education and modeling)
- Internal locus of control
- Personal sense of efficacy



Factors that may have been detrimentally affected by having a serious mental illness

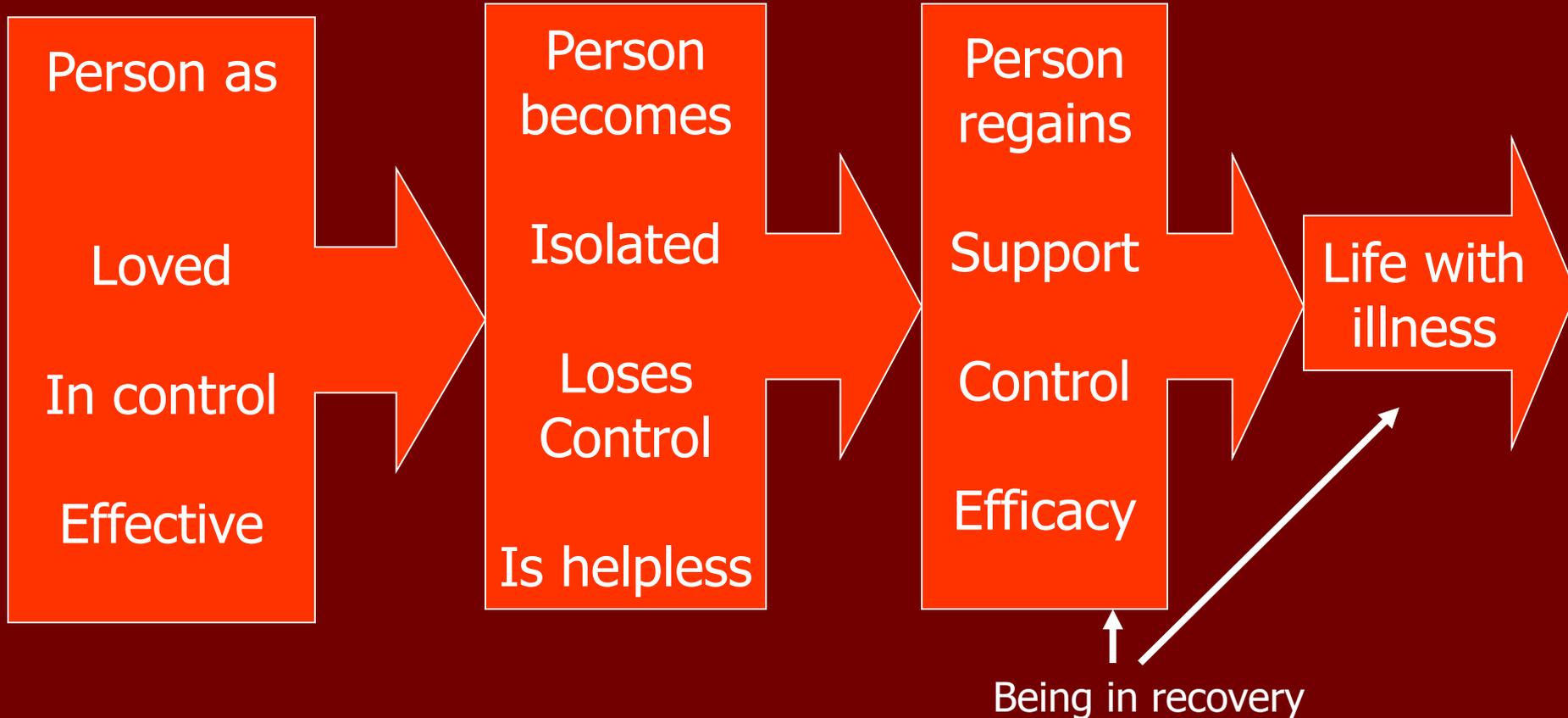
- ✓ Availability and consistency of social support (through stigma, rejection, and alienation)
- ✓ Accurate and accessible information (and, if needed, health education and modeling) (through stigma and discrimination)
- ✓ Internal locus of control (through illness/symptoms)
- ✓ Personal sense of efficacy (through illness, repetitive failures, demoralization, and discrimination)

Before they can exercise self-care, then

People with serious mental illnesses will need to:

- Acquire or have social support
- Be provided with accurate and useful information about “self-care”
- Re-establish an internal locus of control
- Regain a personal sense of efficacy

The added burden of having to regain a valued and effective sense of self



Regaining a sense of being loved and accepted ...

- “I’ m nobody till somebody loves me. That’ s the way I look at it.”
- “When I was going through my psychotic changes she was always there for me. She never turned her back on me.”
- “I think [riding the horse] helped me ... It relaxed me. And, well, I guess it made me feel like the horse loved me. Spending time with the horse, it felt like unconditional love... you connect with the animal and with yourself and you’ re outdoors and it does something to you. It’ s hard to explain, but when you go home you think, ‘Wow, another lesson! Wow, I’ m getting better!’ ”

... as a worthwhile person

“I could choose to be a nobody, a nothing, and just [say] ‘the hell with it, the hell with everything, I’ m not going to deal with anything.’ And there times when I feel like that. And yet, I’ m part of the world, I’ m a human being. And human beings usually kind of do things together to help each other out ... And I want to be part of that... If you’ re not part of the world, it’ s pretty miserable, pretty lonely. So I think degree of involvement is important ... involvement in some kind of activity. Hopefully an activity which benefits somebody. [That gives me the sense that] I have something to offer ... that’ s all I’ m talking about.”

Regaining a sense of personal efficacy

“It is being active, and I take pride and I’ m independent to a certain extent . . . like in my jazz music, like I’ll turn on my jazz radio, and I’ ll love it . . . it’ s my interest. I turn the radio on myself, no one had it going to nourish *themselves*, to entertain *themselves*, like parents would at a house. *I* turn it on, *I’* m responsible, *I* enjoy the music, *I* make notes and draw while I’ m hearing it. . . Then I turn it off, then I have some evidence, I ‘ve got something done, I’ ve been productive, I have the drawings to look at. . .

It was for me and by me. My own nurturing. So I’ m proud of this effort.”

“I have a good will, it just takes the right amount, the um, the kitchen has to be right, so to speak, before I do ... the endeavors. The feeling has to be right. Everything has to be right before you can make a cake ... If you don't feel like buying the flour for six months ... then you don't feel like it. Then you get your flour, and then you notice you don't have enough cinnamon, so you wait a while ...”

Regaining a sense of control

“I'm in a contest of will with the world, with nature ... and I say to myself: ‘Well, damn it, you just calm down and drink your coffee.’ And I say to myself: ‘You'll just have to wait five minutes.’ So I wait. And then the roommate's still bugging me out [but] then I have the control, the self-esteem, the confidence, and it's manageable. Then I just proudly walk to my room and take space. I mean, it's successful.”

“Basically, if you know recovery...it is more about taking control of your life and what you are going to do....”

“there is this wicked side of me that can stop me. Just like when I’ m looking for a job and see a job that would suit me, there is a voice that says, ‘Ah, that’ s no job for you’ , and stuff like that. And so I have to work a lot with that voice, ‘Oh, shut up, I’ m going to apply for that job anyway’ .

It’ s a struggle going on inside me all the time.”

I can be a friend

I can ride a horse!

I can make drawings

I can turn on and off my own radio



Scaffolding a new sense of self

Attention to micro-decisions and acts

“People take for granted that you just do things. A person with mental illness, it’s sometimes hard ... it’s like you’re distracted, you can’t get involved because you’re not sort of all there.”

Getting there step by step

“So I take it step by step. I have learned to *hurry slowly* and do it in stages and set partial goals when I have discovered that it makes sense ... doing it by partial goals and making it manageable, then you get positive feedback that it's going okay and then you don't hit the wall. That's my strategy, the strategy for success: partial goals and sensible goals and attainable goals, and that's something I've learned to do in order to achieve things. When I have been able to deal with something that's been a struggle and feel secure, I move on. Step by step, put things behind me.”

“Before ... everything was in the long term... Instead, having to hang on, to find strength, I live small moments more intensely. Now we’re here, you and I, and my whole life is all here, only here. It doesn’t matter what else happens... This moment here is more important than anything that might happen tomorrow.

This was definitely decisive for me, this fact of living intensely what I’m doing instead of worrying about the future or other things was a real support, a cornerstone for everything ... a very difficult awareness, a difficult position to take, but living intensely whatever I’m doing, being very concentrated, for me personally ... I did this and no one told me to do it. I did it on my own and it works. For me.”

“Each time I recover enough, I borrow a dog and go for a walk”

“My first step after getting out of bed was to come here (to the centre); I’ d come here even if it were only for 5 or 10 minutes a day. And those 5, 10 minutes turned into hours, weeks and finally I became the secretary and district representative, and now I write for Revansch! (magazine) and the local newspaper...”

Implications for practice and care

- Most people with serious mental illnesses will be able to figure out how to take care of themselves while living a meaningful and gratifying life in the face of the disorder
- In order to do so, they may first have to regain a sense of being loved and accepted as a worthwhile person who can have some control over his or her life and be somewhat effective in the world
- This may represent a first and essential step toward recovery and a first focus of efforts of peer staff to engage people in self-care

What peers can do

- In order to lay this essential foundation, peer staff need to pay particular attention to the micro-processes and micro-decisions of everyday life. This is because recovery is made up of the same innumerable small acts of living in which we all engage, such as walking a dog, playing with a child, sharing a meal with a friend, listening to music, or washing dishes.
- ***It is nothing more but also nothing less.***

Be Strengths-Based

It is these activities that form the focus of recovery-oriented clinical and rehabilitative interventions. As a result, interventions focus on enhancing pleasure and competence as much as, if not more than, treating illness and remediating deficits.

This is both more gratifying and more fun, as well as more effective.

“You can do it. We can help.”*

- Focus on eliciting and enhancing the person’s own sense of control and efficacy, as only the person him or herself can enter into, pursue, and maintain his or her own recovery
- Focus on identifying and building upon each person’s assets, strengths, and areas of health and competence to support the person’s efforts to manage his or her condition while establishing or re-gaining a whole life and a meaningful sense of belonging in and to the community.

*The Home Depot

Then what?

- 'Invite' people to take up an active role in their own care (i.e., self-care)
- Explore person and family's own understanding of the situation
- Provide information, education, and role modeling related to self-care
- Connect self-care to personally relevant goals, aspirations, and understanding

Patient (behavioral) Activation

- help people prepare for health care visits and ask questions;
- identify and set health-related goals;
- plan specific action steps to achieve goals;
- encourage exercise and good nutrition;
- assist in daily management tasks;
- assist in problem solving;
- provide social and emotional support and feedback;
- and follow up with people over time

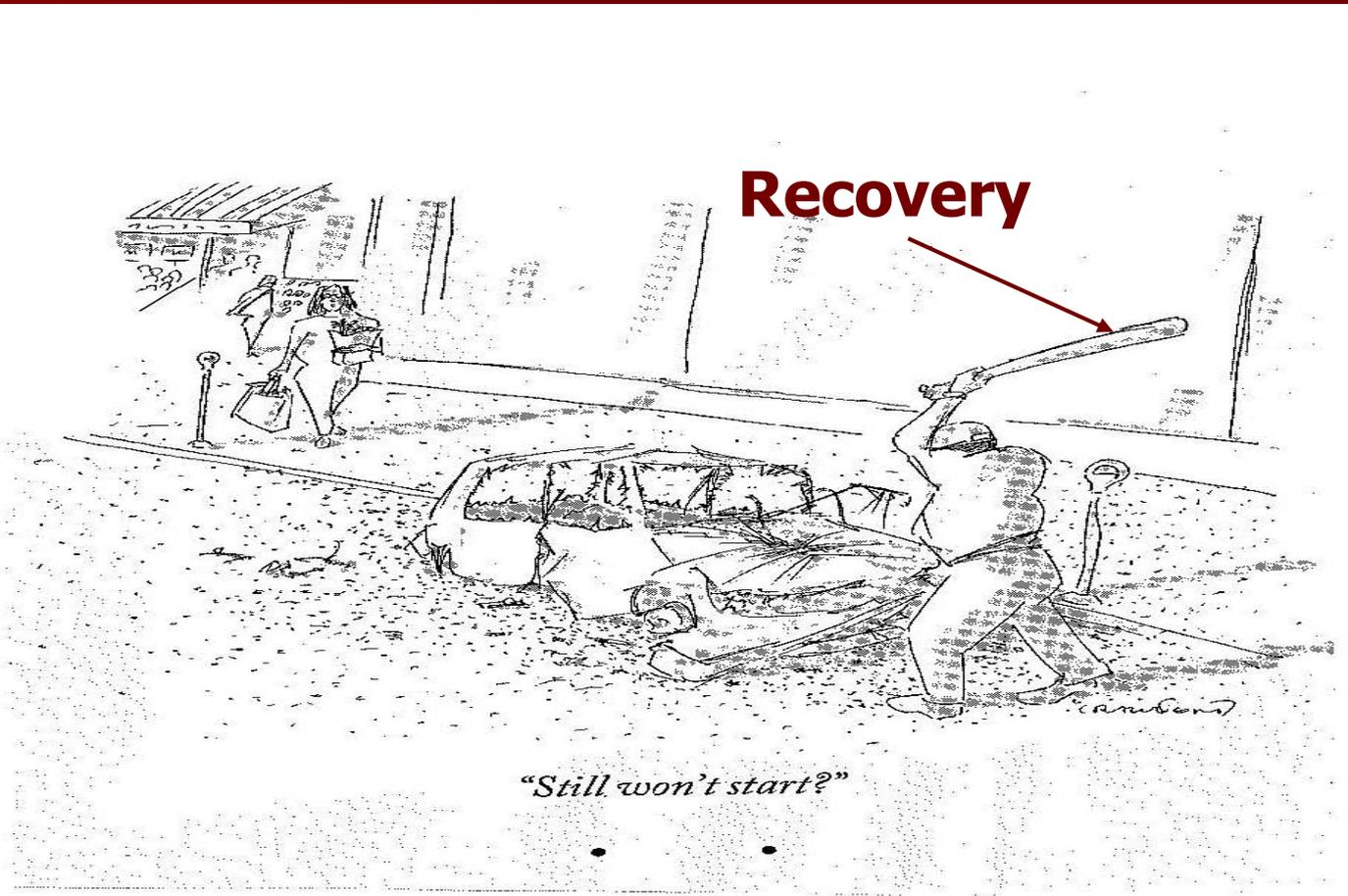
Specific to behavioral health

- Symptom management goes beyond medication adherence
- Auditory hallucinations (“voices”) can be discussed and explored with trusted others, and rendered less disruptive
- Delusions and paranoia can be checked out with trusted others and decreased
- Mood can be monitored by trusted others

Two Key Points

1) There is a **KEY ROLE**
for **TRUSTED OTHERS**

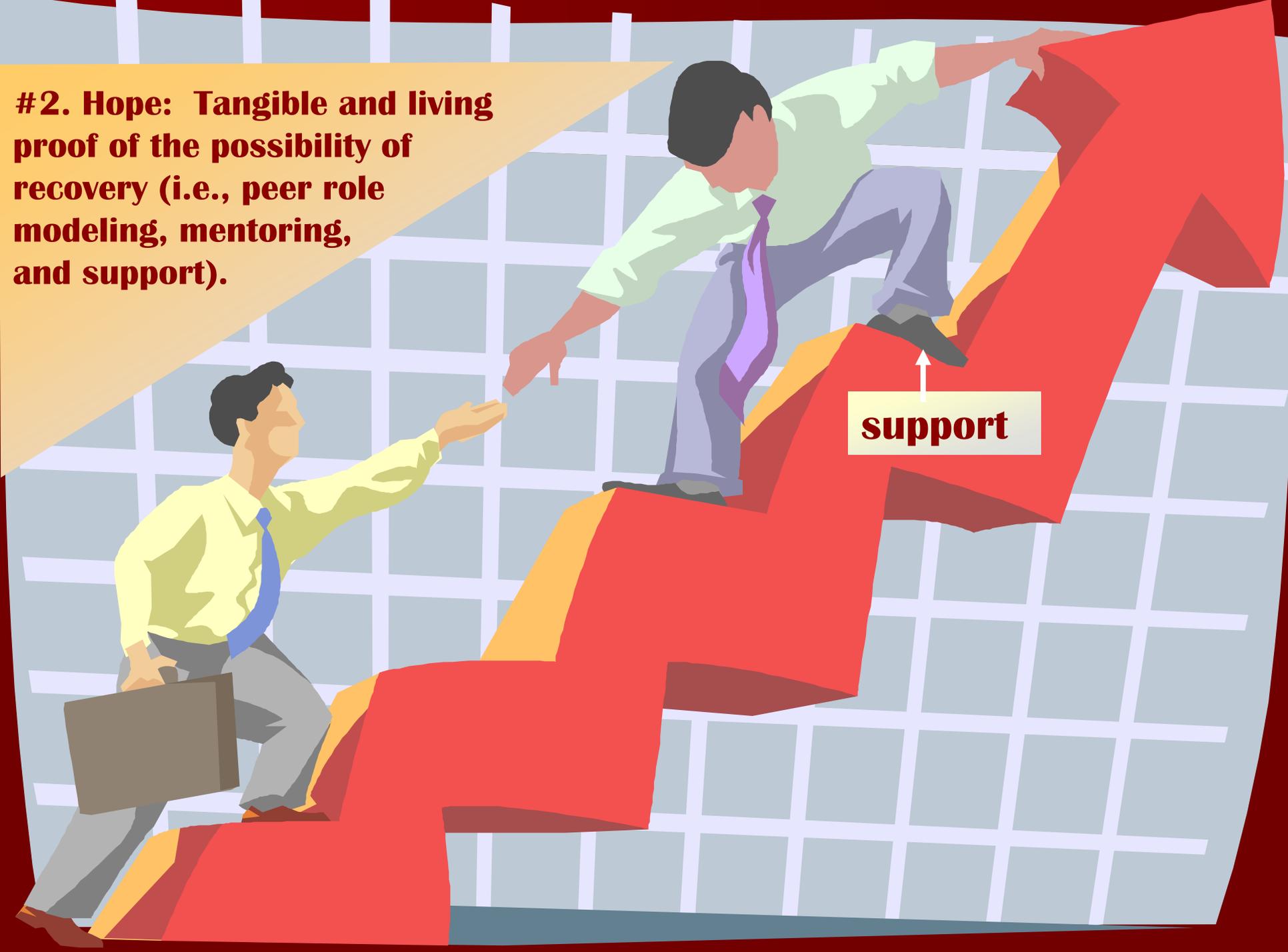
2) Recovery cannot be simply the latest thing we do *to* people with mental illnesses.



#1. Support: Having people believe in and support me (i.e., not having to do things alone).

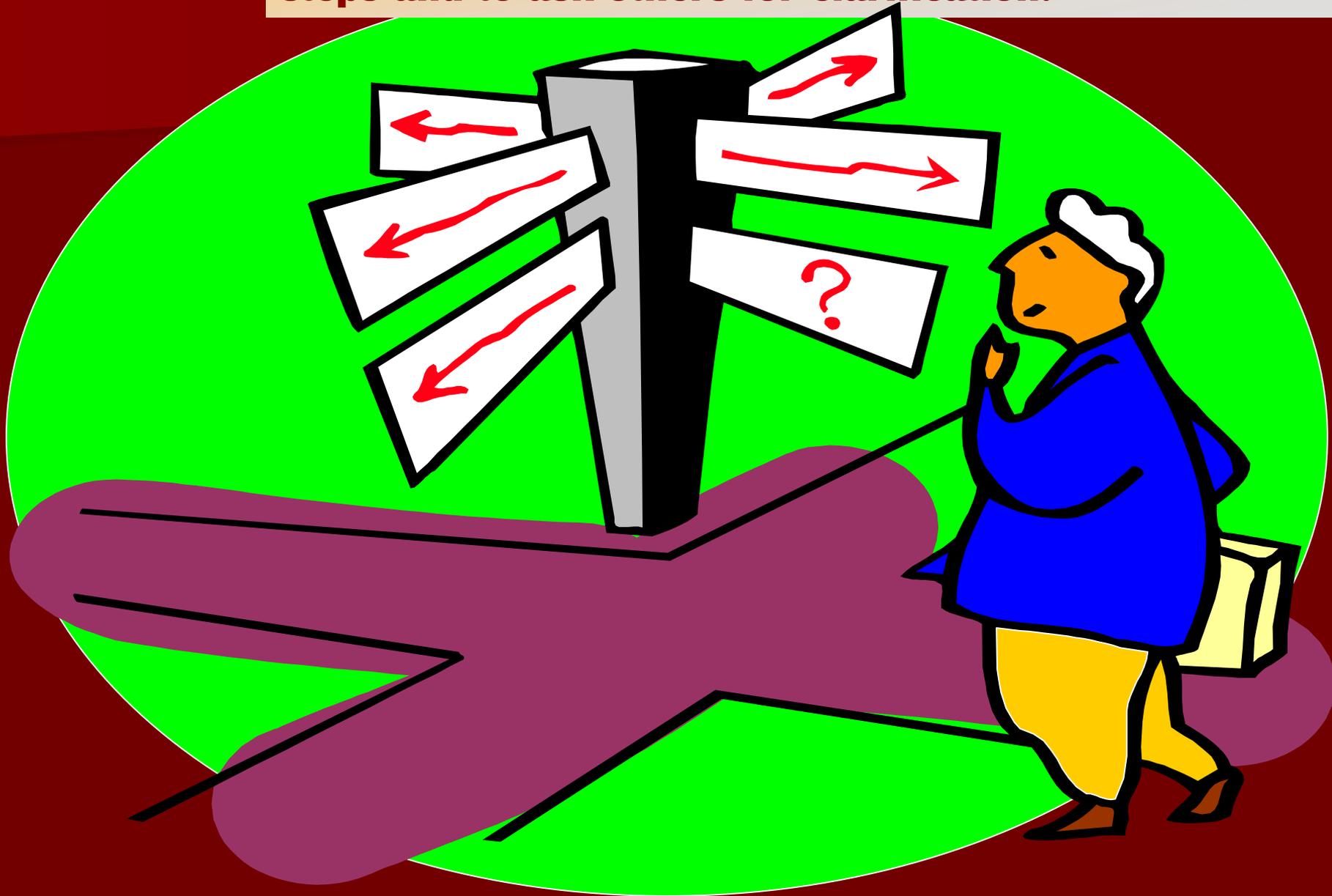


#2. Hope: Tangible and living proof of the possibility of recovery (i.e., peer role modeling, mentoring, and support).

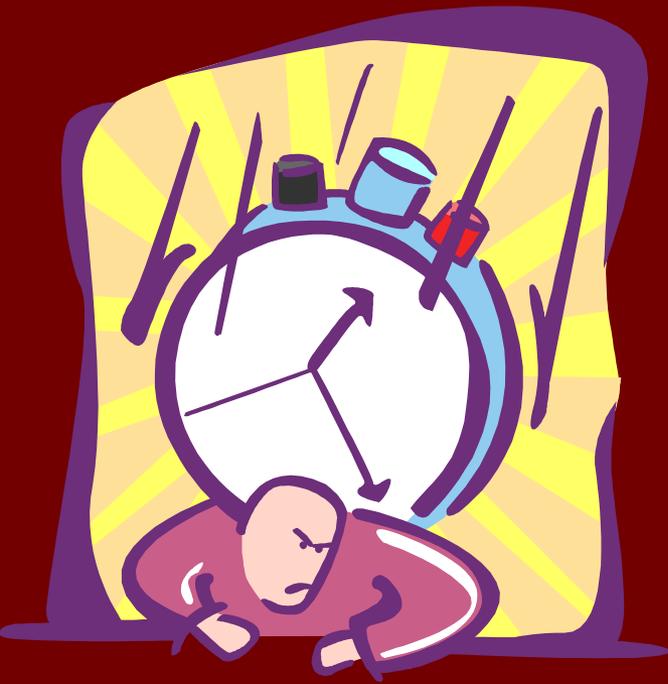


support

#3. Opportunity: Clear directions, instructions, and expectations. Having the opportunity to take initial steps and to ask others for clarification.



#4. Tools: Memory aids and other devices to assist the person in structuring his or her time. We can not assume that people either already have, or will think of, such simple tools of everyday life on their own. Due to learned non-use, they often don't.

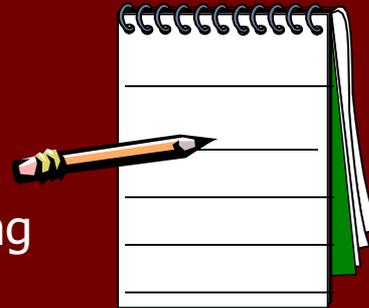


Who would get to work on time without an alarm clock?

A watch with an alarm can remind me to take my medication on time.



Who would remember everything they have to do without writing things down?



What this looks like in practice



Health Care Reform

- Focus on person-centered health care homes (including shared decision-making)
- Inclusion of patient navigators (“community members who are trained in strategies to connect individuals to care, to help them overcome barriers to receiving care, and to assist them in various other ways through their course of treatment”)

Discussion



SAMHSA-HRSA Center for Integrated Health Solutions

**Pillars of Peer Support Services Summit
September 24-25, 2013
The Carter Center – Atlanta, GA**

The Role of Peers In Building Whole Health Self-Management Outcomes

**Larry Fricks
Deputy Director, SAMHSA-HRSA Center for Integrated Health Solutions
larryf@thenationalcouncil.org
404-375-1813**



About the Center

In partnership with Health & Human Services (HHS)/Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA).

Goal:

To promote the planning, and development and of integration of primary and behavioral health care for those with mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety net provider settings across the country.

Purpose:

- To serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development
- To provide technical assistance to SAMHSA PBHCI grantees and entities funded through HRSA to address the health care needs of individuals with mental illnesses, substance use and co-occurring disorders



In the News

‘Peers’ Seen Easing Mental Health Worker Shortage

Pew Foundation Stateline and USA Today Sept. 11, 2013

<http://www.pewstates.org/projects/stateline/headlines/peers-seen-easing-mental-health-worker-shortage-85899504010>

<http://www.usatoday.com/story/news/nation/2013/09/11/stateline-mental-health/2798535/>



The Power of A Peer Provider

It is helpful to understand three things

- 1) The human need for connection**
- 2) The disabling power of a mental illness**
- 3) The shift currently happening in the public behavioral health system**



The Power of a Peer Provider

A Study by Rush University Medical Center in Chicago found that “social ties could play a more important role in determining longevity than even smoking, lack of exercise, or obesity,” and can also “help you live longer and better.”

AARP Bulletin: February 2013



The Power of a Peer Provider

Peer providers bring lived recovery experience that includes addressing whole health, both mind and body. They are hired because of their whole health recovery experience and not their clinical education. This means they can focus on the impact of the illness rather than the symptoms of the illness.



The Power of a Peer Provider

There is a sense of gratitude that is manifested in compassion and commitment.

There is insight into the experience of internalized stigma.



The Power of a Peer Provider

Peer specialists take away the “you do not know what it’s like” excuse.

They have had the experience of moving from hopelessness to hope.



The Power of a Peer Provider

They are in a unique position to develop a relationship of trust with their peers.

They have developed the gift of monitoring their illness and managing their lives holistically, including both mind and body.



THE ACA

Health care reform promotes prevention, whole health and self-management - a critical role for peers trained as whole health coaches

A second critical role are peers trained as healthcare navigators/coaches like being piloted at 2 FQHCs in Michigan



WHOLE HEALTH AND RESILIENCY: THE NEW FRONTIER IN RECOVERY

Up to 80% of health care visits are stress related

Prolonged stress can lead to physical illness and trigger relapse of mental illness and addiction

Trauma, stigma, discrimination and poverty are common stressors for peers



WHOLE HEALTH AND RESILIENCY: THE NEW FRONTIER IN RECOVERY

“When a person is under severe stress, the brain has to work very hard to maintain normal blood pressure, heart rate, and temperature, among other things. If a person experiences multiple, continuous stressors, he starts losing the battle.”

Carter, Rosalynn (2010), *Within Our Reach – Ending the Mental Health Crisis*. Rodale.



WHOLE HEALTH AND RESILIENCY: THE NEW FRONTIER IN RECOVERY

According to Dr. Gregory Fricchione, Director of the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital, “The key to managing stress is resiliency.”

Carter, Rosalynn (2010), *Within Our Reach – Ending the Mental Health Crisis*. Rodale.



THE WHAM TRAINING FOCUSES TEN HEALTH AND RESILIENCY FACTORS

The Ten Factors Are:

- **Stress Management**
- **Healthy Eating**
- **Physical Activity**
- **Restful Sleep**
- **Optimism Based on Positive Expectations**
- **Cognitive Skills to Avoid Negative Thinking**
- **Service to Others**
- **Support Network**
- **Meaning and Purpose**
- **Spirituality**



Role of Peer Health Navigators/Coaches in MI FQHC pilots:

- **Appointment assistance, follow up with specialty services and managing complex health/service systems**
- **Identifying community resources, benefits and referral to outside agencies**
- **Linking to community based formal and informal supports for whole health self-management**



Role of Peer Health Navigators/Coaches in MI FQHC pilots:

- **Developing WRAPs and facilitating classes and groups in WHAM, diabetes, pain management, increasing physical activity, AA, NA, dual recovery**
- **Providing individual support related to self-management of two or more chronic conditions**



“We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.”

Dr. Martin Luther King, Jr.



The Benefits and Added Value of Parent Support Providers (CPSP)

Frances Purdy MEd JD



CERTIFICATION COMMISSION

For Family Support

The National Federation of Families for Children's Mental Health

Presented to the
Pillars of Peer Summit V
September 24, 2013
Atlanta, GA

Agenda

How do we become Parent Support Providers

Certification – Workforce Issue
- Why now?

Funding Parent Support







**Never be bullied into
silence.**

**Never allow yourself to be
made a victim.**

**Accept no one's definition of
your life; define yourself.**

CPSP Credential Definition

Certified Parent Support Providers (CPSP) use their lived experience and specialized training to assist and empower families raising children and youth who experience emotional, developmental, behavioral, substance use, or mental health concerns. CPSPs partner with child and family serving systems to improve family outcomes and strive to eliminate stigma and discrimination

CPSP is Across Systems/Disabilities

- Children and youth rarely only have one category of challenges: mental health, substance use, intellectual disability, learning disorders, autism spectrum, physical disabilities
- Even when one child or youth could be squeezed into one category, there often is a sibling that does not fit the same category

Differentiation

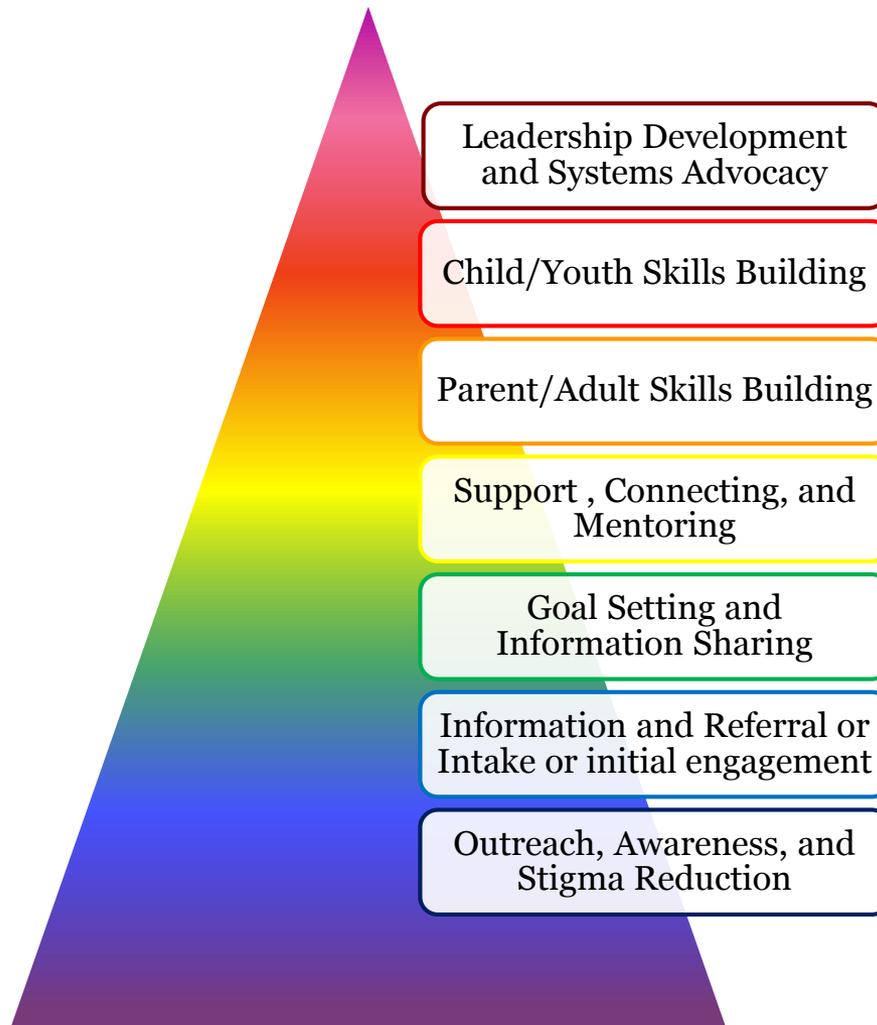
This is **not** a clinical service.

It is a **peer-to-peer** service.

The Parent Support Provider is a peer of the person doing parenting. Their relationship is based on the strategic sharing their own parenting with knowledge from training and “relevant life experiences”

Life Lessons Learned

CPSP Services



National CPSP Domains of Competence

- Ethics
- Confidentiality
- Effecting change
- Behavioral health information
- Education information
- Communication
- Parenting for resiliency
- Advocacy in and across multiple systems
- Empowerment
- Wellness and natural supports
- Local resource information

WORK PLACE TRAINING

*Advanced and Specialized
Knowledge and Skills*

CERTIFICATION

Minimum Competence to Perform - Knowledge, Skills, and Abilities

EDUCATION (Certificate)

*Life Experience, Classes, Workshops,
Independent Learning*

Operational definitions

CERTIFICATE – the recognition of completion of a training or educational program (which may be based on reaching a certain level of proficiency or just “seat hours”)

CREDENTIAL – the recognition of successful completion of a training, educational program, and/or documented experience that adheres to established professional standards set by an Institution of Higher Education, professional group or organization, eg. MSW, JD, RN, etc

CERTIFICATION/Certifying– The process of voluntary recognition of an individual who meets specific established knowledge, skills and attitudes/dispositions for initial and continuing practice as set by a standardized process in accordance with an appropriately accredited organization.

LICENSURE – mandatory, regulatory structure for authorizing or permitting a specific scope of practice of an individual professional. This may include specific endorsements that defines the population served or topic content allowed within the license

ORGANIZATIONAL ACCREDITATION – voluntary recognition of an organization that meets specific established standards or criteria, eg JCHO, COA, CARF, CHEA, ANSI/IEC

Reasons for Certification

- Mobility
- Recognition of a profession
- Assurance for public safety
- Uniformity of the standard of practice
- Uniformity of the scope of service
- On-going competence
- Requirement of funding and accreditation of agencies
- Supplements the workforce to provide the day to day wellness, rehabilitation and support needs of family members
- Can provide an alternate workforce when clinical professionals are not available to provide all the specialty clinical needs of families

National CPSP Requirements

- Documentation of lived experience parenting a child/youth with emotional, behavioral, developmental, substance use, or mental health issues
- 88 contact hours of training in 11 domains
- 1,000 hours of supervised experience
- 20 hours of peer supervision
- Disclosure of any legal involvement
- Agreement to adhere to Code of Ethics
- Passage of national performed-based exam
- Payment of fees

Advantages of National Certification

- State does not duplicate cost and time to develop or administer the credential
- Easier to market since it is the same as other states/counties
- State/County can administer a higher standard
- Outcomes can be compared across states/counties
- Supplement the workforce to provide the day to day wellness, habilitation, support, self-advocacy and leadership skills

Effectiveness of Parent Support

Two publications with citations at <http://certification.ffcmh.org/resources>

- Reduce the rate of missed appointment and premature terminations from treatment thereby reducing overall cost by at least \$300 per month compared to teams without a Parent Support Provider (Davis-Groves, Byers, Johnson, McDonald 2011)
- Reduce lengths of stay in foster care and a reduction in out of home placements. (Marcenko, Brown, DeVoy, & Conway, 2010)v (Romanelli et al., 2009)
- A 2-year control group study (October 1, 2009 to December, 2011) compared youth whose parents received Targeted Parent Assistance from Keys for Networking with a matched control group of youth involved with juvenile justice (JJA) who did not receive parent support. The relative risk of entering detention or a correctional facility was reduced by 86% and the relative risk of being placed out-of-home was reduced by 90%.
- Children will stay in school rather than drop out (Kutash et al., (2010)
- Parents more than four times as likely to be successfully reunified with their children than a comparison group without a PSP (Anthony, Berrick, Cohen, & Wilder 2009)
- Qualitative secondary data analysis demonstrates that having family involvement at the system level requires an engaged, locally developed, autonomous family organization.
- Systems of care sustain when there is a family organization functioning as an equal partner agency within the system.

Funding Authorities to Consider for PSP

Section 1905(a)(13) [Rehabilitation]

1915(b) waiver authority [Waives freedom of choice and statewideness]

1915(c) waiver authority [Home & Community Based Services (HCBS) alternative to institutional level of care]

1915(i) State Plan Amendment [HCBS without a waiver for specific population]

Money Follows the Person [Enhanced Federal Match for 365 days for transition after 90 days in institution]

ACA Navigators and assistance

Early and Periodic Screening, Diagnosis and Treatment EPSDT

Funding to Consider for PSP

IDEA or other education related navigators

Placement in Juvenile Justice Programs to provide support and transition services

Placement in Child Protection intake and support

Placement with Health Care

Community Health Workers

Support through the transitional age to adulthood

Transitional Age youth support

Presenter

Frances Purdy, Director
Certification Commission for Family Support
9605 Medical Center Drive #280
Rockville, Maryland 28050
fpurdy@ffcmh.org
240-406-1472
www.certification.ffcmh.org

What's Right With Georgia?:

Peer-Based Recovery Support

Creating a Sustainable Peer Workforce

Pillars of Peer Support

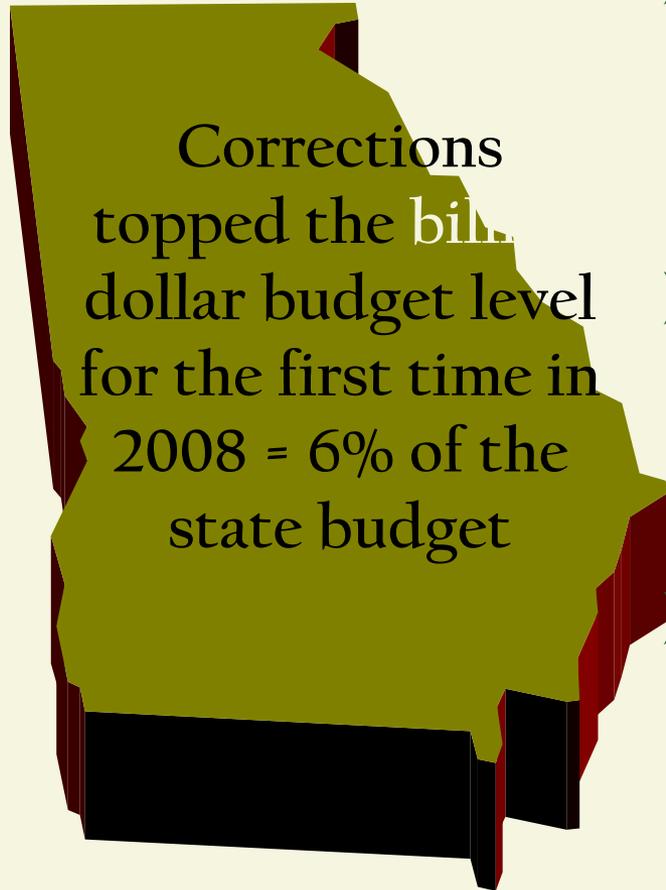


September 24, 2013
The Carter Center

What's Right With Georgia?

- ❖ **1991** - Georgia Mental Health Consumer Network is established
- ❖ **1993** - Office of Consumer Relations and Recovery is created
- ❖ **1999** - Medicaid Rehab Option
- ❖ **2002** - First Certified Peer Specialist Training
- ❖ **2005** – DBHDD (then MHDDAD) established 1st Office of Addictive Diseases
- ❖ **2010** – First CARES training
- ❖ **2012** – DBHDD/Office of Recovery Transformation

Georgia Facts – The Problem



- **9th** most populated state yet 4th largest state prison population
- **1 in 13** adult citizens are under some form of correctional supervision
- Addiction prevention & treatment services were **cut 24%** in the 2010 Budget

Why CARE?

A Person's Perspective

I've been trying to stay sober for over 20 years – through the military and most of my adult life. I went to a program for a year and stayed clean, saved plenty of money to start a new life. My first day out I went right back out there and wound up drunk, high and living on the streets again. And do you know the worst part? It's starting to feel normal. They say human beings are the most adaptable animals on earth. And I've adapted to getting a piece of cardboard and sleeping in a doorway. That is the saddest thing. But I'm going to keep coming back here until I get it. You people love me and let me know I can do it.

~Anonymous person struggling to recover

A Solution

MISSION

The mission of *Georgia CARES* is to promote long-term recovery from substance use disorders by providing experienced peer support and advocating for self-directed care.

CARES Vision Statement

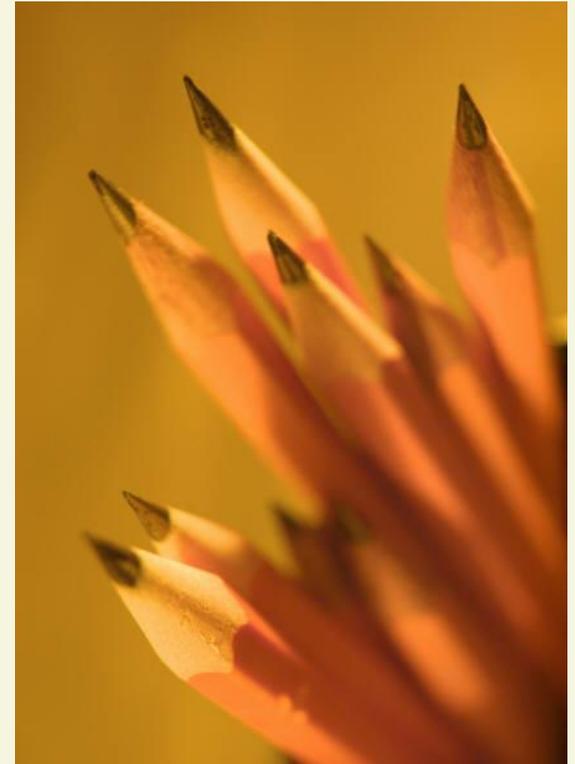
We envision a recovery-oriented system of care that supports self-directed pathways to recovery by building on the strengths and resilience of individuals, families and communities.

Our Values

Hope Wellness Diversity Recovery Integrity Commitment

CARES Core Competencies

- ❖ Recovery Groups
- ❖ Individual Recovery Check-Ins
- ❖ Recovery Advocacy
 - ❖ Self
 - ❖ Peer
 - ❖ System



Certified Addiction Recovery Empowerment Specialist (CARES) – Beginnings.....

- ❖ Focus Groups around the state
- ❖ Meetings with key stakeholders
- ❖ Who's with us?
- ❖ Workforce development initiative from DBHDD/Office of Addictive Diseases



CARES Contract

40 Trained Peers/Year

“Fidelity” Activities

Monthly webinars

Stay connected.....



How CARES?

- ❖ Criteria:
 - ❖ Medicaid Billable Provider?
 - ❖ Will be hired by above if complete CARES?
 - ❖ Work in the field?
 - ❖ Interested?
- ❖ Submit CARES application
 - ❖ Writing Sample
 - ❖ 2 Reference
- ❖ Interview
 - ❖ Group Process



Who CARES? ~ Writing Sample....

- ① The Applicant demonstrates that they possess the values of CARES
- ② Applicant possesses the leadership qualities for CARES
- ③ The Applicant demonstrates or promotes recovery in their life
- ④ The Applicant contributes to community efforts for sustained recovery
- ⑤ The Applicant's overall writing sample is in alignment with the mission and values of CARES

Who CARES? ~ References....

- ① The Applicant demonstrates leadership qualities as it relates to CARES
- ② The Applicant is working a quality recovery program
- ③ The Applicant works well with diverse groups of people
- ④ The Applicant conveys hope to others regarding recovery
- ⑤ The Applicant demonstrates reliability and accountability in Recovery

Who CARES? ~ Interview....

- ① Did you answer the question?
- ② Were you able to use your story to help someone?
- ③ Did you demonstrate flexibility relative to recovery pathways and philosophy?
- ④ Did you have positive energy – (we want to be around this person)?
- ⑤ Were you listening and did we experience empathy?

You can do this, we can help!!



Neil Kaltenecker
neil@gasubstanceabuse.org



www.gasubstanceabuse.org

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Trauma: Planting Seeds For Healing and Recovery

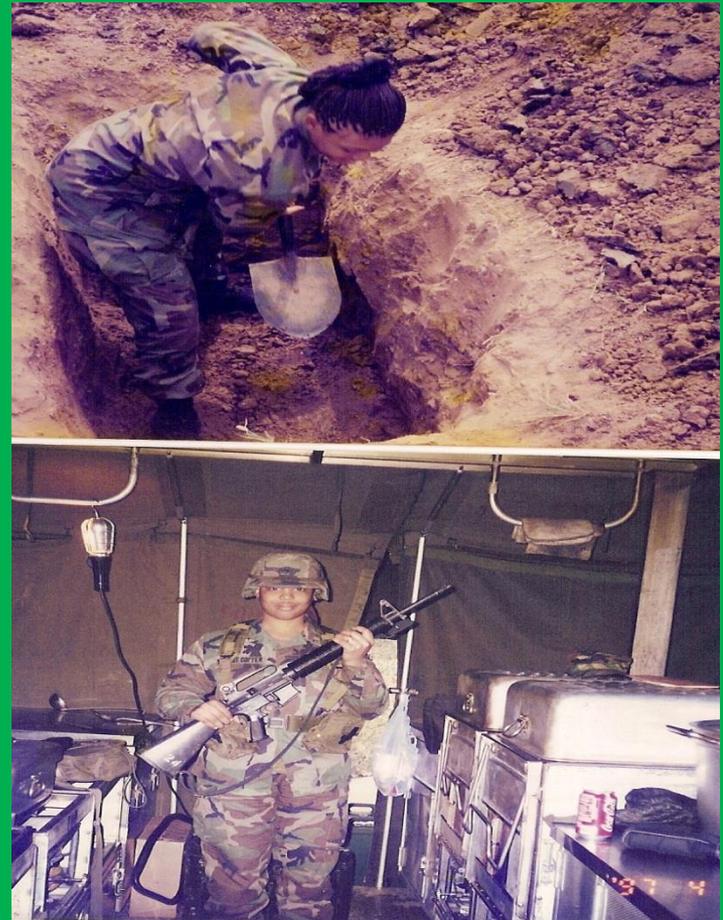
1Corinthians 3:6

Charryse W. Copper,BSW
Just Wright Consulting, LLC
(786)308-7651

info@justwrightconsulting.com



US Army



11th Judicial Circuit Court Criminal Mental Health Project-Jail Diversion Program



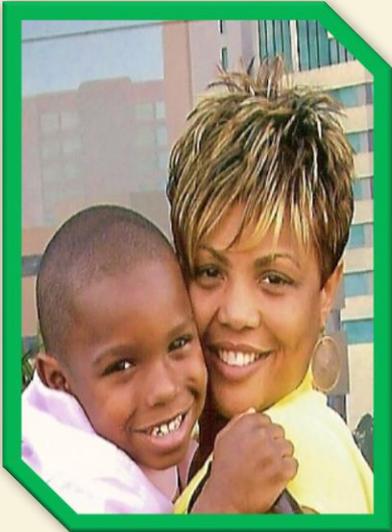
Mother



My Nieces & Nephews



My Love, My Son, My Dominic



The End is Really the Beginning of

- d

Planting seeds of Healing, Hope & Resilience.

Youth Peer Support

Pillars of Peer Support Services Summit

The Carter Center, Atlanta, GA

September 24, 2013

Technical Assistance to System of Care Grantees

- * A move towards expanding services What is happening
 - * Is it effective
 - * How is it funded
- * Evolution of youth involvement
 - * Tangible
 - * Functional

*The Interest and Why

*Common premise: Youth can be served well by their peers, and near-peers, in ways that may be difficult for traditional practitioners to accomplish.

*Tasked to find examples of this, and share the findings

*The Interest and Why

* The promise ... and the challenges Example of the YSS role in CMHI

- * High levels of excitement and enthusiasm about the possibilities, early positive examples
 - * But not universal positive reception
 - * Lots of questions about the role and how to define and support and sustain it
- ## * Philosophy and practice at Pathways
- * RTC commitment to involvement
 - * Priority for young people (and others)

* Why did we choose
this topic?

* 19 questions developed to gather data about programs across a variety of organizations

* Some examples of questions that were asked of participants:

* What are the key roles these positions play within your community's continuum of care?

* How are these positions funded?

* Please briefly describe what the training consists of for these positions

* Question Development

- * Selection of participants based on knowledge of local activity and referrals
- * Outreach to individuals working in various settings including mental health agencies, family organizations, and grant-funded programs
- * Data collected from 29 participants

* Participant Selection and Outreach

Arizona

California

Florida

Georgia

Kentucky

Maine

Mississippi

Missouri

Vermont

New Jersey

New York

North Carolina

Oklahoma

Oregon

Pennsylvania

Texas

Utah

 **States Represented**

- * Age requirements run a spectrum from specifically defined to more flexible:
 - * Contract says 18-25, 21-24
 - * 18-26 preferably
 - * We don't limit by age, however, we grade in interviews how they will be perceived by youth
 - * 18 and older; 18-34

* Findings Overview: Eligibility

- * Desired experience also runs a spectrum
 - * Personal experience with mh; self-identify that “mental illness has significantly impacted” (not nec. received services.)
 - * Family experience with mh (need to know how system works)
 - * Lived experience and been on young adult council
 - * Lived experience, recovery for at least two years
 - * “The youth must be able to provide first-person knowledge and his/her stories of recovery to infuse hope and self determination to participants and their families”
- * Difference between desired experience from interviews and requirements from job descriptions

* Eligibility, continued

* Education

- * Many places require HS degree, some state HS degree or GED, for some, working on either is sufficient
- * Again, differences between what people said and what was on job descriptions

* Other:

- * Drivers' license; social security card, citizenship, background check

* Eligibility, continued



*What About Titles



*What About Roles

Individual
development

Youth
development

System
development



One-on-one:
-wraparound,
TIP, RENEW
-individual @
drop-in
-navigator

**Skill
development
groups:**
-community
-program
drop-in

**Youth
groups:**
-community
program

**Leadership
groups:**
-community

**Attend meetings,
provide training:**
-state
-county or region
-agency, program or
local

* Role Variations

- * In general sites are exploring assessment using
 - * Satisfaction—both for youth leadership activities as well as one-on-one
 - * Vignettes and personal stories, interviews with youth who have received services
 - * For various one-on-one—TIP, wraparound, RENEW—looking at overall outcomes but not at this point separating out contribution of peer
 - * Also for one-on one-- Progress on goals
 - * Fidelity to components

* Assessment

*Training varies across sites

- * Underdevelopment in most locales (with notable exceptions)
- * Seemed to slant towards loosely structured training
- * Task and agency based skills training (ex. Wraparound, WAP, HIPPA) opposed to positions specific professional development training.

*Training

- *Who supervises these positions
 - *Clinical Director/Wraparound Supervisor
 - *Specialized Program Manager/Director
 - *Agency Director
 - *Near Peers/Family Support Coordinators

*Supervision

* Certification

- * Most sites want it, several sites are working towards it, and few have achieved certification for YPSS
- * Adult based certification is utilized yet has it's limits (Ex. Intentional Peer Supports *IPS*)
- * Certification is offered in topic areas like wraparound

* Certification

* How are these positions funded

- * Funded through federal and local grants (ex. SAMHSA's System of Care and Healthy Transitions Initiative)

- * Recognized as not sustainable

- * Local/State tax levy (California)

- * Medicaid and Managed Care

- * Mental health and child welfare case coordination funding

* Funding

- * Hiring and retention- it can be hard to fill positions and keep them filled
 - * hard to find the right combination of experience and qualifications
 - * requirements can be rigid
 - * characteristics of the job can lead to rapid turnover
 - * part-time, no benefits, lack of career ladder
 - * lack of clarity regarding role, how to carry it out
 - * unsustainable funding sources

* Challenges

- * What makes the position different from existing peer support (adult system) or family support (children's system)?
- * Are age definitions too rigid? What is the most important dimension of "peer-ness"?
- * How to ensure sufficient support
- * How to demonstrate the unique and positive contribution of peer support
- * Need for sustainability versus possible downside of Medicaid funding

* Challenges

- * Laura Goodwyn, Research Assistant, American Institutes for Research and the Technical Assistance Partnership for Child and Family Mental Health
- * Janet Walker, Director, Pathways RTC
- * James Sawyer, Federation of Families for Children's Mental Health, and Youth Involvement Content Specialist for the Technical Assistance Partnership for Child and Family Mental Health

* Who helped research

- * Youth MOVE National

- * YMN National Commission on Peer Supports

- * Developing National Youth Peer-to-Peer Support Standards

- * Identifies furthering the development of youth peer support as a top priority

- * Multiple states, local governments, and programs have committed to advancing the development and implementation of youth peer support

* To Come

*Contact Information:

James Sawyer, MS, NCC, LPC

m_james_sawyer@yahoo.com

208-353-3826