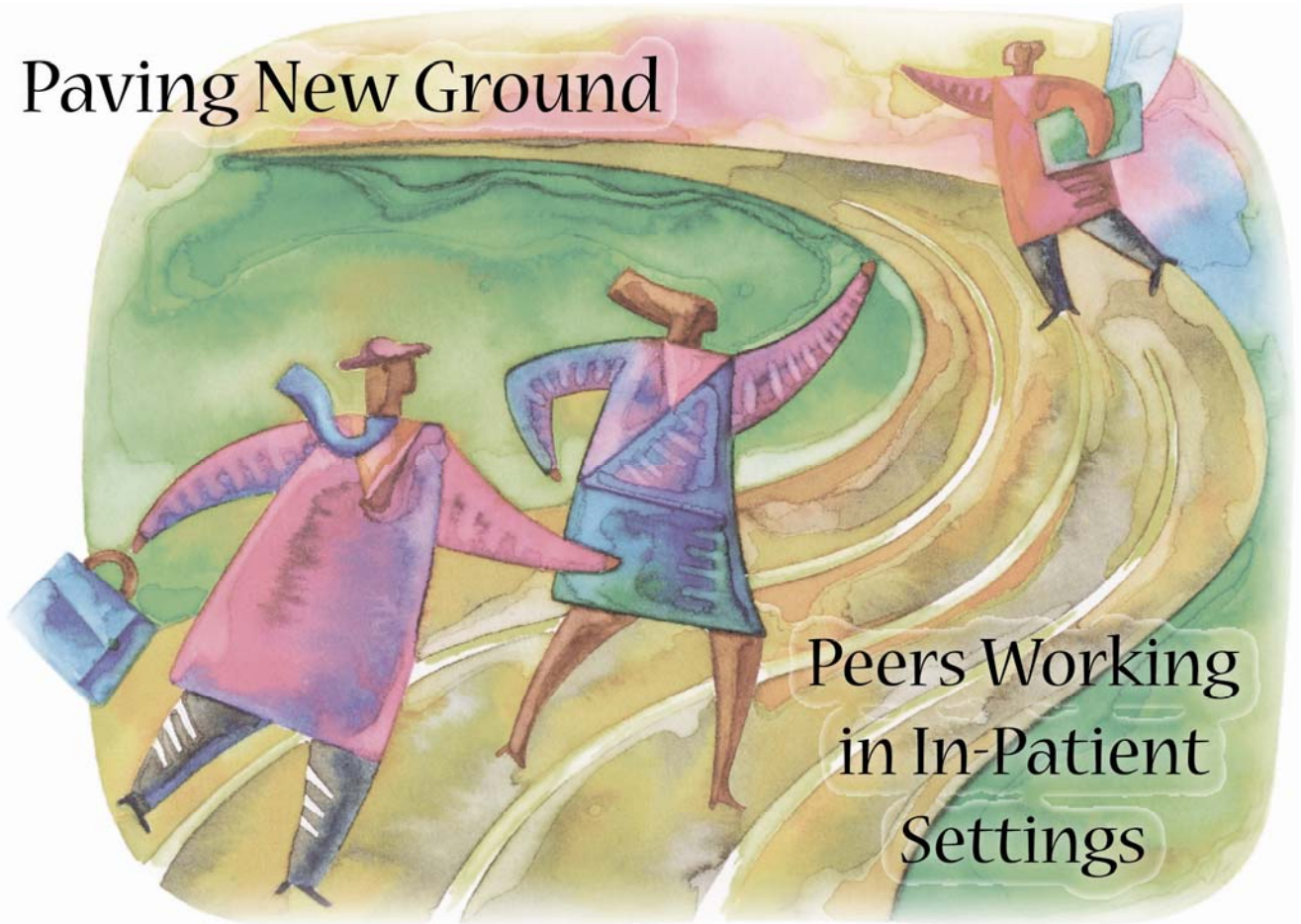


Paving New Ground



Peers Working in In-Patient Settings

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Acknowledgements

The people to whom we owe the most gratitude are peers that started developing these roles long before there was any credibility or even vision for them. Early pioneers, who years ago, stood up to say we needed alternatives to treat people humanely rather than with coercion and force. Now many of these people are peer employees who, in the last few years, started working in many different community mental health settings and, most recently, in inpatient hospital and institutional settings.

This work is dedicated to peers who, in the early days of this work, often worked in stressful situations and were given menial tasks to perform; their roles were not well defined and they weren't always free to disclose their mental health experiences with others. They deserve to be honored because it was often lonely working in settings where they were not valued for their unique contributions.

This “lessons learned” guidebook is based on the stories of many individuals who are working in state and other community hospital settings, both peer providers and non-consumer providers and administrators. Work in this area is often intricate and complex. We thank all of the contributors in the guidebook (too numerous to mention) and honor all of their contributions.

This guidebook would not have happened without the support of the National Association of State Mental Health Program Directors (NASMHPD). Kevin Huckshorn, the dynamic and dedicated director of NASMHPD's National Technical Assistance Center (NTAC), made this publication possible and gave it her keen eye and thoughtful attention through its birth and growth. Sarah Callahan, deputy director of NTAC, gave constant support to the process. Her even temperament and steadfastness was greatly appreciated as she compiled, edited, reviewed, and gave advice.

Thank you to Dawn Rix for the cover design; Joyce Jorgenson for her monumental work on the Road Map that preceded this project. Thanks to Mary Jensen and Steve Harrington, both whom, without being asked, stepped up to the plate to make final recommendations and do final editing, which is greatly appreciated.

This work was done with special appreciation for my daughter, Wendy, who shares with me a history of emotional difficulties. It is hoped that the results of these efforts will make it easier for us and others like us in the future.

We thank the many people we continue to learn about—peers that are working in a variety of inpatient settings throughout the country—peers filling new roles, adding to the path: Paving New Ground.

Introduction

The National Association for State Mental Health Program Directors has been a leading force in the country, actively advocating the meaningful involvement in the mental health service system of current and former recipients of services. A review of NASMHPD's published reports found, as early as 1989, a statement that [consumers] "have a unique contribution to make to the improvement of the quality of mental health services." (1989). "Position Statement on Consumer Contributions to Mental Health Service Delivery Systems." Alexandria, VA.

One of the most effective strategies was the development of Offices of Consumer Affairs within state mental health agencies. By 2000 there were 26 state Offices of Consumer Affairs with many states considering creating similar positions. The time was right for a manual to be written as a guide for the steps that go into selecting and hiring directors and for the effective use of these offices. Joyce Jorgenson and Andrea Schmook, two leading directors of offices of consumer affairs, took the lead in writing "Offices of Consumer Affairs: A Pathway to Effective Public Mental Health Services." Today there are 48 state Offices of Consumer Affairs.

Similarly, when NASMHPD's created the National Executive Training Institute in 2002 to focus on the reduction of the use of seclusion and restraint, one of the six core strategies identified as crucial to this work was the development of "Consumer Roles in Inpatient Settings." One training module developed was devoted to understanding the rationale behind self-help, peer support, and to highlight the variety of consumer and family roles and responsibilities in inpatient settings that have proven to be effective culture change tools. When NASMHPD's seclusion and restraint reduction curriculum training started, Tom Lane, Gayle Bluebird and Joyce Jorgenson were lead presenters.

When the "consumer as provider" initiative first began there were only a few examples of positions that had been created for consumers in inpatient settings. While Offices of Consumer Affairs had become common in state agencies, little had been done to create positions in inpatient mental health provider settings. Most of the opportunities available were either voluntary positions or resident advocates that were not necessarily positions filled by consumers.

As NASMHPD began to conduct seclusion and restraint reduction training all over the United States, and internationally, interest began to surface about developing new key roles for consumers to work side by side with traditional mental health staff. Gayle, Tom and Joyce stayed involved in the development of some of these new positions and worked toward how to best replicate those that demonstrated significant success. Over the last five years a variety of consumer positions were created. There was no one pattern; no one type of position. Conceptually, the rationale for the creation of these positions was easy to present and understand. But it was obvious that there were many different aspects to the successful development and maintenance of these positions over time. How are peers or consumers best utilized? How do facilities prevent burnout? What does it mean to have a person with a mental illness working as an equal? And how will staff to respond to a peer in a new direct staff position?

As the Director of NASMHPD's Office of Technical Assistance, many hospital administrators began to ask me and my staff these questions and we quickly realized that we only had some of the answers. The NASMHPD consumer experts' experiences, opinions, and concerns became increasingly important to utilize when planning technical assistance projects, developing training packages, and as team members providing onsite technical assistance. The demand for additional information on the subject continued to grow so, when Gayle called one day to propose she develop a guidebook as a beginning how-to on the subject we said, "Yes!"

This "guidebook" evolved over time and includes a collection of stories and narratives followed by best practices guidelines based on the information gathered in the narratives. It is not meant to contain all of the answers, it is a continuation of an important dialogue that the mental health field needs to participate in and support.

In collaboration with the author and others, it was decided that posting this report online would be a good way to make sure the information is easily available and accessible to everyone, free, and not dependent on a formal publication process that can take years. The guidebook is an easy read, informative, and enjoyable. We hope you, the reader, will agree.

As a beginning we hope that this guide stimulates dialogue. Perhaps you would like to add a comment or question a particular statement, practice, or recommendation. There will be time to refine and add to this guide.

NASMHPD and I wish to thank Gayle for the many hours she put into this unique and innovative work and for the travel she undertook to facilities that created these positions. There were many other consumers who made this guidebook a reality, beginning with Tom and Joyce. Important contributors also include the many mental health leaders who had the courage to support the development of these positions in their facilities - they are pioneers in their field. These include Andy Phillips, Western State Hospital, Lakewood, WA; Susan Shobe, Alton Medical Center, Alton, IL; Peter Driscoll, AMISTAD, Portland ME; Tony Riccitelli, Worcester State Hospital, MA; Ed Amberg, Montana State Hospital, Warm Springs, MT; Lori Ashcraft, Recovery Innovations, Phoenix, AZ. We also thank Tanya Stevens of the Peer Bridgers, NYAPRS, Albany, NY, Sheila Hollingsworth of the Baltic Street Mental Health Board, NYC, and Sharon Jenkins Tucker of the Georgia Mental Health Consumer Network for their contributions and support.

NASMHPD and all others involved in this project would also like to thank the Substance Abuse and Mental Health Services Administration, specifically the Center for Mental Health Services, for generously providing the resources to be able to develop this onsite guidebook. As the Director of NASMHPD's Office of Technical Assistance and the Coordinating Center for the Prevention of Violence and Traumatizing Practices, I am grateful for the opportunity to support this project and to have a front row seat watching these new practices unfold before me.

A handwritten signature in black ink that reads "Kari Ant-Hudak". The signature is written in a cursive, flowing style.

A “Lessons Learned” Guidebook Overview and Introduction

Overview

Psychiatric hospitals and state institutions have become increasingly aware of the development of peer specialist roles in inpatient settings and are showing an interest in establishing similar positions in their facilities. Roles for peers, once more common in outpatient settings, are now being created in inpatient settings. Despite the increase many hospitals are uncertain about how to establish and make the best use of these unique positions.

While recognizing there is no one correct way, this “lessons learned” guidebook will identify and highlight some of the hospitals in the country that have been most successful. Through the use of stories and narratives, we will go on a journey to learn about the average day of peer specialists, their special challenges and rewards, and what they most value in their positions. We will also meet their supervisors and hospital/institutional administrators. Whenever possible we went on site to meet personally with the individuals interviewed but since this was not possible in all cases, some interviews took place over the phone.

Learning through experience is the best way to learn. This guidebook will help us appreciate what is possible and to help other hospitals and peers envision and actuate their own futures.

This is no ordinary adventure; it is often spectacular to see what persons in recovery from mental illnesses can do!

Background

Several factors have been influential in promoting the concept of peer specialist roles. First, the President’s New Freedom Commission Report, released in July 2003, made recommendations that the mental health system be more consumer and family-focused after identifying their lack of involvement as a major weakness. The report states, “Consumers will play a significant role in shifting the current system to a recovery-oriented one by participating in planning, evaluation, research, training and service delivery.”

Several federal agencies promoted consumer involvement including the Center for Mental Health Services (CMHS), Substance Abuse Mental Health Services Administration (SAMHSA), which integrated consumer/survivors in the development of training materials, research projects, in meetings on mental health issues and special initiatives. Recent grants issued to states to transform their mental health systems or to reduce the use of seclusion and restraint come with requirements that consumers be involved in planning, advising, and as employees in newly implemented programs.

The National Association of State Mental Health Programs Directors (NASMHPD) also contributed a great deal over the years to promote consumer roles, in particular supporting the development of state Offices of Consumer Affairs (OCA’s) and, more recently, working to reduce seclusion and restraint in treatment settings through training, the National Executive Training Institute (NETI) that was created with consumers included both as faculty and advisors to the program.

As a result of these national efforts, facilities are beginning to recognize the ability of persons in recovery to help transform systems into environments that replace historically rules-based treatment with treatment and environments that promote empowerment, hope, respect, and healing. Peers working in staff positions are among the best resources to serve as role models and to help people in care have a voice. They are often the most capable at helping peers focus on identifying their personal recovery needs. It is in this way that peers are able to help transform a state’s mental health system.

Roles and Titles

Peers work in many different capacities: as advocates, counselors, educators, and evaluators throughout the country in public and private facilities. Some roles are created as peer staff roles with direct involvement with service recipients to provide peer support and counseling. A more common position created was peer advocates who address complaints and grievances and assure that patient rights are protected.

In Florida and Pennsylvania there are several examples of peer-run drop-in centers operating on the premises of some state hospitals that operate with a high degree of independence. Peers in these settings provide a place for recipients of services to get away, relax, play games, have refreshments, make new friends and strengthen independence. While this is still a new concept, many other state hospitals have begun to show an interest in developing similar centers.

“Peer Bridgers” are teams created to help transition people from hospital to community when people in care are ready for discharge. Peer Bridgers begin working with people three to six months prior to discharge to teach needed skills after discharge. They follow newly transitioned people to their apartments or residences to help them adjust to independent living and learn about community resources. These teams are now prominent in many states, some with different names, but the state of New York is credited with developing the concept.

Many crisis centers are beginning to hire peers. In Maine a team of peer specialists provide support to people who come into the emergency room in psychiatric crisis. In Arizona, META Services Inc. (now Recovery Innovations of Arizona), operates peer-run “Living Rooms” located in crisis centers. People can stay in the Living Room section of the crisis center for up to ten days. There are furnished rooms with comfortable couches, client artwork and pictures on walls, and kitchens for people to get their own snacks. Programs are recovery-oriented including having each individual write their own recovery plan and watch recovery videos instead of TV.

Peer providers are helping to develop creative arts programs and hobby groups based on the interests of people they are serve. One frequent complaint from persons in care is lack of interest and boredom with repetitive groups with titles they don’t identify with, e.g. psycho-education group. At Riverview State Hospital in Maine, a peer specialist team has been very successful in providing a wide array of different groups for people to select and sign up for.

Involving peers has the potential to create culture change in every aspect of treatment. They can make recommendations for improving forms and assessments, conduct interviews or do surveys to obtain information regarding consumer satisfaction. Their ability to relate to service recipients creates safety for that person to express themselves, which allows professional staff to devote time in areas where they are more needed.

They are able to influence the physical environment such as recommend colors on walls that are more appealing and suggest designs or furnishings that help promote comfort and healing. They can help develop “Comfort Rooms” that are created for relaxation and are participatory projects between patients and staff. The list is endless. The most creative use of peers’ services/input is when an individual can help design their own job description with their supervisor with duties that are best suited to the peer providers and focus on their abilities and talents.

Titles

Titles of peer roles are almost as varied as the roles themselves. “Peer Specialist” is the most common and familiar title, which usually implies paid staff that received training and certification to deliver peer support services.

Examples of other titles are:

- Peer Mentor/Peer Counselor
- Peer Advocate—Consumer Advocate
- Recovery Support Specialist
- Recovery Aide
- Client Liaison or “De-briefer”
- Peer Specialist or Peer Support Specialist
- Peer Bridger
- Office of Consumer Affairs Director or Recipient Affairs Director

Career ladders are also beginning to emerge. In many states there are categories for Peer Specialist II and III that call for higher pay and higher levels of authority, usually requiring advanced training. Most exciting is the phenomenon of some professionals adding peer specialist to their titles. One registered nurse made the choice to be a peer specialist, which allowed her to disclose her psychiatric history. There are many other examples, some embedded in the stories of peers in this guidebook. They share that they originally worked in a professional capacity but when the opportunity arose for them to “come out” as a consumer, or because of a particular job opportunity, they were eager for the change. In many cases, their roles are as supervisors to other peer specialists working on a team in a hospital or community.

For the purpose of this guidebook, choice of language regarding terms used for patients or other titles and roles reflects the choices made by the person interviewed or of the state or facility featured. We prefer to use the word “peer” to describe an individual giving or receiving services; “peer provider” or “peer employee” for a person in a paid position; and “peer support” to describe the type of work they perform. Other words frequently used include “consumer” or “consumer/survivor” that describes long term ex-patient activists and advocates involved in mental health systems change. Persons receiving services will be described as “service recipients,” “service users” or “persons in care” with an occasional use of “patient” or “inpatient”, which is sometimes reflective of the facilities.

Understanding Peer Support

It is important to understand the meaning of peer support. What makes peer support different?

First, someone defined as a “peer” or “consumer” is a person who currently or formerly received mental health services and who self-identifies as a person living in recovery with a mental illness. Peer support operates from the position of experiential knowledge, “I know because I’ve been there” or “I’ve been hospitalized too” or “I’ve been on the streets, homeless” or “I, too, have been in restraints and seclusion.” Because of their roles peers can help another make recovery real, happen faster and often know solutions that really work. Peer approaches lead to consumer-centered outcomes.

While peer support may seem like a fairly simple concept, there are things peer support is and is not. It is especially critical to differentiate between peer support and clinical or medical model treatment prior to undertaking the creation of peer positions. Without this understanding there is a danger that peers will function as tokens or in subservient positions doing menial tasks that miss the dimension that makes these roles valuable.

Sherry Mead states:

“Peer support is not like clinical support, nor is it just about being friends. Unlike clinical help, peer support helps people to understand each other because they’ve ‘been there,’ shared similar experiences and can model for each other a willingness to learn and grow. In peer support people come together with the intention of changing unhelpful patterns, getting out of “stuck” places, and building relationships that are respectful, mutually responsible, and potentially mutually transforming.” (Mead, 2003)

Sally Clay describes the values and principles of peer support, specifically the “Peer Principle” and “Helper Principle.” “The peer principle,” she states, “emphasizes the equality and reciprocity that should exist within the peer relationship, with both peers sharing and learning with each other. The Helper Principle suggests that ‘working for the recovery of others facilitates [one’s] personal recovery.’” (Clay, 2005).

Peers working as peer specialists are often more tolerant of people’s behaviors and are more prone to think about whether a person has a history of trauma or a life experience that may contribute to their behaviors. They are often better equipped to provide empathy and hope to people they serve because they share some of the same experiences.

Peers often have compassion and empathy in abundance. Clay states, “Since we have been crazy ourselves, we feel compassion for the confusion of others rather than fear of their madness, and we strive to offer unconditional respect to those who are ‘in the same boat’ as we are.” (Clay, 2005).

By sharing their stories of recovery, peers can instill the hope in others that *their* circumstances can also change; as role models they inspire others to aspire to become peer providers. They also inspire hope for themselves. Often, peers learn about themselves when they tell their stories. One peer specialist explained, “I am not afraid to tell other peers my experiences because every time I tell my story it helps me to see things--about myself and my own story--and understand them in a different way.”

It was not surprising that all of the peers interviewed for this guidebook, when asked, agreed that they loved their jobs. Though their reasons differed some, they all agreed they felt rewarded when they helped others. Helping others, they found, changes lives and makes people happy. They found they were caring for others in the way in which they would want to be cared. We might call this the “Peer Golden Rule.”

Peer Specialist Training Programs

Peer Specialist training programs have been a major factor in promoting the development of peer positions. Recognized training programs first developed in the states of New York, Georgia, Colorado, Arizona and Kansas. They are now available in many other states including Illinois, Hawaii, North Carolina, Michigan, New Hampshire, South Carolina and others.

The Georgia program started in 2001 with 35 current and former mental health consumers who completed the training. In 2005, there were 285 graduates filling key roles in the public mental health system in Georgia. Georgia is the first state to implement Medicaid reimbursable services for peer support under the Rehab option. (SAMHSA has created a toolkit that will serve as a guide to help other states develop Medicaid reimbursable services which is now available.)

The Georgia Peer Specialist Certification Project conducts ongoing training at least twice annually and holds quarterly continuing education seminars and workshops for those already certified. Georgia peer specialists are required to stay abreast of emerging best practices in mental health recovery.

Recently, a partnership was created between the Georgia Peer Specialist Project and the Medical College of Georgia’s School of Psychiatry. The partnership was created in order to develop a research and evaluation arm for the implementation of peer support and its recovery. The curriculum will contain modules based on recovery to train medical students and residents.

In 2001 META Services in Arizona was also in early stages of development and today is a large training program for peer support. META (now called Recovery Innovations) receives money through The Rehabilitation Services Administration to fund the creation of a training center to teach mental health services recipients to work as peer support providers. The first classes graduated 15 Peer Support Specialists in 2000. Today over \$6,000,000 of Medicaid reimbursable peer-support services are provided by Recovery Innovations’ peer staff with over 225 Peer Support Specialists working in a range of peer run and multi-disciplinary recovery

programs. Recovery Innovations also established a relationship with Boston University for ongoing development of peer roles.

In 2003-2004, Illinois established a Peer to Peer Resource Center as a National Consumer Self-Help Technical Assistance Center under a contract with the Center for Mental Health Services. The program provides peer specialist training in different states throughout the nation. This program is run by DBSA (Depression Bi-Polar Support Association), which reportedly is the largest consumer-directed mental health organization with staff and governance composed mostly of people living with mental illnesses. Their program is currently being evaluated by the University of Illinois at Chicago, which is also a source of funding.

Many states are modeling their training programs with adaptations of the above models. Staff from both the Recovery Innovations (former META) and the Georgia program travel to other states and internationally to help set up training programs tailored to individual needs.

Each of the training programs is established with different sets of time frames for training and different requirements for testing. All have certain training components in common in their curriculum that includes understanding recovery principles and peer support, practice of good listening skills, rights education, confidentiality and ethics issues, conflict resolution and suicide prevention. Most curriculums also include an introduction to WRAP (Wellness Recovery Action Plans) developed by Mary Ellen Copeland.

Research—Evidence Based

The evidence base for peer provided services is small. Several studies have shown positive effects of peer specialists on ACT (Assertive Community Treatment) teams for persons with serious mental illnesses. These studies show that having peer specialists on teams results in improved quality of life in living situations, finances and improvements in social functioning and coping skills compared with those who were served by teams without peer specialists. (Felton et al, 1995; Klein et al, 1998)

Clarke (*et al*) (2000) found that a consumer-run ACT team versus a non-consumer ACT team had fewer hospitalizations and emergency room visits and, overall, significantly longer community tenure than non-consumer ACT team clients.

One study (Salzer and Shear, 2002) showed benefits to peer specialists themselves, including improvement in their recovery, increased feelings of social approval and self efficacy, professional development skills and stable employment.

Anthony (2003) expresses concern about the studies heretofore undertaken:

“What studies have been done continue to assess traditional measures of individual growth and functional outcomes in the absence of exploring the evolving cultures and communities of peer support. Research is needed that examines the extent to which peer support programs create new norms, language, relational roles, and clarify the kinds of help and support that people find useful.”

Mead and MacNeil (2003), with similar concerns, undertook a study to develop fidelity standards of peer support in an ethnographic evaluation study of a peer run crisis program. Over the course of a year they visited peer supporters, community providers and family members. Through taped conversations, unstructured interviews, recorded meetings and groups, as well as other types of observations, they arrived at seven fidelity standards. Some of these standards included the re-naming of experiences, the development of community provided by peer support, and the level of mutual responsibility that is involved in establishing relationships. Other standards related to safety and the importance of peer support being clear about setting limits, something that is sometimes difficult for peers to establish.

As interest continues to grow and more and more peers are employed in meaningful peer roles, there will be a need for studies that stray from traditional research standards and involve compatibility with values that have been created to define peer support.

Larry Fricks, director of the Appalachian Group Consulting and vice-president of the Depressive Bipolar Alliance, sums up the reason for peer support: “Trained peers are powerful change agents and good fiscal investments for transformation to a strength-based recovery system.”

About this guidebook

Work on this “lessons learned” guidebook began in August 2006. The first area of focus was determining where and in which states there might be exemplary roles held by peers in inpatient settings. The primary goal for the guidebook is to present a variety of types of peer roles in different institutional and hospital settings including crisis and forensic. We want to show how these roles can accentuate good practices and how they may contribute to reducing incidents of violence and use of seclusion and restraint. We felt it important to show a contrast of peer roles in different stages of development around the country.

The guidebook is written for all levels of staff including administrators, nurses, social workers, line staff, peer providers and others already in, or aspiring to, such roles.

Visits were made to as many facilities as possible. By going into the work environments, we were able to see and feel it for ourselves and speak directly with administrators, nurses, social workers, and persons receiving services to find out what they think. With limited space and time, we tried to give each person the opportunity to tell their stories in their own voice.

Not everything is rosy. There are many challenges for both providers and peer providers. The ways in which they work out the kinks is important. Peer provider roles are still new; there is no one way to develop them correctly. Much of the way is finding one’s own way, charting one’s own path.

Despite the challenges, there is much these roles have in common that can make them successful. We will present some of the common threads in a list of positive pointers and things to avoid.

We will also make a list of creative strategies that many of the peer specialists found helpful in their work. Anyone can use them; they are simple but profoundly important to people in care who often complain of boredom.

This guidebook is a celebration for hospitals that rarely get a chance to celebrate their successes, peer providers who are paving new paths as pioneers and have little time to take a break--and the readers who want to celebrate their successes and be inspired to create new paths of their own.

Hopefully, **YOU** will be inspired to include peer provider roles on your staff, incorporate the use of peer volunteers, and use the knowledge and talents of those you serve!

References

- Anthony, W. (2003). Expanding the evidence base in an era of recovery. *Psychiatric Rehabilitation Journal*, 27 (1), 1-2
- Clarke, G., Herinckx, H., Kinney, R., Paulson, R., Paulson, R; Cutler, D., & Oxman, E. (2000) "Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: Findings from a randomized trial of two ACT programs vs. usual care" *Mental Health Services Research*, 2, 155-164
- Clay, S. (2005) "About us: what we have in common" in Clay, S. Ed. *On our own, together: peer programs for people with mental illness*. Vanderbilt University Press: Nashville
- Felton, C., Stastny, P., Shern, D., Blanch, A., Donahue, S., Knight, E., & Brown, C. (1995) 'Consumers as peer specialists on intensive case management teams: impact on client outcomes' *Psychiatric Services*, 46, 1037-1044
- Mead, S. and MacNeil, C. (2003) discovering the fidelity standards of peer support in an ethnographic evaluation (Unpublished manuscript)
- Salzer, M.S. & Shear, S.L. (2002). Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal*, 25(3), 281-288
- Solomon, P. & Draine, J. (1995) 'One-year outcomes of a randomized trial of consumer case management" *Evaluation and Program Planning*, 18, 117-127
- The President's New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America. Final report*. DHHS Pub.No. SMA-03-3832. Rockville, MD: U.S. Department of Health and Human Services

Personal Stories

**Personal Experiences and
Job Descriptions or Examples**



**Laura Van Tosh, Director, Consumer Affairs Director
Western State Hospital
Lakewood, Washington**

Laura Van Tosh has a history of being involved in the “ex- mental patients consumer movement” for many years. When she took her position at Western State Hospital in 2005, she had already been an accomplished writer, policy maker, researcher, and going back earlier, an early pioneer in Philadelphia (1980s) with other mental health consumers and ex-patients at a local program in Philadelphia that would later become a national technical assistance clearinghouse for mental health consumers. Prior to leaving for Washington she had been working at a state hospital in Maryland as an advocate and also maintained a policy and advocacy consulting business.

She moved to Washington to be closer to her family and took the job as Consumer Affairs Director at Western State, soon after, with a great deal of enthusiasm and hope. Of all her many accomplishments, she felt that her contributions would be greatest felt among people in the real trenches in a state hospital. She had chosen to work at one of the largest state hospitals in the country with 1000 patients on grounds—also because many people were staying for long periods simply for lack of stable housing and treatment in the community. Her challenge would be to find a way to change that, and she would make it her highest priority to get people out with the goal of never coming back. Later, she would come to realize that this goal might not be realistic for everyone; some people do come back, but she would continue to work with people with exactly the same goals, only then she would approach the goal with the question, “How can we make it different this time?”

This writer had been to Western State only three months after Laura started working there in 2005. At that time, Laura had organized a panel of consumer leaders to speak to patients about recovery that included me, as well as Paolo del Vecchio, from the Center for Mental Health Services, and two other leaders from the Northwest region. The room filled up with over 100 people, both providers and patients; the first time, according to Laura, that a large group of patients and staff gathered together to listen to consumers talk about recovery. If this meeting was to serve as an indicator of the future, the information she gave now would not be surprising. The following information was obtained during a telephone interview.

Laura starts by talking about the innovative way she does orientation—a monthly occurrence for 50- 60 new employees that takes place over a five day period. Laura is listed on the agenda, with her name and title, Director of Consumer Affairs, and the title of her presentation, *The History of the Consumer Movement*. It is her intention to show how the early history of psychiatric survivors has impacted changes in the mental health system and to explain, in part, her motivation for being there.

With this title, people are already looking at her, totally befuddled. What is this? What does this mean? Who are you? And what is an Office of Consumer Affairs? She begins to draw on the blackboard, making sure, as she talks to me, that I am clear about her not being an artist, and that the drawing that she places on the blackboard more resembles a second grader’s work.

She asks her audience to tell her what she has drawn, for despite her lack of artistic talent, she has been able to draw what looks like a reasonable outline of the United States. After that is made clear, she labels the area where the state of Massachusetts would be located and explains that this is where a group of ex-mental patients first began to organize, calling themselves the *Mental Patients Liberation Front*. She explains that people then were very angry and that hospitals, at that time, were not like they are today. She points to where California would be and tells them about the *Network Against Psychiatric Assault*, an organization that put out a national newsletter, *Madness Network News*. In Kansas, she explains to them, is where the disability movement began, primarily for persons with physical disabilities.

Anger was the fuel that mobilized these new civil rights activists. Laura explains to them how anger gave way to production and consumer operated drop-in centers began to form in large cities where people could go to

socialize and network with each other. The centers were self-governed and not based on medical model or clinical protocols. Anyone with a mental health diagnosis or history of hospitalizations was welcome to come. Much later, many of these same individuals and their efforts would be recognized by the federal government and they would be invited to become involved in policy making all the way to the top level of government. They would also apply for and be granted funds to initiate self-help demonstration and research programs.

Finally, she brings things up to date and writes on the blackboard the name, Dan Fisher, MD, PhD. She explains that Dan was the only consumer member of President Bush's New Freedom Commission and that he was responsible for organizing many people to testify. The outcome of that: "*People Can and Do Recover*," And one of the findings of the Commission report.

At some point, soon after giving them a consumer movement 101, she turns and looks out of the window. Again, people are wondering what she is doing. She is about to tell them her personal reasons for what she is doing.

"See that window over there?" she asks, pointing to a window that can be seen in the next building over. "That is the window of the room I was in when I was a patient here at this hospital in 1979." She tells them that patients did not have rights then; there was no protection and advocacy system and she tells them a little of what it was like to be a patient at that time. 1979 was not long ago—perhaps they will see things from a different perspective, she hopes, but she never knows.

At the end, some people will have gotten the message, but most do not come up afterward to talk to her. Laura explains that she doesn't stop to find out who understands or who doesn't. "I have been able to keep marching forward," she says. "If people don't come up immediately there are ways in which they share their understanding later, usually in indirect ways, by trying to be supportive, or showing an interest in what I'm doing. Sometimes people find a way to help a patient in a different way than before."

But she is also aware that emails sometimes buzz between people trying to figure it all out. Some people, she realizes, resent her because she took an important position that someone else potentially could have had who had more tenure. Also, she is aware that there is resentment about her desk being in the administrative office with top executives including the CEO, Andy, of whom she is highly complimentary.

"If it weren't for Andy I would never have been here. His leadership and support has helped me to do a lot here. This could have been a 'consumer empowerment' job on paper only," she says,

"Andy," she tells me, "is a quiet leader." And it is from him that she has learned a lot about conflict resolution. "I might have made the wrong moves if it hadn't been for his being here." He has been her guide and she points out the importance for someone in her position to have someone "guide you through the political waters."

Laura's most recent accomplishment is the opening of the *Infinity Center*, a patient run resource and drop-in center located in a building with 3500 square feet, including room for several offices. She explains that at one time the building had been an activity center, but later was made into a staff lounge. Patients began to complain that they were bored and had nothing to do but smoke. When she approached Andy, the CEO, about the possibility of using it as a drop-in center he made a decision to do it without a lot of discussion. Laura recently hired a consumer affairs associate, someone who will report to her, and will work at the drop-in center. Patients who participate in the hospital's employment program will also work there.

The way that Laura describes the *Infinity Center*, one is certain to find it interesting. Most of the planning was done by the patients, including naming the center. They also got to choose colors and decorate it. They sponge painted the walls purple, ordered furniture of their choosing and made the entire center very modern looking and cheerful. "It is really something to see," she said, and she meant that from an artistic standpoint, as she knows of my interest in the arts. Because they could only work on this several hours a day, for which, she points

out they were also adequately paid, it took longer than would be expected to complete the project. The center is now open several hours each day and as well as Saturday, when patients had virtually nothing to do.

Patience is something Laura has had to learn. She acknowledges that things move slowly, particularly when you are trying to accomplish systems change. “The challenge,” she said, “is not to get stuck in impatience, as when changes *do* get made, it may take more time but changes are incremental.”

One of the other achievements that Laura is proud of is a committee that is called “*I CAN or Independent Client Advocacy Network*” and there is a contest underway for a logo. This committee is representative of all of the units of the hospital, but instead of having each unit vote on a representative, which is typical practice at many hospitals, everyone who wants to come is invited. In this way, people who want to come; do come. Over 50-60 people show up at a meeting where they may have a speaker or where they learn about new proposed policies that they are asked to give their input. It is their decisions that will count regarding what they want in the new treatment mall, for example. They are also helping to advise administration on changes to the current levels system. The meeting is facilitated by Laura, she explains, but they mostly run it themselves.

Patients, much to Laura’s recommendations, are now serving on hiring committees for hospital leadership positions. Each interviewing committee includes two people who have been selected based on her recommendation and that of the wards where patients reside. They also get paid for their time.

Even though Laura has given a good description of some of her special projects you wonder what her day is like. She explains that during most of her day, she is out seeing patients providing individual peer support. She sees individuals at their or often at staff request, some whom she follows closely to prepare them for discharge or to help them work through a difficult period. She might take someone for a walk or help them with a problem they are having regarding the level they are on. She goes to de-briefings after someone has been secluded or restrained.

She also works on policies. One of her next challenges is to tackle the five-inch policy manual and recommend changes so that policies are patient-centered and recovery- oriented. She sometimes takes the time to do national work as she continues to be sought after as a consultant or she helps to develop programs at the local and state level. If time were not a factor this interview would continue. Laura would continue to tell more stories, illustrate more of what she does, exuding excitement that is infectious. You want to be there to see her in action.

In conclusion, Laura cannot say enough about how much she loves her job. “Every day is an adventure,” she says. “It is like live TV. You don’t know what’s going to happen. But it does take focus to be there, really truly be there for the patients. That’s what works, even for those who doubt you. When you tell other staff that you do what you do because of the patients, there is little for them to say otherwise. *When you’re there for the patients, everything else follows.*”

Comments from Andy Phillips, EdD, CEO of Western State Hospital:

It is important for every mental health organization to have a consumer hired in an executive management position. That person sits in on all management meetings and has a voice in policy and funding decisions. A consumer executive has a unique voice that must be heard. For all of us traditional professionals it is a challenge to incorporate consumer recommendations. We are not acclimated to hearing a consumer voice in management team meetings. Working through the discomfort is essential. Other members of the executive management team must offer support and encouragement. It is a lonely task to be the voice calling for a delay in processing or implementation of an initiative until consumers weigh in. Peers can be frustrated by the delay and likely changes that will occur. It is a heavy burden for a consumer leader to shoulder.

**Director of Consumer Affairs
Consumer Affairs Officer
Western State Hospital**
WMS Recruitment Announcement

Location: Lakewood, Washington
Salary: In the process of establishing.
Division: Mental Health Division
Posting Date: August 27, 2004
Closing Date: September 10, 2004

AGENCY PROFILE:

The mission of the Department of Social and Health Services is to improve the quality of life for individuals and families in need. The Department helps people achieve safe, self-sufficient, healthy and secure lives. In accomplishing this mission, the Department offers comprehensive and coordinated social, health and financial services to meet the unique needs and strengths of individuals and families.

ADMINISTRATION PROFILE:

Western State Hospital (WSH) is a fully JCAHO-accredited facility with over 1800 employees providing evaluation and acute and long-term psychiatric health care for approximately 850 geriatric, forensic and other adult patients.

Western State Hospital (WSH), in Lakewood, is the second oldest state institution, founded in 1871. The hospital now includes 56 buildings with 32 wards on 264 acres. It is the largest state-operated psychiatric hospital west of the Mississippi River. There are three clinical centers: the Center for Adult Psychiatric Services (CSA), serving individuals civilly committed under the state's Involuntary Treatment Act; the Center for Geriatrics Services (CGS) for assessment and treatment of individuals 60 years of age and above; and the Center for Forensic Services (CFS), serving court-committed individuals who have special security needs. The vision of Western State Hospital is to provide quality treatment within an environment that ensures public safety, emphasizes patient choices, furthers individual dignity, and reflects a safe, interactive and patient-focused setting.

POSITION PROFILE:

As a member of the executive management team utilizes the full scope of management principles, organizational and communication skills to bring a consumer's point of view to all areas of program development, policy formation, program evaluation, quality assurance, system designs, education of mental health service providers, and staff providing direct services. Serves as a systems change agent. Develop goals, strategies, outcomes, plans and procedures to promote dignity, respect, acceptance, integration, and choice for those receiving services from the hospital and/or Program for Adaptive Living Skills.

DUTIES:

- Develops and manages short and long term operations of the hospital's consumer affairs program.
- As a member of the Executive Management Team develops and influences the decision-making regarding policies, procedures, and standards of patient care.
- Communications on the advocacy issues of the patients and clients served by WSH and PALS.
- Serves on a varied employment selection panels and committees to represent patients and clients concerns, viewpoints, and voice.
- Meets CMS certification for investigating and responding to patient complaints, patient rights violations. Participates on the AROI team for investigations of abuse.

- Organizes and track patient complaints, resolutions and potential actions.
- Meets with community and ESH Ombudsman to provide a seamless response to patient complaints no matter where they occur.
- Train staff in patient rights/advocacy. Work with Program Managers for follow-up to patient complaints and ensure implementation of systems change.
- Meet w/families, provide them with community contact resources, and assist them in presenting issues to the treatment team.

DESIREABLE QUALIFICATIONS:

- This position must be filled by a self-identified current or former mental health consumer/survivor as defined by the National Association of Consumer/Survivor Mental Health Administrations (NAC/SMHA).
- Requires a mental health consumer’s viewpoint of major service related mental illness issues such as stigma, parity, service delivery, diagnosis, treatment and recovery.
- A management-related graduate level of education or state equivalent.
- Demonstrated skills in:
 - Program management skills.
 - Decision making skills.
 - Policy development and presentation skills.
 - Ability to develop outcome-oriented strategies, goals and management plans.
 - Negotiation and problem solving skills.
 - Public relations and communication skills.
- Ability to recruit ongoing client representation from diverse populations and geographical regions

APPLICATION PROCESS:

Interested applicants should submit:

1. A letter of interest, including the title for the position for which applications is being made;
2. A current resume outlining educational background, recent experiences and qualifications, explanation of pertinent experience, names dates of recent employers and reason for leaving; and,
3. A minimum of four current or recent employment references (one supervisor, one subordinate) with current telephone numbers.

In addition we encourage you to complete and return the Applicant Profile Form found by clicking on the link at the bottom of this announcement. Information gathered will be used for statistical purposes only and will be kept confidential.

GOLLOAE@DSHS.WA.GOV
OR
 Western State Hospital
 Human Resource Office, Attn: Anne Gollogly
 9601 Steilacoom Blvd SW
 MS: W27-19
 Lakewood WA 98498-7213

The Department of Social and Health Services is an equal opportunity employer. Women, racial and ethnic minorities, persons over 40 years of age, persons of disability, disabled and Vietnam era veterans are

encouraged to apply. Persons of disability needing accommodation in the application process, or those needing the job announcement in an alternative format, may call (360) 664-5862 or (360) 664-6178 – TTY.

We ask you to voluntarily answer the **Applicant Profile** questions and return it with your completed job packet. This information will be treated as confidential and will be used by authorized personnel only.

**Cindy Mayhew – Recovery Support Specialist,
Alton Mental Health Center
Alton, Illinois**

It was not surprising for me to hear Cindy Mayhew talk about what was important to her in her role as a Recovery Support Specialist at Alton Mental Health Center in Alton, Illinois when I talked to her recently to integrate her story into this guidebook.

I had previously met her in the fall of 2006 when I was at the hospital as a consultant to conduct dialogues and role plays on all patient units. At that time, Cindy was a relatively new employee, having been employed for only six months. She had been extremely helpful to me in the dialogues, almost acting as a co-facilitator and always encouraging patients and staff to participate in the role plays.

Now, six months later, I wanted to know more about her role as a Recovery Specialist and how she felt about her job. What follows is what she had to say on the subject:

“When I look back regarding my interests and where my work has gone, there is a real pattern of being interested in partnerships. Therapeutic care occurs when partnerships are established between the consumer and their care providers, including family members. I believe partnerships are possible when individuals are given tools and are empowered to participate fully with their care providers and their input is respected and valued by the provider. Dialogue and education are needed on both ends for this partnership to be successful.”

Cindy said she thinks like a mediator. “I see the importance of each party at the table dialoguing with each other so that each other’s perspective can be understood and valued. Understanding brings ‘richer’ relationships and partnerships. And it truly *is* a great feeling to be listened to and understood.”

She states that her ability to understand may come from years of being misunderstood. “I like to be able to fit into another’s shoes,” she said, “and to be able to sit down at the table where one person might be empowered and the other disempowered and, at that time, they might be adversarial with each other. When you can open up communication and have a dialogue, however, understanding can come from that.”

Cindy became familiar with peer roles and initiatives when she had been in the state of New York during the 90s. After working with survivors of domestic violence, with pregnant and parenting teens and on homeless issues in other parts of the state, she eventually worked in consumer operated programs in Albany, prior to coming to Illinois. She believes that her work history with consumers and understanding of the issues shaped her for the work she would do at Alton Medical Center; work for which she is both passionate and knowledgeable. She also recognizes that many people do not have the benefit of having experiences in peer organizations or a full understanding of peer support”

There have been many other factors that led her to her work. In college she became an advocate for herself and other single parents, which taught her a lot about justice, equality and empowerment. But one of the main influences in her life has been her spirituality that she calls her *Soul* purpose in life, not to be confused with *sole* purpose, she clarifies, to make sure I understand. Though she has a B.A. degree, she said it took her many years as her college education was interrupted due to mental illness and hospitalizations; a typical experience for many consumers.

When she came to Illinois in 1999, she put the word out of her interest in working in the area of peer support, but there did not seem to be anything available at that time. In 2005 she attended a Certified Recovery Support Specialist training that was offered for the first time in Illinois. In fall of the same year an opportunity arose at Alton Mental Health Center as a contractual recovery specialist for the “Reducing Restraint & Seclusion Initiative.” While the position was originally for a contractual employee, a full time position was created for her instead.

She reports to the hospital administrator, Susan Shobe, and Dr. Kachigian, the medical director of the hospital. Both of them are equally invested in recovery principles; which has given Cindy a lot of freedom and flexibility to explore how to meet the job requirements as she sees fit. Cindy states that while she is grateful for a liberal administration, their philosophy often conflicts with many of the staff's beliefs.

She learned early on that staff's concerns were different from the administration's concerns. While administration might be focusing on recovery issues, the staff was more concerned about safety. "During my first six months," she said, "I realized that staff saw the 'patient voice' growing, while feeling that their voice was not being heard amid lots of changes in policy and procedure. Their feeling was that administration was overlooking real safety issues. This 'disparity', as they saw it, was leading to resentment and more resistance to change. It resulted in statements like "Pretty soon they will throw away the keys and patients will just take over."

As the Recovery Support Specialist, she felt that it was important to encourage all the "voices" in this hospital community to be heard – that the recovery principles needed to apply, not only to those they served, but to the workforce as well. Without staff's input you would not get their true investment in the campaign to create a recovery-oriented system of care. The first step was to get staff input. I worked with a committee to develop a PARTNERS training on trauma informed care and recovery for which we did round table discussions and strategizing. The roundtable discussions included persons from administration, as well as management and staff at all levels of care. Patients were also involved in these trainings and discussions, telling their stories and bringing their own perspectives on recovery. We trained about 220 employees and began to give them 'their voice'.

Cindy thinks it has made a difference. "Not all of the staff recommendations have been implemented," she said, "but they brought more understanding of what staff members think and care about. Definitely, more staff members showed a better understanding of the campaign and more confidence & willingness to implement new approaches and strategies."

Cindy states that her main job is to empower individuals being served at the hospital and she is always trying to find new ways to do that. She talks about the newsletter she helped start with the patients tying it in with the importance of people having valued roles.

The newsletter, published quarterly by and for patients, gives Cindy an opportunity to encourage people both individually and as a group. "The rewards are many," she said. "We have a great deal of fun producing it and when something they wrote or designed is in print, we all feel proud."

A particularly poignant success story is the African American gentleman who felt he never had anything to contribute anywhere. Cindy relates, "When he became involved, he said that he felt that no one ever thought he had anything to contribute, but that just asking him to be part of the newsletter committee made him feel important for the first time in his life. From there, he became committed to telling his story during staff training. I remember him getting up and talking about what he went through when he heard voices and how it affected his life and influenced the crimes he was charged with. When he shared it with the team everyone was deeply affected-- It was so powerful."

Cindy said it was hard for her to believe that others had not heard his story before. She said she believes that after he told his story, staff that had worked with him saw him more as a person with an illness, not a person who committed crimes. "When others change their perceptions of a person in this way, you see more compassion and kindness, rather than judgment and fear," she said. "*It is so powerful,*" she emphasized again, and at this point Cindy took a few minutes to cry.

Cindy has many roles at the hospital, serving on committees such as the administrative and executive clinical management committees. Serving on a committee is not her favorite activity; nor is being involved in rewriting

policies. “I am more interested in empowering people by just doing it” she says, “like getting someone to stand up and tell their story”, like the gentleman who she just referred to. “I want to see the patients have opportunities in valued roles so they can first feel good about themselves and thus be more invested in their own wellness.”

She likes teaching people skills and points out how wrong it is to put someone on a committee who doesn't know how to have a voice. “It is important to first teach people-skills in order to participate meaningfully.”

Her job has frustrations as do all peer specialist jobs, but one of her main frustrations is the amount of time she has to take to be part of certain committees, or working directly with the clinical team concerning a specific individual. “I don't mind working with individuals,” she says, “but my main interest is in working with groups or in culture change and empowering individuals through peer groups.”

Sometimes she thinks they see her as a miracle worker—“they have someone no one can work with and they want me to come in and work some kind of magic. I find that if a person is unwillingly to invest in their recovery the best I can do is really carry the message of hope and the possibilities of recovery to that person, vs. the team wanting me to do things like convince them to take medications or incorporate time with me into their behavior plan, or convince them to go and visit a group home.”

Sharing frustrations doesn't last long. Excitedly she tells me, “You know what we're doing soon—we're planning a strategic planning day for consumers with a small party in the afternoon to celebrate the patients in leadership roles. As a leadership group we will decide what directions to take in order to contribute to the improvement of the hospital environment and carry the message of recovery to peers. I will also be working more closely with the clinical team to assure that individuals in leadership roles are getting acknowledged at the hospital and in their court reports.”

Cindy is being recognized in the state for her talents. She is being asked to head up a leadership council and is on a statewide trauma workgroup, as well as being asked to present at mental health and substance abuse conferences. This might be another frustration, at times, as when she admits that she likes to be acknowledged for being a good speaker, but she wants to make sure it does not fragment her work at the hospital.

Mostly, she has a lot of hope for her future. “All of this that I have been holding, I can now bring my voice forward—a big issue for a trauma survivor. For someone who was totally disempowered as a child it is extremely important that I now have my voice back and have something to give.”

Words from Susan Shobe, COO of Alton Medical Center:

“Originally Cindy's position was to be funded from the Seclusion and Restraint grant, but it was supposed to be 20 hour per week or less. I interviewed Cindy and decided I didn't want her to be part-time; I wanted her full-time, so...I gave up a direct care position in our staffing plan and hired her using our Personal services funds. So, she is now a full-time, AFSCME (union) direct-care staff person. We wrote the job description prior to hiring her and worked out details of her daily activities after she came on board. I have her reporting directly to the Medical Director (and myself) and I'm very happy that we hired Cindy.

The benefits are many. She is a resource to the Treatment Team, she participates on our Leadership Council, also; she is an advocate for the patients. She has shown staff and our patients that people with Mental Illness can recover and have productive, valuable careers. She gives us the patient perspective and keeps us mindful to focus on strengths, not weaknesses or problems.

Challenges include that we have to accept that changing a culture can be slow and you have to have patience (when anger seems easier and discouragement, likely.) Initially, some direct-care staff are somewhat suspicious and threatened by the Recovery Specialist. It's especially important that the Recovery Specialist is able to establish a rapport and prove her value to the team. When Cindy first arrived I took her to each treatment team

and stressed that she was not “management” but was a member of their team. I explained that she was not a spy, that she was a resource, a tool for them; that having her could make their jobs easier and safer. I explained that she could provide the patient perspective and that patients would more than likely relate better to her and that she could be a mediator of sorts at times.

I believe that Cindy has gained the respect and trust of staff and patients alike. New initiatives she has introduced include a (PAC) Patient Advisory Council and a Patient Newsletter. She is conducting WRAP classes and is introducing a version of WRAP that is applicable to a hospital setting utilizing the PSP (Personal Safety Plan).”

Recovery Specialist Annual Objectives

October 2006

Objective 1: *Encourage and Promote Recovery at AMHC by assisting patients in realizing alternatives they can use to avoid restraint and seclusion.*

1. Patient Education & facilitation of WRAP groups.
2. Work with patients and staff on using personal safety plans effectively.
3. Participate in clinical meetings to address individual patients concerns & issues.
4. Monitor use of comfort rooms and procedural issues on units as well as review comfort room satisfaction surveys.
5. Patient Newsletter
6. Facilitate the sharing of "stories of recovery" in the hospital setting to bring hope and the real possibility of recovery to both patients and staff.

Objective 2: *Encourage and Promote a Recovery Oriented and Trauma Sensitive System of Care at AMHC.*

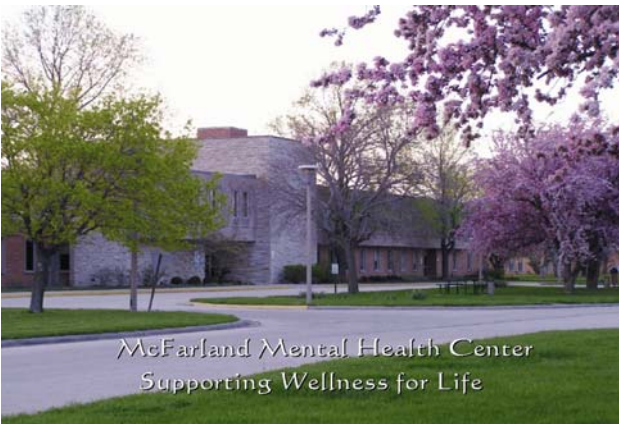
7. Provide PARTNERS training for staff and ensure patient representation at this training.
8. Present a training module on recovery to new staff during orientation.
9. Provide information on mental illness, trauma issues, peer supports, and recovery principles to both staff and patients
10. Assist with policy and procedure development and implementation regarding patients and recovery best practices to reduce restraint and seclusion.

Objective 3: *Give voice to patient needs and issues through my participation and patient's participation in the hospital environment.*

11. Encourage patient's to be active and contributing participants in their treatment team meetings and in reaching their treatment goals.
12. Schedule and Chair the Patient Advisory Committee (PAC).
13. Active involvement in Partner's Campaign & promote patient representation in this campaign.
14. Active hospital committee participation addressing patient concerns & suggestions for change.
15. Promote patient representation on additional hospital committees.
16. Develop patient recognition program for staff.
17. Conduct patient surveys when needed.

Objective 4: *Represent patient issues, identification of needed resources, and quality of care issues through participation on statewide and community committees and regulatory agencies. Work closely with network recovery specialist to represent the department, hospital, and network to community groups.*

18. Attend Recovery Services Development Group Meetings - Face to Face bimonthly.
19. Participate in RSDG Hospital Subgroup teleconference meetings every month.
20. Participate in Facilitator/Recovery Specialist teleconference biweekly for SAMSHA grant and other related meetings.
21. Additional coalition/committee participation where representation for the patients may be needed.



When Mark Schutter, MASMHO President, asked me to submit an article featuring a new initiative used in the hospital in which I work and utilized within the Illinois Mental Health System, I knew immediately what topic I would choose: **Recovery**. I am very pleased to share with you the following article authored by Nanette Larson, Illinois Department of Mental Health Recovery Services Director and Christine Elvidge, a Recovery Specialist from McFarland Mental Health Center. To me, this article demonstrates the passion, dedication, and the difference a few individuals can make.

The State of Illinois serves approximately 13,639 consumers with mental illnesses each year. The system is comprised of nine state hospitals and one treatment and detention center serving sexually violent persons. McFarland Mental Health Center, one of the state operated psychiatric hospitals, is located in Springfield, Illinois. It is a 120-bed hospital serving a 40 county catchment area. Over the past few years, the staff have become dedicated to the belief that “All persons can recover from mental illness”. Further, it is believed that “wellness” is achieved, in part, through the promotion of an empowering, violence-free environment.

In 2005, the State of Illinois received a three-year Substance Abuse and Mental Health Services Administration (SAMSHA) grant designed to identify effective alternative practices to the use of seclusion and restraint. McFarland Mental Health Center was one of two state hospitals selected to receive grant funding the first year. The intent of this grant dovetailed nicely with initiatives previously targeted by this hospital and evolved into what is known as Project S.A.F.E. (Safe Alternatives Fostering Empowerment). Project S.A.F.E. is a strategic initiative which encompasses all functional areas of the hospital.

Through the use of consumer input, the system of care has shifted toward a recovery-oriented system. A key to the success of Project S.A.F.E. is the expansion of recovery services. The Illinois Department of Human Services (DHS)/Division of Mental Health (DMH) has been in the process of facilitating the transformation of the Department to a recovery-oriented and person-centered system. In an effort to meet this end, DMH enlisted the Bureau of Recovery Support Services to assist in developing priorities and goals which reflect the interests of persons served. The DMH Bureau, led by a self-disclosed consumer of mental health services, consists of numerous other consumer representatives who work as Recovery Specialists within the state mental health system. McFarland Mental Health Center was able to recruit and hire two Recovery Specialists and is in process of hiring a third. These individuals are instrumental in the promulgation of the Wellness/Recovery model.

A positive outcome of Project S.A.F.E. has been the beginning of a change in the culture and attitudes of consumers and staff. Daily community meetings, a Consumer Advisory Council, consumer representation on key committees, and the presence of Recovery Specialists on the units ensures consumers are actively involved in all levels of decision making. The addition of artwork, comfort kits, and comfort rooms inspired by consumers, has positively impacted the recovery process, illustrating the difference between decorating and empowerment. Although the units were nicely furnished, they needed a personalized touch. One decision was to purchase new artwork. The units looked much more inviting with the new scenery, but that is not what made this project such a success. It was the process that made the difference.



First, Christine Elvidge, Recovery Specialist, designed an array of pictures with inspirational quotes. Each person on the unit had a chance to vote for his or her favorite piece of artwork and determine the placement of each item. The ability to have a voice and make decisions proved to be empowering. *“Empowered people, in my experience, recover much faster. The sight of all the people on the units participating, making decisions, and knowing that their opinion mattered, is one I will hold onto, and will ultimately help all who participated”*, said Elvidge.

The comfort rooms and comfort kits are tools designed to assist people to calm and sooth themselves. These tools have been successfully utilized on all of the adult units this past year. The finished product was exciting, but it was teamwork of staff and people served that made the success of this project so rewarding.

First, consumers developed a list of techniques and items that were personally calming. The hospital purchased a variety of such items and tailored each comfort kit to the specific requests of each unit. Examples of items included inspirational books, lotions, tools with which to color and create, MP3 players with relaxing music chosen by the unit, stress balls, microbead pillows, a plush dog, journals, eye compresses, bubbles, etc. After the kits were completed, the Comfort Rooms were furnished with an overstuffed recliner, a TV/DVD and video players, and artwork. Each unit was given the opportunity to name their comfort room. After names (Lincoln Lounge, Chillville, The Relaxation Sanctuary, and The Magical Room) were determined, ribbon-cutting ceremonies were scheduled. Those on the unit helped decorate and enjoyed ice cream sundaes. Everyone received stress balls and had an opportunity to tour their Comfort Room.

The purpose of the Consumer Advisory Council is to support and empower consumers to participate in planning and improving the quality of the programs, policies, services, and resources provided by the hospital. Three representatives from each of the adult units are chosen monthly to participate in the council. Each meeting has a different focus, and the representatives from each unit come prepared with suggestions, information, and input from their specific unit.

The Council provides suggestions on a variety of topics including the admissions process, discharge treatment instructions, the menu, what classes people would like to see on the unit, how to keep the units safe, and personal safety. One of the first suggestions from the council was to have a “Staff Appreciation Award”. Each unit votes for the person who showed the most kindness and respect to others. Consumers present each winner with a Certificate of Appreciation and a Gift Card. This process appears to have a positive impact on relationships between staff and those served. Other accomplishments of the Council include the addition of caffeinated coffee with breakfast (previously only caffeine-free was served), more available reading materials, and more available groups. The Council has also been instrumental in making improvements to the dietary menu.

Elvidge states, *“We have found that consumer input not only empowers those we serve, it benefits staff, too. Since most staff don’t see those they have served unless they return to the hospital, recovery is not always evident to them. However, when those served on the unit become excited about giving input, staff see people blossoming and become a partner assisting those served with recovery rather than just doing a job.”*

The spirit and enthusiasm expressed in this article come nowhere near the compassion put forth daily by the Recovery Specialists. For those of you who have not hired a consumer of mental health services who has experienced wellness in their path to recovery, I would encourage you to do so. They provide invaluable perspectives of mental health recovery that you just can’t learn from a book!

Scott Viniard, Hospital Administrator
McFarland Mental Health Center
Springfield, Illinois 62704

**Peer Specialists in Maine - Amistad
Maine Medical Center, Portland
Riverview State Hospital, Augusta**

Overview:

The state of Maine has had a lot of opportunities for consumers to be involved in the transformation of their system by involving them in greater decision making and in developing opportunities for new programs and initiatives. An organization, Advocacy Initiative Network (AIN) is involved in influencing legislation, serving on work groups and developing special projects; an office of consumer affairs operates in the state Department of Health and Human Services. In addition, there are several major consumer operated or managed programs in the state, “Amistad”, being one of them, with its byline, “People Helping People.”

It is believed that the peer support program at Riverview State Hospital in Augusta may be one of the largest programs to offer peer support to ALL of its patients in a state hospital and for peer staff to be involved in ALL major decisions. Part of the success of the program may be attributed to it being administered by an outside agency, Amistad, which is located in Portland where they have a peer drop-in center and other programs that operate daily. They administer a second hospital program at Maine Medical Center in Portland where a team of peers provide support in an emergency department. This is believed to be one of the few in the country where peers work directly in hospital emergency rooms.

The contrast of the two peer programs in hospitals is dramatic. Peers working in the emergency room are there primarily to give individual support to people coming into the E.D. in crisis, while peers working at the state hospital are much more integrated into the life of the hospital providing a great variety of services and playing a key role in policy and decision making.

This was not my first time to Maine. I had visited there as part of a review team in 2005 and was aware of many of its successful peer program. For the purpose of the guidebook, I came to see the inpatient programs in more depth. You will go with me to an evening at the E.D. where I shadow a peer specialist, then you will get information about the programs from interviews I had with peer supervisors of the programs, clinical providers and with Peter Driscoll, the CEO of Amistad.

Part I. Maine Medical Center

I am at the Maine Medical Center in the Emergency Department on a rainy evening in November, 2006, where I am met by Paula Gaillard, a peer specialist, who has been working in the emergency room for a year. She has agreed to let me shadow her and interview her for the purpose of the guidebook. Paula is dressed in jeans, high-top boots, sweat shirt and several layers of shirts underneath, looking rugged and vigorous. “It is often cold down here,” she said. “This is what I usually wear.”

We walk through a narrow area that serves as the nurses’ station (much too small but plans are underway for a move) into an area where there are four small cubicles that serve as holding places for people who have arrived there in crisis, most often involuntarily after they have been picked up by the police. Paula explains that she is one of three team members that works part time to cover the hours from 5:00 to 11:00 PM seven days a week.

On this particular evening two people are in two of the rooms, and a large number of clinical staff and one psychiatrist are seated in the nurses' station. Paula stops to introduce me to the staff. I note that their attire is more formal and they all seem very busy. Paula tells me that there is an unusual number of staff in the nurses' station this evening; none of them take time to talk but they are friendly when Paula introduces me.

Paula points out that most people sit for long hours, sometimes up to eight or twelve hours. These long waits, however, served as the impetus for the E.D. peer program, after a community needs survey identified that evening hours were when people needed the most services, including people in the community and at the emergency room at the local hospital. They felt that emotional support was particularly needed for people who come to the emergency room unexpectedly, which can be particularly frightening.

Often, Paula knows some of the people who are brought to the E.D. Such is the case with the first person we meet. The woman is very angry and expresses her desire to go home. We do not get the full story but learn that she had been involved in an altercation. We talk to her for a little while and agree to come back later.

The second woman we meet with has a long complicated story. She explained that she became very depressed recently over losing her job, but that she has not been treated for mental illness for many years. Her job, she said, has been the most important part of her life, which has sustained her through many life challenges. She admits to having a substance abuse problem that led to a DUI and later the loss of her license. Her story becomes more and more complicated. Her boyfriend, whom she has depended on, has a drinking problem as well. In addition to all of her other problems, there is no bus transportation where she lives, consequently she drove without a license and was caught. I note that Paula is a good listener; we both sit and listen as the woman seems eager to talk and needs very little prompting. Stories *do* take time though and I can see why peers might spend hours just listening. The woman does not seem to see any way out, though she does not mention being suicidal.

Paula shares that she is a peer specialist with a past history of her own. She talks about how she spent years sitting on a couch doing nothing, her hospitalizations; her diagnosis of bi-polar disorder. She tells her how much she values her work as a person with a psychiatric history.

The woman seems to be reassured. At this point, the doctor wants to meet with the patient and Paula and I politely leave the room. When we return, Paula tells her about resources in the community, including the Amistad Peer Support and Recovery Center and the Maine Warm Line, another program of Amistad's.

While we were talking to this woman the first woman is admitted amid loud protests that we can easily hear. It is doubtful that Paula would have prevented her admission as Paula later learns that she may have been violent prior to coming to the E.D.

Paula and I go to a lounge to talk where we can be more comfortable.

We talk about the woman we saw and identified many services that could be helpful, one of them being legal services, substance abuse services, and perhaps other services that might help her with job counseling or even transportation needs. We were not sure if hospitalization would be helpful as many of her problems were

situational. My question was whether she would be communicating her assessment to the social worker or doctor. This answer seemed to be dependent on whether the social worker asked her opinion, which tonight may not happen. Paula said that she is sometimes asked her opinion but she does not always volunteer information.

Working for Amistad, she explains, gives them independence but it does have a tendency to separate them off. "Some of the staff does not always know why we are here, particularly staff in orientation." When they first started working in the E.D., she told me, they were told they could not "hang out" in the office, because of confidentiality. (Earlier she had pointed to a bulletin board to show me where a sign had been posted with the intention of keeping them out of the nurses' station.) "This made us uncomfortable," she said. "We did get that corrected, but it hasn't solved all of the problems. Certain people still do not talk to us, while others have become quite friendly and often ask our opinions." She said it has definitely increased her self-confidence.

I am interested to know if she would like for her work to be more integrated clinically but she says, "Actually, I like it the way it is and I love what I do. We do not do any charting nor do we read records. We do have our own record keeping but it is mostly for follow-up and to track whether people take advantage of resources we offer." She told me that they are not invited to hospital staff meetings but they do have their own staff meetings once a month at Amistad and a social worker liaison attends as a link from the hospital.

Paula sees her role primarily as a support to the individual, which she likes. "First," she said, "I establish a comfort space with the individual I'm speaking with. I always share where I've been, something about my experiences. Once you have that comfort in place, everything opens up. The bottom line is JUST Helping. You give as much information as possible. Resources-- what you know. Whatever experiences you've had in common, you try to share what has been helpful to you. A lot of times people are afraid to ask doctors questions. I let people know what they can do, drawing from my own experience. I am *never* afraid to tell my peers my experience."

The next day I learn more from the other team members as we all meet at the Amistad Peer Support and Recovery Center. People at the meeting included Paula, Jerry Bradley, Kevin Wolf, Simonne Maline, their supervisor from Amistad, as well as Peter Driscoll, Amistad's Executive Director and Mary Jean Mork the Social Work Clinical Supervisor, for the Emergency Department, who attended the meeting to offer a hospital perspective.

Simonne explained that the program started with a grant from Maine Health Access Foundation (MeHAF), a private health care foundation that was created after a sale of Blue Cross Blue Shield to Anthem. Funds are offered for small innovative programs for which they were able to be funded for several new peer programs.

Jerry told me that he was one of two original peers who started the program in December of 2002. The program started with their being "on call" but it was soon apparent that that was not very efficient. In 2004 they transitioned to having regular hours, though they would each work part time. "Our 'on call' pay was just \$2.00 per hour. Now we are paid \$12.00 an hour, starting salary," he said. The pay is just enough for them to continue on SSI (Social Security Disability). One of them, Kevin, goes to college during the day. Jerry runs his own non profit foundation that acquires computers and offers training to people with disabilities.

One of the success stories is told by Jerry about a young man who came into the E.D. threatening to hang himself. Jerry was there to pass the time with him and had a memo pad. Ironically, they would eventually play a word game called “Hangman”. Jerry said that it led to both of them talking about their lives, and he said, quite proudly, “The guy went home in a few hours with a different perspective—no longer suicidal!”

Kevin talked about his use of humor. “If I can just make them laugh once it breaks the ice and everything changes,” he said. “I will try anything and I have lots of gimmicks; hats that are made from rubber gloves, toys I pull out of my bag, including the joke of the day from Comedy Central on the internet.”

When we discussed how the program might change, there was resistance among all of them. They expressed fear that their dress would have to change and that they might have to meet Medicaid guidelines which, they believe, would change how they approach people. This fear is not without merit as later Simonne would explain that emergency departments have very separate guidelines which are stricter and less flexible than state hospital guidelines.

Mary Jean Mork, the social worker administrator, is very recovery oriented and was instrumental in getting the program started. She agreed that peers might have to change if they became more integrated with staff. While she is not often on site, she works with another social worker, Kathi Reinfelder, who is the onsite supervisor for them at Maine Medical. Mary Jean felt that it would be helpful for new staff to learn about them in orientation. She also agreed that staff would benefit from receiving training from peer specialists on recovery. She was interested in looking at other ways for their work to be more effective.

Training for the peer specialists in the E.D. is mostly informal, learning on the job, but they get 24 hrs. of initial training in peer support, trauma, suicide assessment, history and philosophy of Amistad as well as the Consumer Movement. In the beginning they shadow peer specialists on site to get a sense of others people’s styles. They also have an orientation with the social work liaison in the Emergency Department and an understanding of how the hospital works.

Regarding training on peer support, Jerry remarked, “You can’t be trained on peer support. You can’t train people to be who they are. And you can’t train to have experiences.” They all agreed.

Several months later, I speak with Simonne Maline, the supervisor of the E.D. program to get an update.

Simonne explained that her own role, as supervisor, is challenging because she supervises a lot of people, 12 of them are peer specialists on the warm line, in addition to the three individuals working on the E.D. staff. She is looking forward to re-shifting job responsibilities for her soon so that she will have more time to devote to the emergency room staff, admitting that the Warm Line has demanded more of her time in recent months.

When she is able, she anticipates making some changes to the E.D. program. She plans to pilot pairing a social worker in the E.D. with a peer specialist in order to create more collaborative relationships. She will also start orienting all new emergency clinical staff with one of the peer specialists in the near future. They are also beginning to take a fresh look at data collected to determine how many people have followed up with resources that were suggested to them.

Simonne informs me that the State Office of Consumer Affairs has established a requirement that all peers working in mental health programs and facilities receive peer specialist training and be certified in the near future. This will include all of the peer specialists working at Maine Medical and at Riverview State Hospital as well as warm line staff. This training, she believes, is a huge burden to the programs as it does not train the staff in the practical things peer specialists need to do their job, and although it is a model of how to do peer support, it is not the model we follow.

Simonne's story and history is an interesting one. She had worked as a professional social worker in several different capacities, including working in crisis respite programs prior to 1994 when she got "sick" and was hospitalized for mental illness. This left her out of work on a leave of absence for two years. She said she came back to the same agency two years later and then joined Amistad in 2004. "This has been my most rewarding job in my professional career," she said. "My life experience is an asset, not a liability. It is required! It really informs my work every day and it has personally helped me transform a lot of pain into meaning and fuels my passion to make the mental health system a kinder, gentler place."

Simonne was told by doctors that she would never work again, something that many consumers have been told. "Thank God, I didn't believe that," she said. "When we talk about stigma we've done a lot more work to reduce stigma in the general public, but I believe that the majority of stigma is in the mental health provider world. If people were looking to mental health providers to help us, and they don't believe recovery is possible, we're up a creek. That's where our next big effort has to be."

Part II. : Riverview Psychiatric Center, Augusta, Maine (Peer Support Team Administered by Amistad)

The second day of my visit to Maine I went to Riverview State Hospital in Augusta where a team of peer specialists have been working there for three years. The program at Riverview was the inspiration of the Court Receiver, appointed to bring the hospital into compliance with a long-standing consent decree that was initiated 17 years ago. It has received tremendous praise from patients and staff, and the court receiver has described it as one of the most significant changes that she has been able to bring to Riverview.

My impressions of the program had been formulated from a first visit made to the hospital in 2005 when I was part of a federal review team. At that time I met briefly with the team of peer specialists and with clients they serve there to look at consumer satisfaction. What I saw made a lasting impression, including the comforting atmosphere of the newly built hospital that has cheery rooms with lots of light, a modern cafeteria and café, a beautiful library with updated books, and a modern gym and recreation area.

At the hospital I meet with the peer specialist team. Holly Dixon is the director; other team members are Heidi Smith, Lisa Willis, Eric Knight and Leslie Caswell. In addition to this group two other peer specialists work weekend hours but were not at this meeting. There are also plans in the near future for an expanded program of "Peer Bridgers" for discharge planning that will involve additional peer staff.

We meet in their office that has limited space with desks and computer space, each area decorated and personalized. Most of their time, though, is spent on the units. Holly explained that Peer Supporters (as they are sometimes called) or Specialists; are with patients at every step during their stay at Riverview. Heidi works on

the admissions unit and is present for all new admissions; the others are assigned to each of the four units of the 92 bed hospital. Holly's role is administrative. In addition to supervising the team, she attends all policy and executive meetings and works closely with the administrator of the hospital, Brian Daskivich. She explains, "Although I work for Amistad I am an accepted member of the executive team of the hospital as well." Holly came to the team in February 2005 after she had already been working as a professional social worker at the hospital. When this job came to her attention she had not disclosed her psychiatric history up until that point but is now always open with the exception of when she goes to professional social worker conferences and meetings.

Each of the team members has a different story of how they found out about the job. Holly heard about the program when it began and happened to walk into a conversation about the director's position and thought it was the perfect opportunity. "Where else could you do what you love and be open about whom you are as a whole person?" Heidi had been working as an office manager when the team was first started in 2004 when she saw an ad in the paper that asked for persons with a mental illness background. At the time, she said, after finding out they were truly looking for persons with mental illness, she was sure that's what she was meant to do for the rest of her life. Lisa had been working as a recreational therapist in the hospital when she first learned about the job. It took her two years to apply. Eric is the only male person on the team and heard about the position through a friend and they thought it was the perfect job for him. He agreed-- And Leslie came because a close family member had been diagnosed with a mental illness and she wanted him to feel like it wasn't something to be ashamed of and that it is okay to talk about. She wanted to show him that you can still get a job and live a productive life regardless of having mental illness. There is a sense of permanency to the team as several of them, including Heidi, Eric, and Leslie have been with the team from its inception.

I asked them what they thought about working for an outside agency in that they are quite a distance from Portland where Amistad is located. Did they think it was an advantage as did the E.D. staff?

They all agreed that it was a plus because they said it gives them more freedom to be better advocates. Lisa said they sometimes have felt free enough to challenge doctors. One example is when a patient wanted a different discharge plan than was being recommended by the doctor. "The doctor wanted the patient to go to a residential treatment program but the patient wanted to go to their own apartment," Lisa said. "We were able to advocate for the individual's wishes."

Heidi gave the example of how she is able to "hug" her clients. "I'm a Hugger," she said. "While hospital staff would be forbidden to touch people Amistad allows us more flexibility. Also, I often hold people's hands when I walk them to their unit," she said. "I know it makes them feel safer when they are going to a place that is unknown and often frightening."

They all felt they have won the trust of most staff and this may be the factor that is *Key* to making them feel more open. While it has not always been true, most of the doctors now value their opinions and frequently ask for them to be involved in crisis and other types of situations. The team believes their efforts have contributed greatly to the reduction of the use of seclusion and restraint which now occurs rarely at the hospital.

I wanted to find out more about their treatment mall called the "Harbor Mall". I knew that they offered groups based on the clients' expressed interests. Heidi explained that each of the team members offer a hobby group or

support group that are requested or sometimes because of their own talents or special interests. Sign-up sheets for groups are posted on the library windows where people can sign up for them. “Some of the groups include cooking, collage making, spirituality, humor group, and AA and NA groups,” Heidi said, “but they change every three months according to new suggestions and recommendations.” (Note: in most hospitals you will still find treatment groups with medically oriented titles; psycho-education group, medication management, etc.) I wanted to make sure these were *treatment* groups, not recreation or rehabilitation groups. “That’s right,” Heidi said, reassuring me that I had interpreted this correctly.

Eric explained that they all work a bit differently, depending on which unit they work in. Working with forensics, for example, is different because many of the people have been there for years. Their goal is to provide a more homelike environment and programs that may involve education or different types of recreation. Acute units require someone to work with people on short-term goals. Heidi works on the admissions unit and loves her work there because she gets to orient people to the hospital.

Their work encompasses many different activities in addition to providing individual peer support. They take minor complaints and grievances and frequently have them resolved before further action is necessary; they administer consumer satisfaction surveys, and they train staff and clients on recovery issues. One thing they had not anticipated was being asked to chart on patient records.

This issue had them all concerned. “Clients know that what they tell us will not be recorded. It makes them feel safe,” said Holly. “We are afraid that clients will no longer trust us if they feel we are charting on them.” After we left the team meeting we go to meet with the administrator, Brian Daskivich, who would explain his reasoning on the subject.

First, he could not have been more complimentary of the team. He said that he has been impressed with their work and that having Holly on the executive team also makes a big difference. He sees little difference as to whether Holly works for Amistad or for the hospital. In any case she is present at all executive committees and contributes a great deal!

Regarding documentation, he clarified that there were three different areas that peers were being asked to record information:

1. Upon initial contact when person admitted,
2. To document client preferences, and
3. Significant events or critical incidents.

I could see how this issue would be dis-comforting to the team, but could also see it to the team’s advantage ultimately. I recommended to Holly that they begin to see this as potentially positive. Perhaps the peer specialist team could make a difference in how information is documented. If the client agreed to what they record on their chart their work could be a model for other parts of the country, for clinical staff as well as other peers--Personally, I liked the idea and saw it as revolutionary!

Next Holly takes me so that I can talk to Diane Pearson, an RN who was there from the beginning of the peer program. She said she was there when the peer program started in May 2004 when the old hospital was still being used. (It still stands as somewhat an eyesore next to this beautiful new building situated on a hillside.)

She said four people started on the team and the hospital was anxious to get the program started. Planning was limited-- there was no welcome planned-- but Diane found a room for them and got them a welcome card and flowers.

Staff, she said, had many questions. They wanted to know: Can they sit in rounds? Can they give their impressions? Do they have to document? And can they look at records? Doctors were very resistant. They thought that they would interfere in crisis situations. Many of the staff thought that they were going to be patient advocates, thinking that they would be “spies.”

At first some staff started to go to extremes—having peers do errands or treating them condescendingly. There were two nurses and one mental health worker though who were consistently supportive.

When things began to change is when they developed a Peer Support Oversight Committee, which began with only selected employees who were supportive to the peer specialists. They helped to pave the way for other staff members to feel more comfortable.

Of course, she admits, that has all changed and most of the staff is now happy to have the peer specialist staff. She continues to be one of their strongest supporters.

I ended my day at the hospital talking to three inpatients who confirmed what I was already sure of. They think the peer specialist program is great. One of them said, “I can talk to the peer team better than other staff because they understand me. They make me feel safe and it helps me a lot.”

Peter Driscoll drives me back to Portland when the day is fading. Peter is the CEO of Amistad, a very special person that his employees all talk about with devotion.

As we drive the sky is changing from all colors of blue, purple orange to grey and black. Peter tells me about his own role at Amistad. He tells me that he has been the agency director for 15 years and is careful to point out that he was hired by a largely consumer board of directors. It has been a point of contention to some consumers in the state that he is not a consumer; consequently, the agency does not meet the narrow definition of consumer operated programs. The unfortunate consequence to this is that Peter is not always invited to meetings where other peer directors are present. “This winds up being unfair to the consumers who hired me. They are not represented and are left out—a bur in his cap,” he adds.

On a happier note Peter talks about a Memorial Service that honored persons who died at the old state hospital, Augusta Mental Health Institute (AMHI), two years ago. This was a cooperative project in which *all* of the consumer agencies were involved. Volunteers read 11,500 names over an eight hour period, names that were found, not at gravesites at the hospital, but by going through patient records one at a time since the year 1840. “It was an extremely moving experience for all of them,” he said.

Peter talked about other projects that are sponsored by Amistad, including the Peer Support and Recovery Center, a drop-in center that serves nearly 150 members per day. Many people come for lunch where they pay \$1.25 per meal. Activities include games, tournaments, and support groups of all types. Also, there are many field trips to local parks and places for hiking and swimming and other types of activities. I had noted pictures in the hallways and in the restaurant when I visited the Peer Center. Peter is featured in many of these photos engaging with members while fishing or other outdoor activities; obviously having fun.

Another major program that Peter tells me about is the Warm Line that is considered one of the most comprehensive in the country. Open every day from 5:00 PM to 1:30 AM the service provides a telephone number for people to call who just want to connect with someone because they are alone or frightened or feeling sad. This program is for people in the entire state of Maine.

Peter shares with me other plans they have for the future. They hope to do some training and in fact, have been asked to go to Delaware to talk about their peer support programs in the emergency room and at the state hospital. His staff calls him a visionary. "We voted him in. We want him to stay," they said.

Peter may be the visionary; but everyone shares in making the visions happen and to be successful. They are an exciting group and I felt proud just to have been there to be able to tell their story!

Job Description
ED Peer Specialist
Amistad, Inc.

Amistad is a peer support and recovery center open to adult consumers of mental health services and other life challenges.

Several fundamental beliefs are key to the operation of Amistad.

The first is that Amistad is a peer-managed organization. For too long professionals have decided what is best for consumers. Our belief is that consumers are the experts in their own lives. In this Center, consumers make the major decisions regarding the policies and priorities for the Center and its operation.

The second is that we believe that people, even those with severe and persistent mental illness, can lead full, rich, productive lives when given the skills, tools, courage and support to act on their own recovery. We have an unwavering commitment to this belief.

The next is that all members of this community should be treated with dignity and respect at all times. Members have long lived with the stigma of their illness and suffered intolerance, discrimination and humiliation as a result of it.

Lastly, we believe that the opportunity to socialize, develop and maintain friendships as well as have fun in a safe and accepting environment is crucial to recovery and an important component for an individual's well being and a strong community.

All staff of Amistad are expected to bring, teach and model the recovery philosophy.

The Peer Specialist is recruited to work in the Peer Support Program that operates in the Emergency Department of Maine Medical Center.

Qualifications include:

- A demonstrated commitment to the philosophy of Amistad;
- A sound understanding of and commitment to the consumer led recovery movement;
- A personal history of recovery;
- Sufficient understanding of mental health practice to allow comfort in dealing with both traditional and non-traditional providers;
- Knowledge of mental health programs and providers in the Greater Portland area;
- Terrific people skills are critical;
- An ability to work in a hospital emergency department while also practicing in a manner that emphasizes peer and natural support and the opportunities provided by an apparent crisis;
- Ability to express yourself in both verbal and written communication;
- Willingness to work 5pm-11pm.

Responsibilities include:

- To act consistently in a manner that demonstrates dignity and respect for peers entering the Emergency Dept;
- To act in a calm, gentle manner and to treat all peers and professionals alike with respect;
- To act as role models, who share personal strengths and skills as well as the hope that recovery is possible for everyone;
- To actively weave the natural principles of wellness into Emergency Dept. conversations as well as modeling and teaching skills of recovery and self care;
- To encourage others to take personal responsibility for their own wellness and recovery;
- To help peers advocate for their own needs and wants;
- Provides peer support on a scheduled basis in the Emergency Dept. at Maine Medical Center to individuals who choose to have peer support;
- To maintain a high level of respect for individuals confidentiality at all times;
- Provides support in a manner consistent with the recovery philosophy, which emphasizes peer and natural support, and the de-escalation of possible crisis;
- To model a recovery approach to crisis within the hospital emergency department;
- To participate in training developed for Peer Specialists;
- To participate in regular staff meetings with other Peer Specialists;
- To maintain records as needed for proper documentation of the Emergency Department Program;
- To participate in regular supervision with the Program Coordinator;
- Other duties as may be assigned to insure the success of the program.

The ED Peer Specialist is responsible to the Peer Services Coordinator of Amistad.

8/05

RIVERVIEW PSYCHIATRIC CENTER

FUNCTIONAL AREA: Provision of Care and Services **POLICY No:** PC 5.50.2

TOPIC: Peer Support Specialist's Role

AUTHORIZATION: _____
Medical Director

Director of Nursing

Superintendent

I. PURPOSE:

To ensure Peer Specialists are integrated into each client's multidisciplinary treatment team.

II. POLICY: Amistad Peer Specialists have been contracted by Riverview Psychiatric Center to work closely with clients modeling recovery and offering hope of a brighter future. They will be involved in all aspects of client care, including admissions, Service Integration Meetings, treatment plan meetings, discharge plans, and aftercare. Their main role in these meetings will be to provide support to and help facilitate a client centered, strength based plan that focuses on each individual client's needs.

III. PROCEDURES: Peer Specialists will engage in the following activities:

1. Peer Specialists will report to Amistad's Peer Support Coordinator. The Peer Support Coordinator reports to the Executive Director of Amistad and under contract reports to the Deputy Superintendent of Clinical Services.
2. Peer Specialists will have regular meetings with their Program Service Director to address concerns and grievance trends.
3. Each Peer Specialist will be assigned to a unit.
4. The Peer Specialist is expected to attend all relevant meetings on the unit that applies to client care when the client wishes to have Peer Support services.
5. Peer Specialists may be asked to meet with clients on other units to meet specific requests, or for other appropriate reasons such as a particular experience or interest that might be helpful to a client on another unit.
6. Peer Specialists may be asked to attend meetings or admissions on other units when coverage is needed and the Peer Specialist assigned to that unit is unavailable.
7. Peer Specialists will be contacted by the admissions coordinator or his/her designee when an admission has arrived. He/she will call the Peer Specialist that is assigned to the unit where the client will be residing or the designee for that unit if the regular Peer Specialist is unavailable. Peer Specialists are

responsible for notifying the admissions office of the designee for the admitting unit if the regular Peer Specialist is unavailable.

8. An important aspect of the role of Peer Specialists is to share their lived experience with the mental illness and recovery process and, most importantly, building relationships with clients. While this may mean more personal disclosure than other professional relationships, it is important that the focus be on helping the client in his/her recovery process.
9. Peer Specialists are expected to be mandatory reporters and will report to the unit charge nurse any statements by the client of suicidal ideation, elopement intent, or threat to harm others.
10. Peer Specialists will honor the privacy of all clients, and will not talk to clients about other clients. All information shared by the client will be kept confidential (except that which falls under mandatory reporting guidelines) unless permission is given by the client to disclose that information. Clients will be encouraged by the Peer Specialist to discuss any clinically relevant information with their treatment team.
11. Peer Specialists will always check with the unit charge nurse to check the level of a client prior to leaving the unit with a client.
12. Peer Specialists will always check with the unit charge nurse before going into a client's room to ascertain whether there are any security issues they need to be aware of. When a Peer Specialist is alone with a client the door to the client's room will always remain open.
13. Peer Specialists will not purchase any items for the client.
14. Peer Specialists are not allowed to transport clients.
15. Peer Specialists will not loan money to clients.
16. If a stat call is placed, Peer Specialists will not be expected to participate in physical control of the client and will only participate in an extreme emergency where no Riverview staff are present or available. Peer Specialists should be in the location to try and calm the client in question or other clients in the area if the status of the patients is conducive to the intervention.
17. Peer Specialists will help clients formulate their complaints cohesively within the framework of a newly developed grievance system.
18. Peer Specialists will respond to grievances/complaints/suggestions within 24 hours to review the grievance/complaint/suggestion to clarify the issue prior to submitting to the appropriate authority. Peer Specialists will not act as an advocate in this manner, but simply be there if requested to help the client through the process.
19. Peer Specialists will have access to clients' medical record to obtain information.
20. Peer Specialists will be responsible for completing incident reports when a situation arises that needs to be documented and they are the first to hear the information. Peer Specialists will report these situations immediately to the unit charge nurse.
21. Peer Specialists will orient to the current unit milieu through discussion upon coming on the unit with the charge nurse.
22. Peer Specialists will attend Service Integration Meetings.

Deni Cohodas, Massachusetts

Deni Cohodas probably has one of the most unique positions of any peer specialist working in a state hospital in the country; she also has an interesting story of how her position was created. I learned about Deni a few years ago, probably soon after she got her position. We had many phone call exchanges; sometimes just to talk with her giving me updates of her work, sometimes for clarification on a particular issue. I met her first when we were filming the video in Pittsburgh, *Leaving the Door Open: Alternatives to Seclusion and Restraint*, in April, 2006, and again, in Massachusetts, at Worcester State Hospital, later that same year, when I was consulting on the development of comfort rooms.

Deni's position has a direct correlation to the reduction of seclusion and restraint. When she first started in her position as Patient Liaison, or as a de-briefer, she worked for two state hospitals in Massachusetts, Worcester and Tewksbury, both located an hour away from each other. How she got her job was totally unexpected and quite an interesting story. I have heard it several times and it is always captivating. She tells it this way:

“I was invited to a NASMHPD conference in 2003 with leadership from Tewksbury Hospital and Worcester State. We were watching the part of the curriculum that talks about the de-briefing process. I turned to the COO at Worcester, Tony Riccitelli, who is now my supervisor, and said something like, “That would be an interesting job. Imagine if we had a consumer to facilitate the debriefings. Patients might be more comfortable if they met with somebody who has the lived experience of seclusion and restraint.”

“Tony suggested I talk with Ellen Flowers, Director of Nursing at Tewksbury Hospital, who would also later become my supervisor. She loved the idea. So the position was developed. Tony and Ellen were already interested in hiring a consumer/survivor for their respective facilities to help with the restraint and seclusion initiatives. The conference helped to mold their idea into a reality.”

Deni states that it is important to point out that the same competitive process was used for the Patient Liaison position as for any other position in the Department. She was fortunate enough, she said, to attain this first position.

She explains that, in the end, they discovered that there had never been any positions created, specifically for de-briefers (that anyone knew of), anywhere in the country, not for peer positions nor professional staff positions. What they were creating was groundbreaking and new but it was not surprising to her that it was successful, as she expressed, with a great deal of enthusiasm, “It works.”

The position would evolve for several years, but continues to have multiple components of the original role, focused primarily on de-briefing each person following a seclusion and restraint occurrence. Later, as the hospitals began to use seclusion and restraint less frequently, her work would focus more on debriefing critical events and working preventatively.

She defines de-briefing as "...a multi-step process to look at what happened to cause a crucial event and how it can be prevented in the future." A second part of the process," she says, "is to facilitate clinical debriefings with other staff at which time recommendations are made to prevent similar occurrences in the future."

The initial part of her job began when she was notified at either hospital when someone had been in restraints or seclusion, at a time when the immediate situation had been resolved and the environment was calm. She noted that many times people did not want to communicate with a professional staff member, even if the person approaching them was not responsible or in any way involved. “A restraint event can be discouraging for a patient and there are a lot of feelings related to the event,” she said.

Deni notes that in some cases, peers may be the most able to reach someone, particularly if they approach them with their own history of seclusion and restraint, their history of trauma, or their own vulnerabilities as a person who experiences symptoms from a psychiatric disability (or mental illness). Sometimes simple self-disclosure about your own experience with mental illness can diminish their anguish and can reassure the patient, making them feel safe to talk about their restraint event.

Making a person comfortable is important. Deni approaches an individual in a non-prescriptive, comfortable way, pointing out that there is no one-way and no one-set of questions. Massachusetts, she tells me, has questions that are typical for debriefings, but she is free to expand on the questions, depending on what she feels might be helpful to the individual involved. “Eye contact is important,” she says. “When I sit next to someone, I always make sure I can see their eyes.”

She may ask someone what happened before they got to the hospital, particularly if they are a forensic or court appointed patient, or a new patient to the facility. An important part of her role is to inform her clients that she is a “consumer” because it almost always makes them feel more comfortable. “They will be able to identify me as a role model,” she said, “but I weave this into the conversation at a time I feel is appropriate.” (Again, there is no one-way, nor one-time that she discloses.) Sometimes she uses the word “patient” depending on the knowledge base of the individual she is speaking to. Sometimes, she notes, people just need to talk. I may say to them, “Let’s go outside so that you can have a cigarette while we talk.” She emphasizes that relationship building with the individual is important and may take place over time.

Usually, she says, when she talks informally with individuals they give her good information that will be helpful in the formal debriefing and which can lead to changes in the person’s treatment plan. She may ask someone, “How do you feel about your experience?” “Do you feel you were approached respectfully?” “Were you treated in a respectful manner at the time of the restraint?” or “What had caused the event?” She wants to know if they think there was anything that might have helped to prevent the incident. She may also ask a question about whether or not staff had tried to calm them prior to the incident, or whether there is anything in their history that may have contributed to them going into crisis. While these questions may be asked, they are not asked in any particular order or written on a form for her to fill out.

When she completes her interview she types up a report with the information and her recommendations. While most of the time she has some recommendations, there are times that she doesn’t have any to make. Later, at the formal debriefing, she serves as the facilitator does with key staff members present. “Prior to this time,” she says, “I usually ask them if they want to present the information themselves or if they want me to present the information they want to share. It depends on whether or not they feel they can.”

Sometimes recommendations are made that might be considered “out of the box”. This too, is the advantage of having a peer conduct de-briefings. They are often able to come up with creative preventative strategies with clinical staff that may not have come up before. She is quick to point out; however, that the team works together, and it is often the collaborative efforts of the team that produces positive solutions.

One illustrative story is the individual who frequently wound up in seclusion and restraints, sometimes almost daily. She said that in working with this individual, she would tell him that she looked forward to the day that he might leave the hospital. That she would believe in him until he believed in himself. It was through collaboration at the debriefings that the team was able to figure out that this individual did best when he went out on passes and it was only after the visits that he did not wind up in restraints. After several days of being confined again, they noted that he would wind up back in restraints. Through the debriefing process, and the work of the team, they decided that though he had been in the hospital for many years, it might be best for him to work toward discharge planning in the next several months. Consequently, they increased his visits regularly. They also created a special program of community supports for him involving the use of a life coach for when he was discharged to his community placement. He has been doing well ever since, she said, and stated that this would be just one example, of many, success stories.

In 2006, Deni was given a full time position at Worcester Hospital. Trying to serve two hospitals at the same time would prove demanding and difficult. The job also had a more expanded definition and it would be important to concentrate her efforts in one hospital full-time. While her work previously focused on persons who had been in seclusion and restraint, now her efforts are more preventative. Sometimes, she said, she also works with people following critical incidents such as a suicide attempt or an altercation between a patient and staff; or with someone with self-injurious behaviors or who is at risk for seclusion and restraint. It is important that a similar process of de-briefing take place with team members as with persons who were in seclusion and restraints. Deni now shows up at the 5-1-7 calls (their emergency help call system). She has been integrated into the staff team(s). She says she now has to caution herself to keep her “eye on the prize”, meaning on peer support and supporting the patient voice. She sometimes has to remind herself that these are the priority job functions.

After Deni left, Tewksbury Hospital began looking for someone to work as a Patient Liaison. Tony, Ellen and Deni wrote up some recommendations for the Tewksbury Patient Liaison. Deni’s list of recommendations would be very extensive and include many of the things she learned while working in her position. Tewksbury would be the next hospital to employ a full time Patient Liaison, but there would later be other hospitals in the state of Massachusetts and in other areas of the country. They recognized the importance of spending a lot of time thinking about how to create a successful role, create an adequate job description and establish an extensive outreach for advertising the position. Ultimately, this would take nearly a year to accomplish, with Tony Riccatelli, Ellen Flowers, and others inputting into the process.

Deni’s recommendations for creating a position were the most extensive. These are some of the ones that might apply to any peer position though it can be noted they are for a Patient Liaison position. These are not all of her recommendations and are listed in abbreviated form:

1. Supervision that is supportive and validating. (This is *key* for any peer role. Supervision must be behind and available to anyone serving in these positions. Key roles, such as Deni's, are best placed at executive or top administration levels.)
2. Must have equal access to and inclusion in policy and programmatic decision-making.
3. Must be empowered to have access to critical record information.
4. Must have an ongoing relationship with the COO and Directors of Nursing and receive a full endorsement of their role.
5. Introduction of a Patient Liaison requires staff outreach and education designed to address questions regarding the Liaison's role.
6. Patient Liaisons require sufficient time to meet new patients and to spend time with people already at the facility so that their first encounter with a patient is not at the time of a restraint.
7. Liaisons need sufficient time to take a close look at histories and notes of high-risk patients and to meet with them one on one in order to offer peer support.
8. Needs to be able to access a variety of staff and shifts.
9. Requires that a person be a full-time employee whenever possible.
10. A commitment to valuing the position with competitive salaries and benefits.
11. Hiring criteria that emphasize real life and professional experience. Other attributes should be excellent listening and negotiation skills, an ability to work effectively with people who are disenfranchised in addition to other skills as well.
12. Need for Liaison to have an organized network through which they can share experience, coordinate efforts and support each other in their roles.

From: Tony Riccitelli, CEO, Worcester State Hospital:

Tony Riccitelli, Deni's supervisor at Worcester had a few things to add, particularly about the importance of integrating these positions with staff. "At first," he said, "clinical staff felt placed in an uncomfortable position. It took them a while to see Deni as staff." It was Tony's job to remind them that she was an employee and should be treated like any other staff person. He allowed the staff to express their concerns and to work through them.

Mr. Riccitelli and others would agree that in the end, what was most helpful was that Deni was skilled at the job of liaison. She brought a commitment to the position and a competence; she was a "good fit". Mr. Riccitelli defines "good fit" as the capacity that any employee has to navigate a work environment in order to maximize their effectiveness. "Deni," he said, "made an effort to understand the hospital, its culture, and staff."

Deni, herself, acknowledges that the job did not come without conflict. She can remember when some teams and staff were resistant to and/or afraid of the change, she believes, fearing their own loss of power. "The most powerful intervention," she states, "happens when she and the team meet with the patient, and either their joint recommendations, or her recommendations alone, based on what the patient expresses, helps to keep them out of future restraints."

At this point, she is frequently asked by other staff to help. She is comfortable serving as a fully accepted team member where "We *all* have the answers. We decide to try everything until something works."

In summary, Deni always finds her work rewarding. She states, “I look forward to other facilities piloting new Patient Liaison positions as they present a natural and logical system of support to patients and staff. The patient liaison role can educate staff at hospitals that persons with major mental illness can lead successful lives. Having a consumer employee on the teams helps bring out the patient’s strengths, so that they can have more of a sense of empowerment in their treatment. She ends by saying; *“This is what restraint reduction and culture change are all about!”*”

**The Transformation Center's
Recommended Job Description
Debriefer/Client Liaison**

January 2007

***Note about This Description:** This recommendation was drafted using descriptions already in existence and written by the facilities which currently have a debriefer. We felt these descriptions were very good, though we found a few items we wished to modify, change or expand upon. Footnotes have been applied to clarify where changes have been made to the original job descriptions.*

Functional Title: Client Liaison/Debriefer

Full-time/Part-time: Full-Time

Duties:

PEOPLE WITH MENTAL HEALTH CONDITIONS AND/OR PEOPLE WHO USE DMH SERVICES ARE STRONGLY ENCOURAGED TO APPLY ¹

GENERAL STATEMENT OF DUTIES AND RESPONSIBILITIES:

Work with clients and staff to ensure a participatory process for clients as it relates to the reduction and/or elimination of restraint and seclusion. Conducts individual client debriefings after incidents of restraint and/or seclusion in order to identify individual, unit and hospital-wide strategies to reduce/eliminate restraint and seclusion. Facilitates clinical debriefings with clients and staff to identify individual unit and hospital-wide strategies that reduce restraint/seclusion. Makes recommendations based on client/clinical debriefings to supervisor and/or teams. Acts as an advocate for the client in treatment planning as it relates to restraint reduction. Assists in the development of training and education regarding the client perspective of restraint/seclusion. Identifies human rights issues as they arise during debriefings and collaborates with Human Rights Officer(s) as necessary.

DETAILED STATEMENT OF DUTIES AND RESPONSIBILITIES:

1. Interacts with clients on a regular basis to establish rapport and refers them to unit staff and the human right officer when appropriate.
2. Assists in monitoring the facilities restraint and seclusion by reviewing each episode and related aggregate data regarding restraint and seclusion use.
3. Conducts individual debriefing of clients and facilitates staff debriefing after the use of restraint or seclusion.
4. Participates in the development of treatment planning which encourages alternate interventions to reduce the use of restraint and seclusion.
5. Participates in the training of staff related to the perspective of persons with mental illness on treatment.
6. Participates as a member of the Executive Team and other restraint reduction related or risk management related committees, as applicable to role.
7. Works collaboratively with facilities Human Rights Officers.
8. Works collaboratively with outside advocates, as needed. This may include linking with the Recovery Learning Community in the area, helping bridge discharged clients to the peer support community, and bringing

¹ Has been changed to person-centered language

into the facility information and resources such as the Wellness Recovery Action Plan (WRAP) and recovery stories.²

9. Compliance with all applicable state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA) regulations which govern the privacy and confidentiality of information about clients.

10. Performs other duties as assigned.

Qualifications:

Minimum Entrance Requirements: Applicants must have at least (a) three years of full-time, or equivalent part-time, experience working in the mental health field³, or (b) any equivalent combination of the required experience and the substitutions below.

Substitutions:

I. A Bachelor's or higher degree may be substituted for a maximum of two years of the required experience.*

*Education toward such a degree will be prorated on the basis of the proportion of the requirements actually completed.

2. Personal experience with a mental health condition may be substituted for a maximum of one year of the required experience.⁴

Note: Having both a bachelor's degree and personal experience may replace a maximum of two years, or equivalent part-time, of experience working in the mental health field.⁵

Preferred Qualifications:

QUALIFICATIONS REQUIRED AT HIRE:

1. Ability to understand, explain and apply the statutes, rules, regulations, policies, procedures, specifications, standards and guidelines governing assigned unit activities.
2. Ability to exercise sound judgment.
3. Ability to establish and maintain harmonious working relationships.
4. Ability to advocate for and/or with clients.
5. Ability to establish rapport with persons from different ethnic, cultural and/or economic backgrounds.
6. Agility to establish rapport with individuals with mental illness.
7. Ability to motivate others.
8. Ability to communicate effectively in oral expression.
9. Ability to write concisely, to express thoughts clearly, and develop ideas in logical sequence.
10. Ability to gather information through questioning or observing individuals.

² The second sentence has been added to expand upon the idea of working with outside advocates.

³ Replaced investigatory or law enforcement work with "working in the mental health field"

⁴ This substitution has been added as personal experience is an important criteria, it expands one's knowledge, understanding and ability to work as an advocate. As such it is recognized as a substitution.

⁵ Added to clarify the need for experience in the field.

11. Ability to gather information examining records and documents.
12. Ability to exercise discretion in handling confidential information.
13. Knowledge of the mental health system, inpatient facilities.
14. Knowledge gained from personally utilizing mental health services.

QUALIFICATIONS ACQUIRED ON JOB (List knowledge, skills, abilities)

Knowledge of the laws, rules, investigative techniques⁶, regulations, policies, procedures, specifications, standards applicable to DMH and especially those guidelines governing human rights and restraint and seclusion.

LICENSE AND/OR CERTIFICATION REQUIREMENTS

License: Based on assignment, possession of a current and valid Massachusetts Class 3 Motor Vehicle Operator's License.

Certification: Certified Peer Specialist (CPS). Candidates either at time of hiring (or early in their tenure as the Client Liaison) will have attended and passed the CPS training and test.⁷

Training: Attendance at the Transformation Center's Debriefing training.⁸ Also all standard training staff receives on restraint/seclusion reduction, such as the 6 Core Strategies.

Preferred Knowledge: Candidates will be well versed and have experience in the field of Human Services, including experience in the areas of client safety, process improvement, systems dynamics and systems re-engineering.

⁶ Investigative techniques had been listed under "required at hire".

⁷ We feel the CPS training is an important foundation for this position.

⁸ The Transformation Center is currently organizing this training. This training is meant to follow the CPS training and will build and expand upon special skills needed by the debriefer.

Article on Massachusetts experience:

Peer Involvement Becomes a Reality on the DMH Restraint and Seclusion Grant

Nicki Glasser

Background:

Sometimes potential for system change comes in “little” federal packages. Recently, the Massachusetts Department of Mental Health (DMH) won a federal grant to eliminate restraints and seclusion in state inpatient facilities. Massachusetts is one of eight states that won one of these grants and there has been much hope in the advocacy community that it will lead to deep, meaningful changes in the state mental health system. But a culture of violence and coercion has existed for so long that creating an alternative culture of empowerment, respect, support, and healing will not be easy. Fortunately, peer involvement in the grant is finally beginning to happen.

Last spring, three peer members of the grant advisory committee, Jon Delman, director of Consumer Quality Initiatives, Howard Trachtman, chair of the NAMI National Consumer Council Restraint and Seclusion Committee, and Steve Holochuck, DMH Director of Consumer Affairs, sketched out a broad plan for peer involvement. Three others also participated, Walter Noons, attorney at the Disability Law Center, and Ed Wang, DMH Director of Multicultural Affairs, and me.

The broad plan was eventually honed into four priority items, 1) a mediated dialogue between DMH staff and peer advocates, 2) training for new peer debriefer positions, 3) peer-led staff training and technical assistance, and 4) peer involvement in monitoring and evaluation. These priorities are overseen and implemented by a Transformation Center team which includes: Gloria Dickerson, Marina Colonas, Keri Fallon, and I, Team Leader/Coordinator. Deborah Delman, Executive Director of the Transformation Center, is an on-going contributor, as is Steve Holochuck, Howard Trachtman, and Jon Delman.

Mediated dialogue

Our first goal is to implement a mediated dialogue for DMH staff and peer advocates; it will be led by a neutral facilitator from the Public Conversation Project. Why? We hope a facilitated dialogue would improve communication. Relations between peer advocates and DMH administrators are often fraught with conflict, high emotions and frustration on both sides. We often don't feel heard by them and are devalued and tokenized in an environment where we believe there should be “Nothing about us without us.” Administrators, on the other hand, often feel demonized, attacked and misunderstood. The Public Conversation Project has a proven track record in helping two polarized groups (i.e. pro-choice and pro-life) come together to hear one another in a respectful and productive way. The first dialogue will take place this fall with the grant advisory committee members. If this dialogue is successful we hope to see mediated dialogues replicated at the state inpatient units; participants would include area peer advocates and hospital staff, administrators, and patients.

Training for new Debriefers positions

Tewksbury State Hospital and Worcester State Hospital created the first peer Debriefers/Patient Liaison position in the nation! Ellen Flowers, Director of Nursing at Tewksbury and Tony Riccitelli, Chief Operating Officer at Worcester State Hospital, developed the "out of the box" idea of hiring a peer debriefer. They hired a person in

recovery from a mental illness to debrief patients after restraints and seclusion and provide peer support. The Patient Liaison also works collaboratively with people's treatment teams in order to advocate for them and strategize techniques to avoid restraints and seclusion. It is a peer/team-centered recovery model. Through a conventional DMH hiring process, Deni Cohodas was the first person hired for this position. Because the role has been so successful, DMH would like to see all inpatient facilities hire Patient Liaison/Debriefers. With this goal in mind, the Transformation Center is planning to hold a training for potential Debriefers/Patient Liaisons in early spring 2007. If you'd like to know more this job and the training, please contact me, Nicki Glasser, at 617-437-6493 or Nicki6000@verizon.net

Peer-Led trainings and technical assistance

The team has two projects under this heading. The first is to provide technical assistance for staff on the importance and value of peer support and issues around hiring of persons with mental illness. We are concerned about placing debriefers into environments where staff is not welcoming to a new (and probably their first) peer staff member, and whose day-to-day activities with, and assumptions about, patients can be disturbing to someone in recovery. Our goal is to smooth the way for peer debriefers while also educating hospital staff about these issues.

Second, we are interested in a national training curriculum from the Substance Abuse and Mental Health Services Administration (SAMHSA) called "The Roadmap to Seclusion and Restraint Free Mental Health Services." Written largely by persons with mental illness, it is an in-depth and enlightened approach to transitioning to recovery-oriented treatment approaches. DMH has suggested we choose a few sections from this three-day training that we feel will be the most helpful for hospital staff.

Monitoring and Evaluation

If non-peers are doing all the monitoring and evaluation on the inpatient units, one is left wondering if the assumptions made from those efforts are accurate. While monitors and evaluators claim to be neutral, in fact, no human being is capable of being completely neutral because we all bring our own life experiences into play in everything we do. For this reason, we would like to see more peer involvement in monitoring and evaluation activities. In fact, there is a precedent of successful peer involvement. For example, Consumer Quality Initiatives (CQI) is a consumer-run and directed organization that conducts mental health quality improvement, evaluation, research and service planning. CQI has been hired by DMH for a number of projects and has been a valuable contributor to DMH policy. We approve of research and evaluation that involve the peer advocacy community in more than token forms.

Final Note

In sum, the restraint and seclusion initiative has an ambitious plan. Our goal is to eliminate restraints and seclusion by helping to change the culture of the mental health system to be more recovery-based. We know that there's good staff and clinicians out there who believe in clients ability to recover and who set a high standard for their colleagues. But we need *every* clinician, *every* administrator, *every* mental health worker to believe in and know how to support our very human capacities to grow, learn, understand our illness, and ultimately recover. Eliminating restraints and seclusion won't be attainable overnight but we cannot sit by idly. We must push the process forward at every chance. The restraint and seclusion initiative is another step in the right direction. Every step forward holds the potential to save a life. There is no time to spare.

Starting Out As a Volunteer

Tom Lane

(Editors note: Tom Lane is a faculty member of the National Executive Training Institute and always talks about the benefits of including volunteers as part of the workforce. His own experience highlights how he started himself as a volunteer. He would eventually go on to direct programs, including the peer bridger program in NM, but later work in executive positions in larger agencies, including the National Alliance for the Mentally Ill.)

When I was first hospitalized for any length of time, it was at the University of New Mexico's Mental Health Center. Over a period of two years, I was in and out of the hospital over 7 times, and received 24 ECT sessions. I also participated in partial hospitalization programs. During all that time, I spent many, many hours talking with my peers, listening to each other's stories. Stories about our past, stories about what brought us to a point in our lives where we found ourselves lock up in a hospital for "crazy people." For most of us, this seemed like the end of the road.

Yet, somewhere inside, in listening and talking and just being together, I came to believe we shared something together. I came to the realization that something was uniquely ours, and only those of us who had experienced what we had gone through (and for many of us, were still going through), could ever understand. During my many stays on "the ward", I can remember seeing folks come in for the first time; what a frightening experience. And I can remember seeing folks come back, some of the same people I had been in the hospital with. I mean, here I was myself, back again.

The last time I got out of the inpatient unit, and went to the partial program, I decided I wanted to give something back. I decided there must be a way for the experiences I had to somehow be integrated into the Center. So, I decided to volunteer, and marched over to the main hospital's volunteer office. I filled out all the required paperwork, and announced I wanted to volunteer at the mental health center. Everything stopped in the very small volunteer space, staffed by mostly volunteers and one paid volunteer coordinator.

"Well, I'm sorry, but people can't volunteer at the mental health center. Would you like to take magazines to the patients' rooms?" she asked. So I asked "Why can't I volunteer at the mental health center? Is there a rule that says I can't?" She looked around uncomfortably, shuffled through my paperwork, and sheepishly looked up....."Well...no, there's not really a rule...it's just that no one has ever wanted to." And so began what would become my new career.

There were so many barriers to overcome. Initially, the Center quickly put up a barrier because I was still getting services there. What did I want to do as a volunteer anyway? It was hard for clinicians to grasp the concept of a "patient" wanting to volunteer in the first place, let alone to presume I had something to offer folks who were locked on the inpatient units. How dare I!! Fortunately, there were those forward-thinking clinically trained individuals who were familiar with the concepts of peer support and mutual self-help. After all, the University's MHC was a *teaching* hospital, so maybe there was something a person moving towards their own recovery would be able to teach the professionals! After much debate, it was determined I had to have someone "sponsor" me into one of the programs. I was very, very fortunate to have a woman named Susan Musante step up to the plate and take me on as the first volunteer ever.

The project was simple; I wanted to go on the inpatient unit I had myself spent so much time on and just be with folks who were hospitalized. I wanted to share my own story, talk about resources in the community (there weren't many), and just try and give something back. It was so intuitive. Fortunately, Susan was from New York, where the Peer Bridger Program had been in place for a couple of years. About this same time (August 1999,) I went to my first national conference, the First National Summit of Mental Health Consumer and Survivors, Consumer/Survivor Summit, held in Portland, Oregon. What a great experience. I came back to Albuquerque more energized, a bit more radical, and more convinced I was doing something that would make a difference.

There were still obstacles. I found out there had been a large staff meeting about my volunteering. Some of the doctors wanted to know how to interact with me; was I a "patient" or what? My own doctor really struggled with this. I had my own struggles, too. I knew people were watching me. I lived under a microscope. Clinicians were constantly looking for symptoms. Fortunately, my mentor, Susan, spent lots of time with me, and helped me with these issues.

OK, now the nuts and bolts of building the program, our own version of a Peer Bridger Program. I started out just going to the unit sometimes on the days I volunteered, which was every day, Monday through Friday, about 5 hours a day. I read lots of info about self-help, getting most of my info from the CMHS-funded Consumer Technical Assistance Centers. I'd made as many contacts as possible at the Summit, and wasn't afraid to call people. I learned you can never have too much information, or too many resources. But I also learned collecting information and resources just for the sake of saying you have them doesn't do much good. I subscribed to different newsletters from the TA Centers, from NMHA and other organizations. I asked for and got multiple copies, and I would take these to the inpatient unit and just leave them. Sometimes folks would ask me about them, and I'd tell them what I knew. Pretty soon, the inpatient staff would call me and ask if I could get more copies, or if I had information on this or that. So, the first part of the Peer Bridger Program at UNM's MHC was becoming a de facto resource clearinghouse.

Once there was a degree of "buy-in" to what the Peer Bridger Program was about, and what the goals were, Susan wrote a small grant to support the program. It wasn't much, but at least I was making a little money, and I actually became an employee of the UNM Mental Health Center! What a trip! My office was in the building where the psycho-social rehab program was housed, which was on the main campus of the MHC. Many of the folks I had been in the hospital with were going to the PSR programs, and were curious about what I was doing. Since the precedent for volunteering at the Center had been set (there were now guidelines and criteria, most of which I helped develop), some folks expressed an interest in wanting to become involved in the Peer Bridger Program.

Up until this point, my work was a one-man show; I'd come to work, check in with Susan, and see what was on the schedule for the day. By now, some of the clinicians and other staff, especially discharge planners, would contact me, asking me to visit a particular person. My schedule was pretty busy for a guy working 30 hours a week. The needs were greater than what I could meet. It was only natural to begin thinking about volunteer Peer Bridgers. But that meant training! It was one thing to just sort of wing it, doing what I did, hunting down resources and educational materials and more or less developing my own methods and approach. It would be

quite another to put structure, policies and procedures, develop a curriculum and training materials for others. This was going to be lots of work!

Initially, 3 people volunteered. I was still doing my “in reach” to the inpatient units. Susan was connecting with people in New York, getting materials from the New York Peer Bridger Program. In hindsight, I think it was part of Susan’s strategy to delegate almost everything to do with UNM’s Peer Bridger Program to me. I think she wanted other professionals to see that people living with psychiatric disabilities are capable of managing such things, and I think she was keenly aware of the importance of leadership development. Anyway, back to my story.

The training curriculum and materials were developed almost in real time as volunteers moved through almost the same process I did. Of course, the “living under a microscope” phenomenon wasn’t as intense as it had been for me, but it was still there. A part of the initial orientation addressed this. I developed the curriculum to follow the natural sequence of how a Peer Bridger would progress, from the initial orientation into the Peer Bridger Program through becoming familiar with the Peer Resource Center (yes, it now had an official name!) and going to see folks on the inpatient units. It evolved over time, incorporating training about helping folks transitioning from inpatient to other levels of services, such as partial programs or PSR programs. The initial training period was 2 months; eventually, it was extended to include a period of “shadowing” an experienced Peer Bridger for a month.

My role had changed by now. While I still did Peer Bridging, my responsibilities were more programmatic in scope. I insisted I be able to continue to do “in reach”; I felt then and still feel to this day, is the one to one work, the connections we make with one another that are core values of our movement. In my role as Program Coordinator, I had to schedule Peer Bridger times, make sure the Resource Center was staffed, respond to requests for 1:1 Peer Bridging services, and a host of other duties. I absolutely loved it. Another aspect of the work was doing staff training about the Peer Bridger Program. It was especially rewarding to do this for the medical students in their third year of residency. For them, hearing about living with psychiatric disabilities from folks who were living it, hearing about it from the “patient’s” perspective was an eye-opening experience. And, it was very empowering for me, as well as the other Peer Bridgers who became involved in staff training.

Another aspect of the Peer Bridger Program involved addressing some of the unmet needs relevant to self-help groups. One of the values I built into the Program was the importance of choices; not just for folks receiving Peer Bridger services, but also for those involved as Peer Bridgers. For example, if a Peer Bridger had an idea or a special project they wanted to work on or try, that was cool. As long as it didn’t compromise anyone’s safety, confidentiality, or integrity of the Peer Bridger Program, we would work on it together. One such project was starting a Double Trouble in Recovery group in the hospital. Being dually diagnosed myself, I saw the need for this, too. After a couple of weeks of planning with hospital administration, we had a space to meet, and staff on the inpatient units knew about the group. Substance abuse counselors were made aware of the group, and within a few weeks, the group had a regular attendance. Within 6 months, we added a second DTR group on the weekend in the evenings, holding it on one of the inpatient units. One of my special projects was one to one support for people just after ECT sessions. I did this mostly in the partial hospitalization program, since many times people would go to have ECT from partial, and then come back very disoriented. Anyone who has had ECT knows what that’s like.

Looking back on it now, the whole experience was one of the most satisfying I've had. Not only did it give me an opportunity to give back, it gave me an opportunity to create a framework for others to give back, too. I saw the barriers created by systems and people, and I learned about ways to break those barriers down. I also learned there are legitimate concerns needing to be addressed when developing a program like the Peer Bridger Program at the University of New Mexico. Anytime there are self-disclosed folks working in traditional mental health treatment settings, side by side with professionally trained clinicians, many issues are bound to arise. Creating an opportunity for peers to help peers in a traditional provider setting is perhaps one of the more difficult things to do. Yet it is one of the settings we can reach folks at a point in their lives when peer support could make a huge difference.

The Peer Bridger Program is still going strong and has grown to include several paid positions. Hundreds of folks have received Bridging services. While I can't speak to what direction these peoples' lives have taken, or the impact of being a Peer Bridger, I can say I believe it was a positive experience for the vast majority of people. Changes come about through programs like the Peer Bridger Program, but it's the people involved who really make the changes. I learned a project like the Peer Bridger Program can't succeed without the efforts of many people. It requires thinking about the organization's culture and knowing the elements that define that culture. Finally, it's vital to have a clear vision of what the goals are; to be able to visualize what it will look like, how it operate, who it will touch! I encourage anyone who has the desire to give back to others, to share your own unique experiential knowledge as a person moving towards living well to do so, in whatever venue suits you best!

**Peer Bridgers
New York State
New York Association of Psychiatric Rehabilitation Services
(NYAPRS)
Tanya Stevens, Project Director, Albany, NY**

Many states have Peer Bridger programs or similarly named programs that are designed to help people transition from state institutions into the community. This unique program originated in the state of New York in 1995 when NYAPRS (New York Association of Psychiatric Rehabilitation Services) began to hire peers to visit with service recipients in the state's six psychiatric centers in six counties: Albany, Ulster, Broome, Queens, Suffolk and Westchester. Their goal was to help ease the transition of people into community life and to significantly decrease their need for readmission. NYAPRS has continued to develop and expand this program along with its many other peer support and advocacy programs for people with mental illnesses.

The Peer Bridger's catchy mission statement sums up what Peer Bridger's do, stated as follows:

"We support each other to get out of the hospital, stay out of the hospital and get the hospital out of us."

I have been aware of the New York program for many years and it is among my favorites. I learned that Tanya Stevens is the current director of the program at NYAPRS and called to talk to her. She told me that she has been working with the program for three years and that she supervises twenty four Peer Bridgers in six different counties, the same ones in which the program started. Prior to serving in this position, Tanya worked on the national Women and Violence Study at Policy Research Associates in New York. This project was the first federally funded outcome study of its size to implement and evaluate trauma services for women who had been in and out of both the mental health and substance abuse services systems. Tanya oversaw the national advisory board and developed key trainings for and by survivors to better the goal of this program.

Tanya was happy to share information about the Peer Bridger program. "Peers working in the program work 15 hrs. Per week," she explained. "The requirements to become a Peer Bridger are fairly simple: In order for a person to become a Peer Bridger, a person must have had a mental health experience in the state of New York and must be able to articulate their own personal story of recovery."

As is true of some of the other peer providers that work for outside agencies; all of the employees of the Peer Bridger program work for NYAPRS, not the hospital. Tanya sees this as an advantage. "Working for NYAPRS rather than the hospital allows the Bridger greater flexibility in their ability to be able to support an individual in the manner he/she deems best."

This made me wonder about how much they work with staff. As it is with the peer roles in the emergency room in the state of Maine, it appeared that Bridger roles might also be devoted more to peer support with less interaction with staff. Tanya explained, "Peer Bridgers do not work with staff or serve as treatment team members, though they may attend treatment team meetings at the request of the recipient. Although the hospital does not view us as staff, they do view us as assets to an individual's treatment. We are seen as a complimentary service."

She explained that their role includes individual peer support and relationship building. Bridgers conduct peer support and recovery groups,” she elaborated. “They help people to determine what resources they will need in the community. After discharge, a Bridger continues to work with the individual in the community, linking them to a wide range of community-based services. They teach them wellness and self-management skills in their home environments.”

There is a very nice carry-over for people to receive assistance while in the hospital and then after they are discharged. The continuity has to be extremely helpful. I asked her whether part of their role was to be an advocate for their clients, thinking that it might be part of their job. However, she explained, “They do not serve as advocates. Our preference is to help people to advocate for themselves. We might explain procedures or direct people to an advocate, but we would not try to handle their complaints or help them resolve issues.”

Tanya explained that she is not the only supervisor. In each of the counties there are team leaders; also they subcontract with local peer run drop-in centers to provide part of the oversight and monitoring of the programs.

“Funding for the program comes from the state,” she explained. The programs probably will not expand as far as increased numbers of Bridgers. However, she didn’t see this as a deterrent. “The program continues to get better and better in terms of what we do—and it will continue to get even better,” she said.

Tanya, among other staff, at NYAPRS was busy getting ready for the annual NYAPRS Conference that is held in September of every year in the Catskills of New York. It is recognized for being one of the best mental health conferences in the country and every year presents some of the best speakers on cutting edge programs in mental health both in the state of New York and nationally. Tanya said she would be doing a workshop on Trauma Informed Care.

Tanya said she was happy working for NYAPRS and expects to be there for a while. I wished her the best!

From the NYAPRS website I learn that there has been one outside evaluation of the program. Outcomes of the Peer Bridger program have been evaluated by Cheryl MacNeil, Ph.D. who identified and examined several areas in which the project benefited those involved:

- The development of a unique and different relationship than what is usually experienced in a hospital setting
- The relief from a state of social isolation and physical enclosure often experienced by those hospitalized
- The ability of people to share with each other their experiential wisdom and survival skills

One of the most significant findings was that the follow-up re-hospitalization of persons served by a Bridger was significantly less than the baseline hospitalization rate.

Baltic Street Mental Health Board, New York City (Another program example)

Marty Cohen, Supervisor, Lodge Bridgers, Baltic Street Mental Health, Staten Island, NY
Sheila Hollingsworth, Supervisor, Bridgers II, Baltic Street Mental Health, Staten Island

Another successful program is the Baltic Street Mental Health Board Program that also operates a Peer Bridger programs in New York City. Baltic Street Mental Health Board is a multi faceted agency that is 95% consumer run and boasts 100 employees. “We are one big happy family,” states, Marty Cohen, supervisor of the Bridges Lodge Program.

The lodge program, he explained, is an advanced program for 30 clients who are served at South Beach Psychiatric Center on Staten Island. In this program Marty works with a staff of three part-time employees that he supervises. They work 11:00 to 4:00 four days a week. Marty said they work with clients and their therapists and often are able to help them get their grounds privileges. They also help them with travel training, learning to ride the bus and getting ID cards. When people leave the hospital they remain with them for three months, occasionally up to six months. “I make it my business to see that they get referrals to other services, like clubhouses,” he said. “We also work on voter empowerment.”

The overall benefit, according to Marty, is that people who are served by a Bridger are often able to develop more trusting relationships. He said they frequently serve as their advocate. “The difference between me and them is that I have power, he said. “I can come in to help mediate.” (Note: this program may operate a little differently than the NYAPRS program, which is true of many different program models.)

He said that the program is very popular and that many of their peers, even among those they serve, want to become Bridgers.” In a subsequent conversation I learned from Marty the story of how he became a Peer Bridger.

“In 1993,” he said, “I walked into an outpatient clinic at South Beach Psychiatric Center where they were doing depression screening. They pulled me right out, telling me that I had one of the highest degrees of depression. They provided me with mental health services that were helpful and which enabled me to work part time. Later, though, I made a suicide attempt and was hospitalized.”

Marty said he was hospitalized a second time again for a few months in South Beach Psychiatric Center. He was placed in a sheltered workshop and worked for 20 cents an hour doing mail work. “This led me to be even more depressed,” he said, landing him another hospitalization at Gracie State Hospital. While there his meds were changed and he learned about peer counseling and he applied. However, on his first attempt to apply he was rejected.

Some time later, in 1996, he saw a sign advertising that the Howie the Harp Center (a consumer run program) had peer specialist training available and he signed up. After graduating, he was offered a job by Isaac Brown, a program director at Baltic Street Mental Health. This, he said, brought him directly back to South Beach Psychiatric Center—a fact he found ironic but he couldn’t have been happier. It all worked out for him. “Now”

he said, “I work full time doing something I love and making a living.” He has been there six years, quite an accomplishment.

I asked Marty if any of his clients had made any comments. One of them Ian, had a positive response to the question about how he felt about having a Peer Bridger. “Having Marty as my Bridger, he said, “helps me to have good self esteem as well as a belief in my own independence. If I had a relapse, I would call Marty, first, before I called my psychiatrist.”

Marty had to leave to go to a treatment team meeting. The doctor was calling a special meeting and his client, Mindy, was afraid. Marty was sure, though, that he would be able to help her by being there to support her because he felt that they had developed a trusting relationship.

I discovered that Marty is very well liked as a Peer Bridger. Sheila Hollingsworth, who I next interviewed, said to me, “Everyone loves him. He is an excellent Peer Bridger.”

Sheila Hollingsworth also works for Baltic Street and is the overall program supervisor for the Peer Bridger project, but she also works hands-on. She works with the Bridges II program, which is distinguished from the other two levels by people’s readiness, capabilities and needs for discharge.

She has been with the agency six years and enjoys being a role model. “Sharing my story helps people to recover as I have. Sheila has a college degree and supervises six full time employees. Like NYAPRS, employees that are Bridgers work for Baltic Street not the hospital. Sheila noted that this left one disadvantage. “We would have better retirement plans and better benefits if we worked for the hospital. However, it is more stable for us to work for an independent agency.” The hospital contracts directly with Baltic Street with funds that come from the state. One of their contractual agreements is that they serve 140 clients per year. “We can usually fill the contract, she said. “It also helps that one of our board members is one of the hospital employees.”

Salary differentials do exist. Sheila is a senior employee and has had several raises. One of the advantages to the job, she feels, is their ability to keep up with their therapy and get their medications. In fact, she explained, it is a job requirement that they maintain their therapy and take medications as ordered. “This has not been a problem, she said. “We haven’t had anyone that didn’t want to abide by this rule. She sees that the job has been helpful in this way because she is able to get her services and be open about it. At another job she would have to hide her psychiatric disability. “Some people get their services at this hospital, while others get their services other places,” she said.

Sheila believes that they are very successful at stopping the revolving door syndrome—people returning over and over to the hospital. “One of the reasons hospitals like to have us here is to stop the revolving door. We have been able to decrease the length of stays from what they were and are also good at preventing returns. Many of our clients live in residences; some people get jobs. Some people choose to travel when they leave,” she said.

We have some people who get jobs doing custodial work. One of our successes is a person who we served who went on to college. She recently came back to paint a mural for the hospital,” Sheila said, proudly. “Another person travels to the Caribbean. She calls us every once in a while. A lot of people call back just for support.”

For Sheila, the job has been great for her. “I like my job,” she said, and I plan to stay a long time.”

Job Posting
PEER ADVOCATE BRIDGER
Kingsboro
Part-time 20 hours - Temporary to Permanent

The Baltic Street Mental Health Board seeks applicants for the position of Peer Advocate Bridger. This program provides hands on advocacy, self-help - empowerment tools and problem solving to clients moving from the hospital, to live successfully in their communities. Peer Advocate Bridger's use group facilitation and individual meetings in the hospital, office and field settings. Position is based in Brooklyn.

ESSENTIAL FUNCTIONS

- Working on both outpatient and inpatient units.
- Provide such services as travel training, connecting to neighborhood resources, and shopping skills.
- Facilitate or co-facilitate groups designed to provide information on self-help and recovery to consumers.
- Facilitate groups to assist consumers in living, learning, working, socialization skills, coping skills, conflict resolution, and medication management
- Provide individual advocacy, self-help and empowerment tools to clients in the hospital and the community.
- Record full case notes and service ours.
- Interact with, establish and maintain cooperative relationships with Kingsboro personnel.

QUALIFICATIONS:

- Personal experience as a recipient of mental health services. Past hospitalization helpful. Basic knowledge of mental health and community resources.
- Good communication skills, knowledge of self-help techniques, and group facilitation skills.
- Basic computer skills a plus. Good reading and writing skills.
- Mica background helpful.
- Bilingual helpful.

Send or fax resume and cover letter

Montana State Hospital
Pat Solan, Peer Specialist
Marijo Jacobs, Peer Specialist

One of our national advocates, JRock Johnson, in Nebraska, said to me recently, when she learned about the guidebook, “All of the hospitals you are reporting on are in large urban states. What about where ‘the fruit does not hang from the trees?’”

This narrative begins with an interview with Ed Amberg, the hospital administrator, instead of the peer specialists, because it seemed important to understand better the background of how peer specialists were hired from an administrative perspective. Often, many of the more rural states do not learn about latest developments and when they do, they think it is not possible for them to accomplish them.

I asked Ed about how they were able to do it. He said, “We became aware of involvement of peers working in hospital settings around the country and heard a lot of good things. In Montana, he said, there is some involvement of peers and family members in the community, but it has been hard to sustain consumer involvement. Peers would say they get burned out or they weren’t ready for this kind of work. Many folks have wanted to do this work but didn’t have the skills.”

He confirmed what I thought I knew, “Where all this started here was with the Resident’s Council. We developed a truly representative Resident’s Council, not just to address grievances or complaints but to become advocates for themselves. Whereas it is easy to say, ‘Write a letter to the administrator,’ we wanted people to advocate for their needs.”

“We had a great leader for the group, Polly Peterson, a psychologist, who has recently left employment with us, unfortunately. She helped the group draft a set of by-laws and helped to create a very well developed council. The group wanted computers and got them. For a fundraiser they built a “kayak” which made money for the group. It became a great opportunity for the group to learn to work together toward a common goal.”

“Currently, every Friday morning,” he said, “they have an Espresso sale where they sell coffee and lattes and cappuccino to both patients and staff in the rotunda of the hospital.” (Note: Having been a reviewer at the hospital in 2006 I would add that the rotunda is a really nice feature because it was a large round space with pillars and lots of artwork, even a piano; that serves as a hub where many different types of activities can happen at once.) He added, “They also had debates and dialogues between patients and staff which became a way for each to develop responsibilities.”

Regarding the hiring of peers, Ed went on to say that after the resident’s council made the recommendation for peers to be hired, it was a very slow process. “People on staff were not sure how much peers could do. We had to educate personnel,” he said. “It also became a ‘union’ issue as there was a question about whether these positions would belong to the union. It was determined that they would not, but, ironically, as it turned out, the positions were initially classified at a pay grade above the psychiatric technicians at the hospital (since then the psychiatric technicians have received an increase and the two positions are now at the same pay grade).

“The first peer specialist they hired,” he said, “did not work out. She was very good, but the job was new and it was too much for her to get things started.” (This was the person I met with when I was there.) Part of the reason, he thought, was because she was the only one hired. They were new at this and she was alone. He explained that they had intended to hire two but one of them had backed out.

“In August of 2006 we hired two more individuals, Pat and Marijo, a male and a female. This has worked out great,” he said. “They do a lot of things together and are a support to each other. They have become WRAP trainers and are available to people to model recovery. People like talking to them because they know that they will not be writing in their charts and they can be trusted (Ed did say that the hospital has begun to work with some people to write in their own records). “We had one program manager have people write their own progress notes. It’s something we’ve talked about and want to promote more.”

Where they are at now is they would like to hire several more people. “We’ve really had some changes since you were there, he said, referring to my previous visit. It’s a long process though, but rewarding.” And, what about restraint? I asked. “Way down-- 94% down,” he said.

I spoke with Marijo Jacobs and Pat Salon. Also joining the call was Cheryl Eaman, the Program manager of the Therapeutic Learning Center (TLC) and their supervisor. Both peer specialists were placed with the TLC Center. They explained that they considered placing the positions directly under Ed, the administrator, but he felt that he would not have the time to guide them in the way he would like to. This seemed to be a good fit, according to Cheryl. On the day of the call, Marijo was absent; I spoke only with Pat, the other peer specialist. (I would try to catch up with Marijo later.)

Pat explained that he and Marijo serve as advisors to the Residents Council. In August of 2007 they will have been employed for a year at the hospital. Pat sounded very upbeat. “It’s been good,” he said. “We have been able to steer a few patients in the right direction—that makes us feel worthwhile.”

Pat said he found out about the job through friends at an employment center. He picked up an advertisement that sought a person with a background in mental illness. His friends knew about the job and understood that the hospital was looking for a person with direct experience with mental illness. While Pat was surprised to hear about the job, he became even more interested when he learned they were looking for someone who had integrated into the community and was far along in their recovery. That might be me, he thought to himself, though he had never done any work of this type. “Work for me,” he said, “had been as an auto mechanic. I had never done any work that did not involve the use of my hands.”

Cheryl interjected, “These guys have been a pleasure to have. There have been peer support specialists hired in the state in outpatient services but Montana State Hospital is the first to hire them for inpatient settings.”

The position is evolving. Everyone seems happy to have things go slow. “It was scary at first,” Pat said, “trying to be friends and to be able to listen without giving advice.” In one situation he thought he may have overstepped his boundaries. Someone said, “Hey, listen, I didn’t come here for advice. I just wanted someone to talk to.”

“I struggled a bit, Pat said, just to listen,”

Pat explained that he had been a patient in the same hospital but it had been 14 years ago. “My recovery was a big deal for the first eight years. After that it got easier. If you do what the doctor says things will get better,” he said. “You can recover.”

Pat said that the staff has been really good to them. “We have not had any problems at all. “Also,” he said, “I knew many people who work here as we live in the same community.”

Cheryl added, “He knows more people than I do, actually.”

Cheryl said that Pat does a good job at seeing people as people. She said that one of the things they have learned is the value of having two people. “Having two people is really helpful. It’s a lot of responsibility, too much for just one.”

She said that both peer specialists work 20 hours per week. There may be an opportunity for hours to be increased in the future but neither Pat nor Mary Jo has expressed the desire for their jobs to expand too quickly. If anything, they believe that it is best for them to work part time at this time and want to move ahead slowly.

Some of their activities include the following:

- Serving as advisors to the Residents Council
- Providing individual peer support and being an advocate
- Participating in orientation
- Serve as a liaison between doctor and patient and other clinicians such as social workers.
- Beginning to get WRAP training started.

Prior to starting their jobs they attended a week of training which consisted of an orientation class that all new employees attend.

They are beginning to train other patients in the hospital on WRAP training and hope that it will hold and continue in the community. WRAP is one program that Pat and Marijo are involved with, but they are also involved in many other things.

Pat had a good story to tell:

“One girl came to us who was applying for Social Security. We had to help with scheduling, making appointments and getting her there. In the process she didn’t have any other support to do this. We were able to access special funds for her to get her birth certificate. The whole thing took two to three months. We literally took her by the hand and helped her fill out forms. We helped her with answering all of the questions that were asked. Without us, she might just as easily have ‘blown it off.’”

“She was discharged,” he said, “and before she left she said ‘thanks’ but we haven’t heard from her since.”

Pat and Marijo serve on a lot of committees. They also spend a lot of time on each wing but maybe not enough time. Pat explains, "I'd like to have even more time on the units. Often, people come to us in our office. They will come wanting help with a particular problem, for example, someone was restricted, or someone lost their pass. But, what I like best is being right where they are, on the units."

Both Marijo and Pat carry keys. "We have keys for 90% of the units, he said.

Cheryl said, "They are ambassadors for the hospital. They are easy to supervise. Always, they pass things by me before they initiate anything, but they are very self-directed. Recently, they gave part of the training to police officers. The response from the officers was that it was the best part of the training."

Later, I speak with Marijo:

She told me that she found out about the job when she was re-locating from Masoula to Deer Lodge, six miles from the hospital. "I had been working as an aide at a Hospice," she said, "and saw the job posted on the internet."

One of the things she discovered was how she could hide from mental illness in her other job. "I could forget I had a mental illness," she explained, "but now I'm exposed to it every day which brings up some fear. Fear of my own mental illness. We talk about this, Pat and I. We also talk about our mental illness with the patients."

Marijo hopes to continue with the job and hopes to increase the number of hours when that becomes a possibility. She sees that they are making progress. They are doing a WRAP group on one unit; another unit is planned for in the near future.

Marijo sums up her comments by saying, "In addition to being role models you give people hope that recovery is possible. By recovery, I mean, not a complete recovery, but the ability to take up roles in the community. I find it rewarding." I am sure she was speaking for Pat as well.

STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION

POSITION
DESCRIPTION

ALLOCATION: To be completed after final classification

approval by the State Personnel Division or by agencies with
delegated classification authority.

<u>Class Code</u>	<u>Title</u>	<u>Grade</u>
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*** PART I: Identification ***

CURRENT CLASSIFICATION: **Code:** **Title:** Peer Services Specialist

AGENCY: **Agency Code:** 6901 **Position No:**

Department

Department of Public Health & Human Services

Division

Addictive and Mental Disorders

Bureau

Montana State Hospital

Section

Unit

ADDRESS:

<u>Building & Street</u>	<u>Room Number</u>	<u>City</u>	<u>Zip Code</u>	<u>Business Telephone</u>
300 Garnet Way		Warm Springs, MT	59756	693-7000

FUNCTIONAL DESCRIPTION OF THE WORK UNIT:

This position is assigned to the Addictive and Mental Disorders Division of the Department of Public Health and Human Services. The Mental Health Division provides inpatient and community mental health services to the citizens of Montana. Montana State Hospital provides inpatient psychiatric services for adults. Peer services provide counseling, support, and advocacy for hospital patients by people who have experienced psychiatric illnesses and received psychiatric services directly.

*** Part II: Job Description ***

1) **ASSIGNED DUTIES:**

%

- a) Provide counseling and support to MSH patients focused on personal experience with psychiatric illnesses and recovery.
- i) Prepare and distribute written materials (booklets, brochures, etc.) concerning recovery from psychiatric illnesses and peer support services.
- ii) Assist with coordination of Resident Council activities.
- iii) Refer patients to other treatment specialists within the hospital and to peer support and other services in Montana communities upon discharge.

50%

- iv) Assist professionals in providing therapy and rehabilitation
- b) Provide advocacy services for MSH patients. 30%
 - i) Assist with grievance and complaint resolution efforts and participate as a consumer representative on the Hospital's grievance committee.
 - ii) Interview patients and report to patient treatment teams following restraint or seclusion events or as otherwise requested.
 - iii) Serve on Hospital committees as assigned by the Chief Executive Officer.
 - iv) Represent the patient's/consumer perspective in management meetings and other activities.
 - v) Educate the general public, mental health organizations and policy makers about mental health issues from the point of view of the service recipient.
- c) Provide education and training to staff and patients of Montana State Hospital 20%
 - i) Provide information about peer counseling, peer support, and consumer perspectives to new employees during orientation programs.
 - ii) Help provide orientation services to patients soon after admission to the Hospital.
 - iii) Provide other types of educational and training services to patients and staff at Montana State Hospital.
- d) Safety and Work Environment
 - i) Performs all work tasks in a proper and safe manner following established policies, general safety rules, and safe operating procedures.
 - ii) Cooperates with other staff and demonstrates respect for other employees, patients, and visitors to the facility.
 - iii) Contributes to ensuring the work environment is safe and well maintained to prevent needless injury, time loss, and expense.
 - iv) Complies with Department, Division, and Hospital policy and direction and applicable state statutes, and consults as needed or required with others to obtain clarification or address concerns.
- e) Professional Development
 - i) Participates in personal and professional training and development activities to stay current with standards for peer support practice.

2. WORKING CONDITIONS AND PHYSICAL DEMANDS:

This is a key position in a state psychiatric hospital. The Peer Services Specialist is expected to perform duties at locations throughout the Hospital including the Transitional Living Units. The job involves providing peer support and counseling for patients and advocating for the needs of patients with staff at all levels of the organization. The job is frequently stressful as an important responsibility is helping to resolve conflicts between patients, staff, and others. The employee may also be exposed to potentially dangerous and unpredictable behaviors caused by people experiencing symptoms of acute psychiatric illnesses. Occasional travel may be required, less than ten percent of the time.

This position will work up to 20 hours per week (up to half-time). Hours are flexible, as set by the supervisor. Evening and weekend work may be required.

3. **KNOWLEDGE, SKILLS, AND ABILITIES:**

Knowledge: This position requires the employee to have first-hand experience as a consumer of public mental health services. The employee must also have knowledge and experience applying principles of mental health peer support. Additional knowledge of mental illnesses, service delivery systems, and peer support modes are desirable.

Skills: This position requires the employee to have effective skills and competence to establish and maintain trusting relationships with people who have serious and persistent mental illnesses. Must also have skills to establish and maintain trusting relationships with other employees responsible for providing care and treatment services. Must have effective communications skills and be a good listener. Must be able to make give suggestions and advice in a constructive manner and must be able to accept feedback. Must be able to deal with criticism appropriately and effectively. Must have excellent verbal and written communication skills.

Abilities: Must have the ability to: share personal experiences with illness and recovery with others; help others understand the consumer’s perspective and subjective experience; to form meaningful and appropriate work relationships with patients and employees of Montana State Hospital. Must also have the ability to manage multiple tasks and priorities.

Knowledge, skills, and abilities are normally acquired through first-hand experience as a recipient of mental health services and as a person well into personal recovery. Must have a high-school education and post-secondary education would be helpful.

5. **MANAGEMENT and SUPERVISION of OTHERS:**

<u>Pos. No</u>	<u>Class Code FTE</u>	<u>TITLE</u>	<u>FTE</u>
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Total organizationally subordinate FTEs: None

6. **SUPERVISION RECEIVED:** Daily supervision will be provided by the Chief of Rehabilitation Services; however the employee will have direct access to the Chief Executive Officer who may also assign work or tasks directly to the Peer Services Specialist.

7. **SCOPE & EFFECT:** This position is critical to help patients have a good experience at Montana State Hospital and develop trusting relationships with therapists and caregivers. It will also be of critical importance in helping Montana State Hospital implement a Recovery Focused Treatment Program. Inappropriate or ineffective relationships, communications, or behaviors have great potential to undermine treatment and potential recovery for consumers and provide them with a good experience with mental health service providers.

8. **PERSONAL CONTACTS:**

Position	Frequency	Purpose
Chief, Rehabilitation Services	Daily	To review assignments, completion of work, priorities, authorization for needed supplies, etc.
Chief Executive Officer and other Supervisory Personnel	Several times weekly	To advocate for patients, identify needs, serve on committees
Patient Treatment Teams, Rehabilitation Therapy Staff, and	Daily	To share information about patient problems and progress. To advocate for patient needs

Direct Care Staff		and represent patient perspectives.
MSH Patients	Daily	To provide direct peer support, counseling, and advocacy services

***** PART III: Signatures *****

IMMEDIATE SUPERVISOR

To the best of my knowledge, the statements in Parts I and II are accurate and complete.

Signature: _____

Date _____

Name: _____

Title _____

(Please Print)

(Please Print)

EMPLOYEE[S] SIGNATURE

Signature: _____

Date _____

Name: _____

Title _____

(Please Print)

(Please Print)

ADMINISTRATIVE REVIEW

Signature: _____

Date _____

Name: _____

Title _____

(Please Print)

(Please Print)

Signature: _____

Date _____

Name: _____

Title _____

(Please Print)

(Please Print)

Agency Director or Designee

Signature: _____

Date _____

Name: _____

Title _____

(Please Print)

(Please Print)

Georgia Mental Health Consumer Network
Atlanta, Georgia
Charles Willis
Sharon Jenkins Tucker

Georgia was among the first to establish training programs for peer specialists and to then have them hired in mental health programs throughout the state. Most of the peer specialists are working in community settings, both peer run and mental health provider agencies. When I called the Georgia Mental Health Consumer Network (GMHCN) office and described the guidebook and the type of person I was looking for, the executive director, Sherry Jenkins Tucker, who is a person in recovery from mental illness, recommended that I speak with Charles Willis.

She told me that Charles has a unique position as the Project Director for the Self-Directed Recovery Project which involves teaching the Wellness Recovery Action Plan (WRAP) to people in inpatient facilities and community settings. He also works with people who have addictive disease challenges and mental health diagnoses facilitating Double Trouble in Recovery groups. He has begun to do training with interns at the Medical College of Georgia along with other members of the Georgia training team. There is a plan in the future to broaden his work to accommodate more people being served in hospital facilities.

“The main thing about Charles,” Sherry told me, “is that he has charisma and personality. He does an excellent job working with a population of people who have addictive disease challenges.” I also learned that Charles is African American and felt that it was important to tell the stories of successful peer specialists who are of different ethnicities, cultures and races.

Several days later on the phone with Charles I found out what she meant by “personality.” I barely had to ask him questions, because as soon as he understood the purpose of the call and the reason for the guidebook he was off and running, with lots to say both about his own history and the work he does. I didn’t hesitate to let him proceed.

“I’m dually diagnosed,” he said, “which means that I live with both mental health and substance abuse problems. The mental health diagnosis came later. I didn’t know I had a mental illness, except that I realized I had had problems since I was age 14. Now I am 53 years old.”

“I self-medicated since I was 14 and have been sober for six years. I’ve been in and out of treatment settings primarily to avoid consequences of losing jobs, being short of money, criminal charges—one or another of which I was always running from.”

“For a long time,” he said, “I worked as a counselor with the Department of Corrections. But, after losing my job which I’d had for 10 years, I went and got a Masters Degree and taught school—but I drank that up too! Burned up, and having messed up several major opportunities, I wound up in the city of Atlanta, homeless, lying around, carrying everything I had in plastic bags.”

“I received disability checks, but I had given up on my life. Also, I had six kids—but I had given up being able to raise them.”

He explained that his life changed when he went to an AA meeting in February of 2001, the 4th of February, he added, wanting to be exact. “While I was there,” he said, “I heard a recovery story that sounded so much like mine, a ‘light’ went on. I thought to myself-- if he can do it-- I can do it. I bonded with him and today he is still my sponsor. It was at that time I began to recognize my mental health problems. I got therapy, and acceptance began to kick in.”

Then he began to volunteer. “I started off volunteering around town with a couple of agencies. It was very useful to me. My first opportunity to work was to teach Double Trouble at the Georgia Mental Health Consumer Network. They put together a proposal and got the funding for the position.”

“Because they knew about me they kept calling and asking me about applying for a position with the Self-Directed Recovery Project (a program that would focus on WRAP training). I was scared at the time. I was stuck. Actually, I was happy where I was, but I took a risk and stepped out of my safety zone. That opened up all kinds of windows.”

“Through this position I have met quite a few people. I could never have envisioned what my life could have become. Now I go around the state and present WRAP training to consumers—a model of recovery to people like me. I try to motivate people in a different way.”

“To describe how we got started is difficult. In the beginning I did a lot of calling around to providers to set up training around the state and I got a lot of rejections—because, they said, they were already doing what I offered. They thought that we were coming around to dictate what they should do. But we weren’t about that.”

“After the first presentation in Metro Atlanta-- my first training with Sherry-- I got my feet wet. I got good feedback and the word got out. It was an opportunity for the Georgia Mental Health Consumer Network to begin to come in.”

“We came in to jumpstart new programs--to bring new jobs—and have fun! It is exhilarating because that is part of what we do; have fun! We’re just people. I want people to know that I’m a consumer. It took me back to my beginnings, how important it had been to see someone who was well—someone who put on a positive front that was really genuine, not phony. Now looking out at *them*—I realized they were looking at *me* in the same way, but I also knew that theirs could still be my story. I could be one of these persons too. But the fact that they were in the group meant that they too, were well—well, in the sense that taking that first small step for them was a sign of wellness.”

“Sherry used her elbow to step in to get us started,” he explained. “She obtained a statewide consumer networking grant from SAMHSA, (the Federal Substance Abuse and Mental Health Services Administration.)” He further explained that at the time they received the grant they already had certified peer specialists working all over the state and training that occurred three times a year. Funding for that was separate.

Charles told me that they are now in their third year of a three year grant. “In that amount of time, he said, “we have taught 1500 people in WRAP and 500 people in WRAP for Work. We also have legislation being considered, that will legitimize the use of Psychiatric Advance Directives. Not only do we get to share our message with thousands of people, we are starting to be invited by providers to do training. He explained that both he and Sherry are members of the Mental Health Planning and Advisory Council and have built relationships there and have begun to build a relationship with the Georgia Department of Corrections. We have conducted a WRAP training in the Metro Correctional Institute—an all women’s prison in Atlanta.

“Another place where we have done training is at the VA Hospital in Augusta, Georgia,” he said. “We also have the first certified peer specialist, Brian Anderson, working in a Veterans facility.”

Training on concepts of recovery also has been conducted with interns at the Medical College of Georgia. The response was overwhelming. Other presenters from Georgia included Ike Powell, and Beth Filson of the Certified Peer Specialist Project.

I asked Charles if he had received the peer specialist training. “Yes,” he said. Many people who work for the Georgia Network are certified peer specialist.”

Interest in peer specialists is infectious. He told me about a recent call. “I got a call last night from the Community Concerns program—a program in Atlanta that is expanding,” he said. “They had a young man call who had been to our conference, and he was asked to become a certified peer specialist for the agency. It was someone I knew and never thought would take an interest, but he has turned around. I get a lot of that, actually, throughout the state.”

In Georgia 300 people have been trained to become peer specialists. They are working throughout the mental health system. In fact, the mental health code requires that certified peer specialists be hired. Peer support programs are also in the community Behavioral Health facilities. Although there are not many working in hospital settings there are some at Georgia Regional in Atlanta and one in Rome, and also one at a hospital in Savannah. Georgia has seven state hospitals.

One of the new projects that they are planning in the near future is a peer mentoring project. Charles said that it will be similar to a Peer Bridger Project and will help people transition from inpatient facilities to the community. “So far,” he said, “a director has been hired who will hire 14 certified peer specialists for the project.”

The state also wants to expand the Double Trouble in Recovery initiative in Georgia. And interest is also high in the WRAP for Work program - a specialized program in WRAP to help people return to work.

Sharon Jenkins Tucker, Executive Director, Georgia Mental Health Consumer Network

I felt it was important to get a broad perspective of the Consumer Network and I knew that Sharon had been in the job for several years. Sharon is a native West Virginian who has been working in mental health advocacy for up to 15 years. She worked as a Behavioral Health Advocate for Legal Aide of West Virginia for 9 years and then worked as the director of

operations for the West Virginia Mental Health Consumers Association for 18 months. In March of 2004 she applied for and got the job as Executive Director of the Georgia Mental Health Consumer Network. Her anniversary is March of 2007. "Seems like a day and a lifetime," she said. In her role as executive director she oversees all of the projects. Including hiring of staff, supervising the coordinator of the PERMES project, which is the statewide consumer satisfaction survey for mental health and addictive disease services, the Double Trouble in Recovery project director, the director of the Peer Mentoring project, the financial manager, the Ponce project manager, two office assistants and Charles. She partners with the Consumer Relations and Recovery Section of the Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases to produce the Certified Peer Specialist Training, the Peer Support Institute and Consumer Council Meeting. "I go to a lot of meetings, and there are often contractual meetings that I need to go to."

Sharon said they have had agencies wanting them to train their entire staff, "a very positive thing." she adds. "We also have had mixed groups of staff and consumers wherein, given a level playing field, staff come away with greater understanding and caring."

"We are concerned about what will happen when our funding runs out for the Self-Directed Recovery Project. But we did apply for another CMHS statewide consumer networking grant that is entitled the Statewide Peer Wellness Initiative," she said, adding that much of their funding comes from the state, but also through the special grants that they apply for from the federal government and other sources. And apply they do!

In closing, both Sharon and Charles had nice things to say about each other. Sharon wanted me to know how fortunate they are to have had Charles Willis show up at their door. "He is very charismatic and full of positive energy that is infectious. He is a walking billboard for Recovery and Wellness. And when I grow up I want to be just like him."

Charles had equally nice things to say about Sherry, "Sherry has brought a thunder to the South. Her desire and love for Advocacy is well known to the state. She has stirred up a lot of red clay. We are privileged to have her."

**Georgia Mental Health Consumer Network
Self Directed Recovery Project
Project Director
Job Description and Job Requirements**

The Project Director of the Self Directed Recovery Project is directly supervised by the Executive Director.

The **Job Responsibilities** of the Project Director include:

- Overseeing the Self Directed Recovery Project (SDRP) and ensuring all performance requirements are met.
- Developing and presenting culturally-sensitive Wellness Recovery Action Plan (WRAP), Wellness Recovery Action Plan for Work and Psychiatric Advance Directive trainings.
- Directly training consumers at peer centers and peer support programs about self directed wellness programs.
- Providing presentations and information session statewide as requested and at two Georgia Peer Support Institute Trainings, three Certified Peer Specialist Trainings, 2 CPS Continuing Education Assemblies and the annual statewide consumer conference.
- Supervising and coordinating SDRP related activities.
- Providing technical assistance to peer centers and peer support programs related to self directed wellness programs.
- Preparing timely progress reports of Project goals and objectives for SAMHSA review.
- Assuring appropriate data is received and reported by the independent evaluator.
- Keeping informed on self directed wellness efforts and information.
- Supervising the development, production and dissemination of a WRAP Workbook, WRAP for Work Workbook and Psychiatric Advance Directive Template.
- Overseeing the development and promotion of the web site, assuring usefulness and cultural appropriateness.

The **Job Requirements** are as follows:

1. Must be a consumer of mental health services.
2. Must have advanced experiential knowledge of coping skills for dealing with difficult feelings and behaviors.
3. Must have advanced experiential knowledge about recovery and ability to support others in the recovery process.
4. Should have a minimum of 2 years experience organizing and facilitating self-help groups (WRAP experience preferred).
5. Should have an advanced knowledge of Georgia's mental health service delivery system and consumers' rights within that system.
6. Must have advanced communication skills.
7. Should have good computer skills and ability to use current technology.
8. Must have own transportation and have the ability to travel statewide.

Georgia Mental Health Consumer Network
Job Description
Executive Director

Under the supervision of the President of the Georgia Mental Health Consumer Network (GMHCN) Board of Directors, the Executive Director carries out the mission and goals of GMHCN as set forth in the bylaws and as determined by the Board of Directors.

Responsibilities are not limited to, but shall include the following:

1. Maintain an office and current membership list of all GMHCN members;
2. Administer any contracts or grants to which GMHCN is a party;
3. Assist the treasurer or bookkeeper in preparing a yearly budget and help maintain financial records that can be properly audited;
4. Help develop fundraising that includes writing grants;
5. Build GMHCN membership;
6. Publish a quarterly newsletter;
7. Organize board meetings that include a written agenda;
8. Attend all board meetings and make quarterly and annual reports to the board;
9. Hire, train and supervise any staff according to board policy;
10. Help organize an annual statewide conference;
11. Perform other duties when requested by the president of the board.

Arizona
Recovery Innovations, Inc.
(Formerly META Services, Inc.)

A co-worker friend of mine used to use the phrase “Widen the Bowl” any time we needed to look at things a different way or expand the vision.

Going to META Services, Inc. (soon to be called Recovery Innovations, Inc.) was that type of experience for me: the need to think bigger, expand my vision and “widen the bowl.”

I had made an appointment to visit META in January of 2006 and was given the address. I was told to look for a green building with red trim and come to the second floor. After finding the building I went to the second floor and was greeted by Lisa Anderson, the executive secretary. My first vision adjustment was in thinking how large the organization was. I knew the organization trained people to be peer support specialists. I had no idea that it was a large full-service mental health service agency with multiple programs that filled almost the entire building with their offices.

While my goal was to visit the Living Room at the Crisis Stabilization Unit and talk to peers working in inpatient settings, I was given a schedule for the morning that would include visits to all of META’s programs to meet with directors and their staff. Later in the afternoon, I would be driven to the two inpatient settings.

First, I was “entertained” at an in-service training on HIPAA laws. All of the staff was engaged in, what looked to be, the TV game, Jeopardy. The room was filled to the brim with all levels of staff, all of whom had cards in their laps; a moderator calling out questions to the current player standing in the front of the room, and a cheering audience when a question was answered correctly. There were even candy prizes! By the time the game/training ended everyone was laughing right out the door. I had been nicely introduced and left with a chocolate candy bar. This is the way to do training, I thought.

In the next few hours I was whisked away to meet with directors of at least a half dozen different programs and other key administrators. A few highlights follows:

The director of the Peer Employment Program, Mike Zeeb, told me that the employment program began in 2002 with a class of 15 peers--people who had received mental health services, substance abuse and/or co-occurring services. Since then, over 200 Peer Support Specialists have been trained and employed on all of the teams of META’s programs.

The RESTART program serves people who need temporary housing after they have been discharged from psychiatric hospitals. The program is led by Vic Pemberton who assigns trained recovery coaches to help individuals “restart” their recovery journey and to integrate into the community. Persons that receive services are set up with community resources, benefits and other necessary supports.

I met with three team leaders of the Peer Recovery team: Bertha, Dawn and Terry. This team is designed to serve people who had experienced lengthy hospitalizations or incarcerations and to help them transition to the community. At the time of the visit there were four teams in place with a total of 40 recovery coaches. Each person served in the program is assisted to develop a personalized plan to identify their needs. “Whatever their needs, we try to help them,” I was told. Some of the comprehensive services included a Warm Line and 24-7 assistance available when needed. It was predicted that this program will continue to grow as the needs continue to grow.

It would be impossible to share information about all of the programs I learned about or the people I spoke to. I learned that their Recovery Education Center has 220 persons enrolled in advanced learning at a community college. Another program, “Another Chance” serves people with substance abuse issues. I was told that META has 10 administrators, 350 middle management employees (I was not sure if that includes the peer support specialists) and 500 service recipients.

I was treated graciously by everyone and was impressed with the amount of genuine interest and enthusiasm people seemed to have for their work. My bowl was continually widening!

The afternoon was devoted to visits to the inpatient settings.

Julie Cohee was my delightful chauffeur and companion who would take me first to the Desert Vistas Hospital in Mesa, Arizona, where she is the Peer Advocacy Supervisor to eight peer specialists and then later to the Psychiatric Recovery Center, a crisis stabilization unit, on the west side of Maricopa County, where the Living Room is located. While we were driving, there was time for us to talk. Julie is outgoing and animated. She does not mind at all sharing that she is a consumer of services and despite a diagnosis she completely turns it around to something positive.

When we arrived at Desert Vistas I met, first, with two nurse managers, Sue Erie and Jacques Lemez. They told me that they usually get “very sick” clients who can often be life threatening. Having peer support, they both agreed, allows their nursing staff to do critical things while peers can spend quality time with people. Staff has embraced the concept and one of the positive outcomes is that in the two and a half years since peers have been working they have been able to reduce the use of seclusion and restraint by half.

Jacques revealed that he had been familiar with peer support much earlier when he had been in Quebec. “We had peer support in place since 1977, he said. “The fact that some clients can make choices about what they need is a God-send,” he said.

While they have eight part time peer specialists working at this time there is the hope that they will hire more. “Bus accessibility is good so people are able to get here easily. Sometimes it is a challenge to find the right people for the job and knowing boundaries can also be a challenge at times,” Jacques said.

While the nurse managers provide some oversight, it is Julie who provides hands-on supervision. When problems arise Julie gets a call, “What can we do to help?” she will ask. Almost always

she is able to handle the situation. Julie interviews prospective new peer support specialists and keeps every unit staffed for both hospitals.

Later, Julie took me on the unit. I observed that one of the peer specialists is helping a client to fill out a form. One of them is sitting, talking to another peer.

When there was a break time, I followed Julie out to the patio, where I was able to talk to four peer support specialists that were working that day. Julie informed me that they all work part time, three days a week, either from 8-11:30 or 2-5:30.

What emerged from our discussions was how each of them uses their individual skills and talents in working with others. Joe likes to facilitate groups, to open people up to talk. "Sometimes we play Bingo or cards," he said, "but when we are playing cards I am also doing peer support."

Beth likes to do word games as a calming device. She has a series of self-expression cards called the Un-Game and also uses the game "Boggle."

Nicole's strength is with the arts. She engages people in art classes as part of relaxation and visualization.

Jay works on the men's unit and has a goal to be a licensed peer counselor. He especially likes working with people one on one and it seemed obvious that he is good with people. "Sometimes activities like filling out a packet such as the Re-hospitalization Prevention Plan or their Discharge Plan, may take two hours," he told me, "but it also a time to do peer support."

Everyone agreed that they love their jobs. "Being a role model provides people with hope," they all agreed. "It helps people to know that if we can make it, they can to."

After our visit at Desert Vistas, Julie drove me to the Crisis Center in Maricopa County.

One way to describe The Living Rooms is: *a place where a person could choose to be a "guest" and hear the message of recovery.*

The Living Room concept began in 2001 when META's two crisis centers were working to reduce seclusion and restraint. Rather than add more staff, more space, and/or more standard treatment a decision was made to create a special space that would be staffed by peers trained to provide peer support to people in crisis. Peers had proven to be effective at being a role model to other peers. They were able to connect with people in a different way, focusing on the person, rather than the problem. The program, now in its sixth year, has proven to be successful.

On the day I visited it was a slow day with only a few people in the center, though I was told, usually beds are filled. I spoke with Jennifer Williamson, who is the counseling supervisor. She describes herself as a non-consumer who came to work at the crisis center only six months before my visit. Initially, a skeptic of the program, she quickly changed her mind when she saw what peers could do.

“My role,” she said “is to serve the Living Room staff (4 full-time, 8 part-time, and several on-call staff). Coverage is provided 24 hours per day. Part of my role is to provide support, conduct training, and to be available.” She maintains an office outside of the Living Rooms where her role extends to other areas of the crisis center.

She explained that people are admitted to the Living Room voluntarily in several different ways. “Some people are admitted from the hospital,” she said, “or they may come to the crisis center and are referred directly to the Living Room by the doctor-- providing they are not in danger to themselves or others. Others are admitted after they have spent some time recovering in the more secure side of the crisis center.” I learned that the average length of stay is two to six days, but some people stay as long as two weeks.

I asked whether people come back after the first admission. “People can come back,” she said. “Building a relationship is important. We try to get people to where they want to be, sometimes that might take a couple visits.”

I was curious to know what happens in the center on an average day. “People get up at 7:00 AM, at which time they make their own breakfast,” she said. “Then there is a goal setting group followed by a WRAP (Copeland’s Wellness Recovery Action Plan) group. Lunch is delivered by a nursing home next door (also, the dinner meal later in the afternoon). In the afternoon there is time for rest or watching Recovery videos and later recreation.” (It is noteworthy that they do not have TV but they do watch movies.) “For recreation there is meditation, arts and crafts, games, listening to meditation tapes and recovery videos.”

Jennifer explained that there is lots of group decision-making or group consensus. “In the past,” she said, “there would be more scheduled times for programs and activities, but it was found that it is better when the group decides on its own, to watch a recovery movie followed by a ‘fun’ movie, for example. We pretty much took ‘*Mandatory Everything*’ away,” she explained. (It appeared that they had discovered that forcing people to do things did not work—what a revelation!) “Every once in a while someone comes in who sleeps all day. We usually find that curiosity gets the best of them the next day, when they come and join the group.”

Jennifer told me about a woman who had been recently admitted whose situation can be common for someone who gets admitted to the Living Room. The woman had come to the crisis center describing struggles she was having at home. She said that she was not going to hurt anyone, but that she needed a place to stay. The doctor recommended the Living Room and said to her, “We have some people who have traveled the road you’re traveling on and would be happy to share with you their stories and provide some support,” asking her if this is something she might like. The woman willingly agreed to be admitted.

Another person who was brought in by her family had never been hospitalized before and was frightened. When one of the peers spent some time with her and gave her a tour of the Living Room, she was comfortable enough to be admitted.

After the interview with Jennifer, I was taken on a tour. The Living Room had the appearance of a living space that is “lived in”--with big cushy couches, rocking chair, artwork on walls that had been painted by consumers, bright colors everywhere, individualized bedrooms with bunk beds,

and a refreshment area where people serve themselves breakfast and snacks. The “open door” office for staff was available to people who wanted to come in and sit. While the more acute areas of the crisis center are locked, the Living Room is not. Doors to the outside are open.

I spoke with Sebastian, a peer crisis specialist who was going off duty, and only had a moment to talk. We agreed to talk later by phone. When we spoke several months later, he wanted me to know his full name is Sebastian James Rivera.

“I’ve been hospitalized 10 times in the past,” he said, “but not since 2002. After I recovered, a friend told me about META Services. It was 2006 when I started classes on peer support. I also took a two-week WRAP class.”

After he finished training, he attended a job fair, he told me, where there were many different agencies present. He was offered six different positions with different companies, but he chose to work in the Living Room.

From the very beginning, he was comfortable working in the Living Room. “The pay is good,” he said. While the usual pay is \$10.27 an hour, he gets paid an additional \$.50 cents, because he speaks Spanish and can act as an interpreter. He also receives health benefits.

Sebastian told me he works eight hours a day, three days a week. He enjoys being part of a team staffed entirely with peer support. “There have not been any problems,” he said, unable to recall anyone who had left employment or had been asked to leave. “Picking the right people to work in the Living Room, though, is critical. You have to have the right temperament for the job,” he added. “Regular weekly staff meetings also help to keep communication open.”

Sebastian said that the day’s agenda is filled with groups that each of the peer specialists conducts, including recreation. They are responsible for writing progress notes every eight hours and a doctor comes by to see each “guest” once every 24 hrs. “We also have a lot of resources—a whole closet filled with information about advocacy, where to go, things to do.”

Sebastian is proud of his independence: his job, his apartment, his recovery. His mother had earlier shared with him that in 1996, a psychiatrist had told her that he would never be well, would never hold a job. “I have proven that doctor wrong,” he said, “and I’ve made her proud.”

In closing, he said he wished all crisis centers could have a Living Room staffed with peers. I couldn’t agree more.

Jennifer shared with me that two individuals who had been working in the Living Room had just started working in the acute side of the crisis center, another recent achievement. She suggested that I might want to interview one of them and a time was arranged for me to speak to Christine Reece. The job title has now been changed to Behavioral Health Tech. Jennifer assured me that while their jobs are more of a challenge, they still share their stories of recovery.

“I like this work a lot,” Christine said, when we got a chance to talk by phone. “I have more interaction with people who need more attention.”

While she has only been in the position for six weeks, she admitted that at first she was afraid. But she finds she is more challenged. “I do the same work as other Techs,” she said, “vital signs, collecting urine and other medical tasks-- and charting, which is different than the way I used to chart. In the Living Room, we reported on what people did, here we record more about their behaviors.”

Christine has been working on becoming a social worker and is 10 hours away from her associate degree. She said she would go on to obtain her Master’s Degree. “It’s been helpful for me to learn about different ‘guests’” she said, afterwards confirming that people are called guests in the acute side of the crisis center as well as in the Living Room.

One of her worries was whether she would still be able to do peer support. But she would find that that would not be a problem. “I will be starting a WRAP group twice a week as of next Monday” she said.

Another occasional concern is when she works with people whose behaviors are much like ones she used to experience. “Though I no longer cut myself, still being around it makes me feel vulnerable. Staff, though, are always supportive.” She said that many of her team mates knew her when she had been in crisis and are always there for her.

Finally, she said, “Everything I’ve come through: jails, probation, trauma history makes me a believer in recovery. People can make progress whether fast or slow. I believe in recovery. Small steps ARE recovery, no matter how slow.”

As if this had not widened my vision enough I also had learned about two people who had been employed by META while they were still residents at the state hospital. It was arranged for me to speak to one of the individuals, Joe Kanter. I would learn that less than a year ago I would have talked with him at the hospital. Now he is out and lives with his parents.

He was happy to tell his story:

“I started working for META in March of 2006,” he said. “I took the training while I was still in the hospital on a forensic unit. I had committed a crime while in a manic episode, first by attacking a former boss, and then engaging in a wrestling match with a police officer.”

After receiving medical treatment for a wound at a general hospital, he said he was taken to jail and stayed there for 13 months. It was during this time that his medication was changed. “While in the mental health pod a doctor figured out that I was taking the wrong medication” he said, “and switched me to something else, at which time, my mind came back to me.”

He continued, “At the end of my stay in jail I was found guilty but insane by a judge and was placed in the state forensic facility. I went in, in July 2004, and in March of 2005 META came in and brought WRAP facilitation training. Initially, I took the training to get away from the hospital unit, as it meant getting away four hours a day, but I found I was enjoying it, and learning something. Several months later, I was able to take Peer Employment training that would provide me with teaching skills and a new concept of recovery.”

“In September of 2005 I continued to do well and META decided they wanted to have classes taught by someone who was still in the hospital. In March of 2006, I started to work for META, teaching classes in the hospital, and in July of the same year, I was able to leave the hospital to teach classes in Glendale. I worked there part time, all the way until three months ago, at which time I was hired full time.”

“It worked out!” he exclaimed. “I mentored a lot with people I could relate to. I felt it was unique to be working outside of the hospital while I was still in. There were other people working on work release programs, but this was different. I was told by META that this was the first time, they knew of, that this had happened.”

“I think it helped a lot, because every day you teach WRAP, you are also working on yourself. I think other state hospitals need to get people working right away rather than spending time trying to get people on SSI. One of the biggest stressors is not having a job and wondering what you’re going to do when you get out.”

Joe said he’s been out of the hospital since December of 2006 and that life is going pretty well for him. “I’ve been lucky to be able to live with my folks. I’m taking the right meds now and everything’s working. I feel like I’m doing well,” he said, in conclusion.

After my visit and later talking to people who work at Recovery Innovations, I had gathered fresh new ideas, new thoughts, and new hope for the future.

My bowl was full!

Final words from Lori Ashcraft –

At Recovery Innovations we have had an integrated workforce for the past 7 years. Peers have helped us transform our organization, making it recovery oriented in design and in service delivery. This has been a remarkable journey for us as we have learned together how to be with people in ways that help them recover. In the crisis services we deliver, we have been able to eliminate seclusion and restraint for the past 6 years. Our peer employees helped us achieve and maintain a new way of being with people that does not require the use of such interventions. We are grateful to have had the opportunity to develop and expand a peer workforce, and to train peers to work in other organizations as well. While we have learned a lot about recovery, and about the power of peer work, we realize we have just scraped the surface of what is possible in terms of transforming behavioral health services. We look forward to learning and contributing more as we continue to learn better ways of being with each other.

Following the above narrative is an article written by Lori Ashcraft, and William A. Anthony of Boston University on the Living Room. Their shared articles are written in a **Tools for Transformation** column in the monthly publication “Behavioral Healthcare” and can be found at the magazine’s website: <http://behavioral.net/Me2/default.asp>. (Go to the section on Archives where you will find each of the monthly issues and all of the articles they contain. This is an excellent resource.)

Issue Date: July 2006

CRISIS SERVICES IN THE ‘living room’

An environment with peer supports helps people in crisis

by LORI ASHCRAFT, PhD and WILLIAM A. ANTHONY, PhD

Have you ever noticed the way we behavioral health folks respond when something doesn't work the way we had hoped? One of our most common responses is to do more of it, to try harder, to test it longer. When it still doesn't work, we all too often conclude that this is the best we can expect and settle for mediocrity.

This almost happened to META Services, Inc. (a recovery services organization in Phoenix) when it was transforming its crisis services. META's first approach to upgrading the program's quality was to add space and do more of what staff already were doing. This would have improved the service, but was it the *right* service to begin with?

During a lucid moment, the management team remembered that phrase about “doing the *right* thing versus doing the *thing* right.” Was doing more of the same program just doing the thing right, rather than doing the *right thing*? Was there a better approach?

Creating a Living Room

Since the organization's overall plan was to develop services that have a strong recovery focus, META had set a goal of eliminating restraint and seclusion practices and was close to achieving it. Adding peer staff (employees having experienced behavioral health crises themselves) to the crisis team had been a key element in reaching this goal. Peer staff had modeled a meaningful way of being with people that was very effective: They were less distracted by people's problems and more able to connect with the person instead of the problem. Peer staff had successfully engaged people who were distant, deescalated those who were agitated, and inspired those who had learned to be helpless and hopeless.

META, therefore, decided to turn additional space over to peer staff and have them offer an alternative to the traditional crisis center approach, thinking that this could be a path to doing the right thing *and* doing the thing right.

Within a few weeks the concept took hold and gained traction. The new peer-operated crisis alternative was aptly named the Living Room, and it occupied a space adjacent to the regular crisis program. More peers were hired to staff the Living Room around-the-clock.

Peer employees had received 70 hours of peer employment training,¹ plus another 35 hours of orientation before they joined META's workforce. A few more hours of training were added in areas unique to a crisis setting, such as maintaining peer interventions' integrity in a crisis setting (Staying aligned with peer principles could be challenging given the work's emergency nature). Peer staffers' most effective contributions come from a position of mutuality, being able to share their own recovery experiences and offering hope.

To create a less clinical and more comfortable and natural environment, META furnished the Living Room with couches and a TV, a refrigerator with snacks, and small individual rooms around the perimeter with futons for comfortable sleeping (if desired). Peer employees could meet privately with people and/or complete paperwork in a couple small office areas.

Initial Resistance

Most of the medical staff in the adjacent crisis program initially were less than enthusiastic about the Living Room, and their concerns mostly were regarding safety. They were afraid peer employees' own recovery would be at risk if they were subjected to the daily stress and risks of a crisis environment. The medical staff were concerned about their own safety, too, arguing that if peer employees could not handle the risk factors, everyone would be at increased risk for physical injury from people who are out of control. The medical staff also questioned if peer employees could carry the workload.

Peer employees responded to the medical staff's concerns by expressing enthusiasm for the opportunity to contribute to the recovery of people in crisis. Peer employees explained that their competencies derived from both personal crisis experiences and from training. Regarding safety, peer employees reminded medical staff that they had been in the crisis clinic several times and had not been frightened.

Coming Together

The first few days of the Living Room's operation were awkward because of these conflicting attitudes, but as relationships between the medical staff and the peer staff developed, the situation improved. The medical staff learned to use and appreciate the peer staff's skills and knowledge. For example, if medical staff were working with someone with a substance use issue, they would have him talk to a peer staff member who had recovered from substance use to explain the process and offer hope.

At one point the peer staff's leader asked the medical director why the medical staff's attitude had shifted, with referrals to the Living Room skyrocketing. The medical director responded, "I can't speak for anyone else, but I've been sending people over here because you guys write better discharge plans than anyone else here."

Expansion

A year later another Living Room opened at META's other crisis facility. Unlike the first Living Room, which was in a locked central space that allowed stays for no more than 24 hours, the new Living Room was unlocked and had eight beds to permit stays for up to five days. Medical staff at the second facility had some of the same initial concerns, but these were mitigated by the first Living Room's strong support from the medical staff. Concerns about the second Living Room being unlocked subsided after a few months of successful operation.

After the second Living Room's first month of operation, the number of people being sent from the second META site to hospitalization dropped from 16 to 6. This reduction was so dramatic that META assumed it was an error, but after the second and third months referrals to hospitalization dropped to 5.

What was the peer staff doing to make such a big difference? Peer staff tended to focus on the person, not the problem. They weren't prone to "pathologizing." Peer staff were more likely to say, "Yeah, I know what you mean. I've been there myself. I'm recovering and so can you. What's worked for you in the past? What can we do to help?" On the other hand, crisis staff trained in traditional assessment and evaluation were more likely to focus exclusively on the person's problems, which appeared to overwhelm the person and render him less capable of identifying workable solutions. Of course, it's important to understand the extent of the person's problems that caused them to seek services from the crisis clinic. Clinical staff is trained to assess safety issues related to the presenting problems. Sometimes, however, this is done to the exclusion of looking at a person's resourcefulness and strengths, and this is the important focus that the peers naturally brought to the team.

Focus Groups

Encouraged by their experiences with the Living Rooms, in the fall of 2005 META organized three focus groups of people who had used crisis services and/or psychiatric hospitals. Attendees were asked, "If you could design an ideal program that you would most want to use the next time you have a need for crisis or hospitalization services, what would it look like?" In summary, the focus groups described a place:

- where they can receive immediate help with life crises;
- that has a holistic approach instead of a singular focus on illness and medication;
- that is comfortable, homelike, and less clinical;
- that is accessible and with regular transportation (people want to be picked up by the facility, not the police);
- where family and friends can visit;
- that is nice enough that they aren't embarrassed to be there;
- where they feel safe (no involuntary aspects);
- where they can make a sandwich if they want to, or make one for someone else; and
- that has a rigorous recovery program to quickly get their lives back on track.

If you have an opportunity to develop a crisis alternative program, we hope you consider the lessons from the Living Room project and the focus groups' advice. During a crisis, people often are open to listening to themselves and others about how to move ahead with their lives. If they are in a setting where they don't feel safe, don't feel like they have any choices in what happens to them, and don't have an opportunity to take personal responsibility for their plans, a chance for recovery can be lost again.

Lori Ashcraft, PhD, directs the Recovery Education Center at META Services, Inc., in Phoenix.
William A. Anthony, PhD, is Director of the Center for Psychiatric Rehabilitation at Boston University.

Reference

1. Hutchinson DS, Anthony WA, Ashcraft L, et al. The personal and vocational impact of training and employing people with psychiatric disabilities as providers. *Psychiatr Rehabil J* 2006; 29:205-13.

Additional Articles in Behavioral Healthcare Tomorrow by Lori and Bill Anthony: Tools for Transformation

To access articles on Website, go to <http://behavioral.net> Click on 'Archives' listed on the left of your screen, click the drop-down arrow under 'search by "Category"' and click 'Tools for Transformation'. Click on the title of the article you would like to read.

[THE VALUE OF PEER EMPLOYEES](#)

Professional staff shouldn't fear peers' greater involvement in the behavioral health workforce

Issue: May 2007

Author: by LORI ASHCRAFT, PHD and WILLIAM A. ANTHONY, PHD

[TURN EVALUATIONS INTO MENTORING SESSIONS](#)

Performance evaluations don't have to be dreadful—try the Get-Give-Merge-Go approach

Issue: April 2007

Author: by LORI ASHCRAFT, PHD and WILLIAM A. ANTHONY, PHD

[A WEEKLY DOSE OF RECOVERY INFORMATION](#)

Weekly refresher courses can help sustain recovery principles and practices

Issue: February 2007

Author: by LORI ASHCRAFT, PhD and WILLIAM A. ANTHONY, PhD

[LET'S TALK ABOUT SOLUTIONS](#)

Organizational leaders can be role models for promoting recovery-based conversations

Issue: January 2007

Author: by LORI ASHCRAFT, PHD, WILLIAM A. ANTHONY, PHD, and LISA ST. GEORGE, MSW, CPRP

[IT'S TIME TO END FORCED TREATMENT](#)

People will experience true recovery when treatment isn't forced upon them

Issue: December 2006

Author: by LORI ASHCRAFT, PhD and WILLIAM A. ANTHONY, PhD

[DIFFERENTIATING A BAD DAY FROM A CRISIS](#)

Providers need to focus more on building resiliency

Issue: November 2006

Author: by LORI ASHCRAFT, PhD and WILLIAM A. ANTHONY, PhD

[HOW RECOVERY HAPPENS](#)

Personal moments can motivate people in recovery and behavioral health professionals

Issue: September 2006

Author: by LORI ASHCRAFT, PhD and WILLIAM A. ANTHONY, PhD

[FACTORING IN STRUCTURE](#)

Recovery needs a solid foundation to take root

Issue: August 2006

Author: by LORI ASHCRAFT, PhD and WILLIAM A. ANTHONY, PhD

[TOOLS FOR TRANSFORMING LANGUAGE](#)

The way we describe people affects how we treat them

Issue: April 2006

Author: by Lori Ashcraft, PhD and William A. Anthony, PhD

[LET PEOPLE MAKE THEIR OWN DECISIONS](#)

Traditional caretaker models do not promote people's recovery

Issue: March 2006

Author: by LORI ASHCRAFT, PhD and WILLIAM A. ANTHONY, PhD

Author: by LORI ASHCRAFT, PhD and WILLIAM A. ANTHONY, PhD

[FROM CONSUMER TO CAREGIVER](#)

Individuals and systems benefit from use of peer-support models

Issue: January 2006

Author: by WILLIAM A. ANTHONY, PHD, AND LORI ASHCRAFT, PHD

Creative Strategies



Creative Strategies: Arts, Humor and Alternative Healing

Peer Specialists are often extremely creative people; their creative imaginations initially helped guide the development of the tools and strategies used in aiding their own recoveries. It is easy for peers to adapt and utilize tools and creative strategies in working with others. Utilization of the tools and strategies listed below is not limited to peer specialists. They can also be implemented by clinical and recreational staff. The key is to identify their usefulness and to coordinate their use in partnership with the individuals whom you are serving.

This list is by no means exhaustive. Some tools involve the arts; others involve fun, and others alternative methods of healing. We invite you to contribute your own creative strategies to this list, the ones that are your favorites, and more importantly, those that persons in your care have enjoyed and would themselves, recommend. We suggest that you keep a list for your own use but feel free to send them to us for further distribution. (Our contact information is listed in the resource section at the end of the guidebook)

This list does not describe how to develop some of these special programs. There is certainly a further need for more descriptions and “how-to’s.” The *Reaching Across With the Arts* Manual posted on the Bluebird Consultant website may provide some of these how-tos and programs. The resource and bibliography section will provide you with information on how to access the site.

1. Introduce journaling (purchase individual journals at Dollar Store)
2. Recovery Videos (Mary Ellen Copeland and others)
3. Reading materials—some inspirational, self-help; recovery stories/books; other recent books on the best-seller list
4. Painting pillow cases or tee shirts (this can be a fun special project resulting in art exhibits with blue ribbon awards and prizes for the best ones)
5. Pet Therapy—Have a pet on premises if possible—if not the local Humane Society often have visiting pet therapy programs
6. Horticulture Programs
7. Talent Shows (be sure to have a microphone and serve refreshments)
8. Display of client’s artwork for enhancing environment (make sure to get consents to use individual’s names)
9. Classes on Yoga/Tai Chi
10. Massage Therapy (utilize local students for head and hand massages)
11. Nail Painting and Make-Up
12. Fashion Shows (get clothes from thrift stores or hospital clothing store if there is one)

13. Joke of the Day Display
14. Wear a funny hat or involve people in a funny hat-making project and exhibit
15. Poetry (have regular groups to write poetry, for display, use in newsletter or creation of small chapbooks)
16. Photography exhibits (photographs taken on grounds of hospital)
17. Storytelling Groups
18. Newsletter Production led by peer specialists
19. Staff appreciation celebrations put on by service recipients led by peer specialists
20. "Hanging out with Peers" Group
21. Comfort Room/Soothing Room kits
22. Designing comfort rooms and developing policies for use
23. Peace Groups
24. Exercise of all types
25. Bubble soap blowing
26. Quilt Making
27. Making Collages on a theme of recovery using pictures from magazines
28. Pizza parties on movie nights
29. A noise fun item: FLAPP (noise putty found at Walmart)
30. Spiral bound journals with blank white covers to decorate: can be ordered from Orientaltradingco.com
31. Origami
32. Scrapbook and photo albums to chronicle recovery journal
33. Comic strips for reading and for collage

Lessons Learned: Tips, Implementation Strategies and Suggested Guidelines



Lessons Learned from Peers Working in Inpatient Mental Health Settings: A Beginning Set of Guidelines

The following information is based on the individual experiences from peer employees in the guidebook and is intended to offer guidance in establishing similar positions in your hospital and institutional settings. Peer providers, their supervisors, and administrators identified many applications and strategies that can be helpful in supporting successful peer employment. Additional information gleaned from peer specialist training programs and peer experts throughout the country has also been helpful.

Up to now there has not been a coordinated effort to develop guidelines for specialized roles that peers provide working in *inpatient* settings. Much of what has been learned is from the “school of experience,” resulting in a valuable body of knowledge of what works, and what doesn’t, for many on this new path.

Not unlike the “pioneer” peer providers filling these positions, these guidelines have been created to lead the way, to offer a beginning set of principles, to offer “the first crack out of the box.” It is incumbent on the reader to review, reflect, and then utilize the ideas and strategies that are most applicable to your situation. Some of the information might be considered essential, but many finer points that could be overlooked, have been included.

It is important to note that most of the information could apply to most positions regardless of their level of authority or formal power in an organization; however, there is an emphasis on positions that are at a management or executive level.

The terms “peer provider” or “peer employee” are the chosen terms for these guidelines because titles of peer positions are so varied. While the term “peer specialist” is often recognizable, many of the peers working in inpatient settings do not use this job title and may not have had peer specialist training. Additional information regarding training needs will become available as peer providers determine the type of training they need.

Many peer providers helped frame the development of these guidelines. I would like to thank the following peer providers: Laura Van Tosh, Nannette Larson, Cyndi Mayhew, Judy Scott, Simonne Maline, and Holly Dixon for their insights. Special thanks to Mary Jensen, a credentialed Recovery Support Specialist RN in Illinois, who went out of her way to edit the entire document.

All of the peer providers interviewed agreed that their work has not been easy, despite the fact that they all feel rewarded and are satisfied. These guidelines are designed to facilitate the hiring process and create “easier” transitions for people filling these challenging roles.

We hope these guidelines are helpful and practical, and we encourage you to use them in whatever way you find most useful in your setting.

Setting the Stage

1. An important first step is to assure that senior administrators approve and are involved in the planning of this effort. The most successful positions are ones that have direct access to the administration and/or report directly to an executive or high level administrator.
2. Conduct a review of the literature on a variety of Peer Support Staff roles to become familiar with different types of roles and their varied responsibilities to determine what will be most helpful in your facility. A wide variety of roles have been written about in the narratives of the guidebook but if you do research in other states you may find that in other states there are other varieties of peer roles.
3. Determine if there are other peer providers working in [inpatient facilities] in your state and invite them to come and speak. This might be a panel discussion, a presentation at grand rounds or a special training that you advertise to all staff and patients with flyers, email and other announcements.
4. Make sure staff have had training on recovery and that their understanding of recovery is demonstrated and reflected in their practice. This kind of training should include all clinical staff, as well as staff from other departments such as security, dietary, and housekeeping. It will also be important to incorporate additional opportunities for learning on this subject as the need will be ongoing.
5. Determine the level of staff and consumer satisfaction. Are staff happy in their jobs; are consumers satisfied with treatment and with the staff working with them? Begin to make changes in a troubled work culture rather than bring a peer into a troubled environment.
6. Create dialogues that allow for discussion between groups of administrators, staff and consumers to talk about their concerns, ask questions, make suggestions and express their fears prior to initiating an effort to hire a peer provider.
7. Conduct training with people receiving inpatient services to educate them on what a peer provider does and how the individual hired will be able to help them. Involve them in as many ways as possible to plan for the position and making sure they are represented on the interviewing committee.
8. Make visits to other facilities that have successfully integrated peer employees on staff. Spend time looking at their policies, types of duties and tasks are involved and what they have learned from their experiences. If possible, include one or more consumer leaders in the team to make these visits.

Creating the Position

1. Organize a planning and advisory committee composed of interested staff, consumers and administrators. The group will serve as a development group for the peer provider position. Later, this group may take on other lead roles, such as acting a “welcoming committee” or ongoing “support group”.
2. Identify “champions” on staff that will take leadership roles in helping to develop the position and to serve on the advisory committee. They can also help to smooth over difficulties encountered by the newly hired peer provider.
3. Involve persons receiving services at all levels of planning. Depending on the length of stay (some facilities have very short term stays) determine how they can successfully contribute to the process including serving on the planning committee. For people in longer-term environments including them on the planning committee is essential.
4. Determine funding for the position(s). If the position is being created with grant money make sure that there will be funding sources available to sustain the position when money from the grant is terminated.
5. It will be ideal to hire two people and/or have plans to hire a second person at a later date. (It has been pointed out by several peer providers, in the narratives, that having more than one person in peer positions is most advantageous for the organization, helpful for one another, and all concerned.) Two people can act as a support system to each other and each person, using their skills, in similar or completely different ways.
 - Facility administrators should consider converting existing vacancies in nursing and/or other job categories with peer providers. In the state of Washington planning is underway to hire peers at Western State Hospital to fill vacant positions in all areas of the hospital. (Note: State psychiatric hospitals are not funded with Medicaid; therefore they do not have to follow Medicaid guidelines for hiring peer providers. This makes it easier to create new job categories)
 - Some states have applied for grants to initiate or sustain innovative peer provider positions. This may also be considered. In the state of Maine a settlement agreement involving the state psychiatric hospital provided funds for a peer support team.
6. Make sure that the benefits package is adequate and comparable to other staff members at similar levels.
7. Weigh the benefits of and/or possibility for subcontracting the position to an outside agency (preferably consumer-operated program delivering peer-provided services). This works well because there can be some increased flexibility for peers working for an outside agency rather than having to adhere to inflexible hospital policies.

Developing a Job Description

1. Determine qualifications (knowledge, skills, abilities, and attitudes) for the job that are consistent with the duties of the position.

The following qualifications could be considered for a peer provider staff position that serves at an executive level position in the organization. These qualifications need to be flexible, based on what experience the person brings and what the organization needs. Many skilled peers may not have completed formal educational degrees but will have a wealth of experience and competencies that can fulfill the job expectations:

- A degree at the Bachelor's level or higher
- Full-time or part time experience working in the mental health field may be substituted for a degree
- Personal experience with recovery from a serious mental illness or history of psychiatric inpatient experience
- Must be open and self-disclosing about the personal experience for the purpose of the job
- Familiarity with history of the "consumer movement"

Other desirable qualifications may relate to skills and values:

- Showing compassion, dignity and respect
 - Active and reflective listening skills
 - Excellent writing skills and verbal speaking skills
 - Computer skills
 - Acting as a role model; sharing strengths and skills where appropriate
 - Having a clear sense of boundaries
 - Mediation and negotiation skills
 - Is far enough in recovery process that they can manage job difficulties without compromising their own personal wellness and recovery, including being able to articulate their own recovery and wellness program if required
2. Develop a job description that has flexibility for the individual after they are hired to make changes according to their interests and vision for the job after they are hired.
 3. Make sure there are not too many initial expectations, immediately post-hire, that would hamper or interfere with the individual's ability to adjust, orient, proceed and succeed at a reasonable pace.

Advertising

1. There is a common belief that advertisements for peer positions need to be carefully worded so that consumers are not discriminated against. It is also important to understand the legal requirements in the state so that advertisements can be quite specific to a targeted audience of persons with mental illnesses and advocacy interests.
2. When the advertisement is not specific people who are not qualified may apply and even be hired. Hiring professionals who may have had mental health services but who identify as professionals “first” and not peers is not goal when filling a peer provider position, in most cases.
3. Many states have been successful at being very specific regarding the qualifications they were looking for and as a result have been successful at having a large number of applicants from which to choose.

A Quick Pointer: Carefully word the ad so that you are as specific as possible. Make sure the title of the position is highlighted. Variations of the job title, including Peer Specialist, or Peer Support Specialist, has now become common. You may want applicants who have received training as Peer Specialists and have received certificates of completion. However, there is no data that supports that peer specialist certification is mandatory, just that it can be helpful. (Note: in some states, such as Illinois and Florida, a credentialing process is also in place.)

Examples of Advertisements:

The advertisement below is from Maine. It was placed in local newspapers and in mental health newsletters as well as at mental health agencies. The response was very positive and resulted in many appropriately qualified people as applicants.

Innovative Opportunity: Peer Specialists

Amistad Peer Support & Recovery Center
is hiring **Peer Specialists** for the Emergency Department
at Maine Medical Center.

Applicants **MUST** identify as a consumer
of mental health services to apply.

For an application please call {person's name}
at [xxx-xxx-xxxx].

The following ad is an announcement that was circulated at Montana State Hospital:

Peer Services Specialist - (Two Part-Time) Peer Services Specialists provide counseling, support, and advocacy for hospital patients based on personal experience as a *consumer of psychiatric services directly*. The position provides peer support and counseling for patients and advocates for the needs of patients with staff at all levels of the organization. This position

requires the candidate to have effective skills and competence to establish and maintain trusting relationships with clients who have serious and persistent mental illnesses. The candidate must also have knowledge and experience applying principles of mental health peer support.

Minimum Qualifications: High School Graduate.

Screening Applicants

1. First, know how your organization is defining a “Consumer of Mental Health Services.” This definition will vary greatly from state to state but here is one that is brief and could be used: “a person diagnosed with a mental illness, who received (or receives) mental health treatment, whose life was interrupted and has a recovery experience to share with others.”
2. In some locations a person diagnosed with a serious mental illness may be enough to qualify. Often, though, there are many other considerations that determine whether someone fits the definition of consumer.

Determine what life experiences are being looked for and how you could recognize who could be a “good fit” for the position.

Determine the importance of a person’s having had an experience of hospitalization. This may be one of the criteria (in some states applied rigidly) but other factors should be considered as well.

It is important to determine that the individual’s experiences are serious enough to qualify and are not those of someone who received counseling for life experiences and difficulties.

It is important to note that family members do not qualify unless they have had a “lived experience” themselves with mental illness.

It can be helpful to rely on the person’s personal story and life changing experiences without applying a rigid definition. Consider some of the following experiences and influencing factors:

- Inpatient hospitalizations
- Diagnosis of a serious mental illness
- School and work interruptions
- Period (s) of homelessness
- A dual diagnosis of a substance abuse condition and a mental illness
- Periods in one’s life of inability to function
- Current or previous period of receiving social security disability
- History of legal involvement
- A history of traumatic life experiences

3. Question whether a person with a sole diagnosis of substance abuse could fill the position. The general rule of thumb is to include only persons with dual diagnoses but there may be positions that would benefit from persons with primary diagnoses of a substance abuse conditions, such as in forensic facilities or in criminal justice facilities.
4. Screen people over the telephone first to make sure that people fit the qualification of having a lived experience of mental illness. You may ask, “What has been your experience with

mental illness?” Persons who qualify will be able to say that they have received mental health services directly. It has been noted, however, that despite careful wording calls will still be received from family members, social workers and other mental health providers who are non-consumers or unwilling to be self-disclosed.

5. Make sure the person doing the screening, preferably another peer provider in a leadership position, knows how to ask the questions to acquire the information. If the facility does not have an employed peer to assist in the interview, a peer advocate working in the community can assist.
6. Asking a person about their history of mental illness is important to the job; however, how this is done or the words used may need to be considered carefully in order to satisfy ADA guidelines or state laws on confidentiality. Usually people who apply are familiar with peer roles and will automatically self-disclose; however, sometimes people will not be familiar with peer roles. If someone does not seem familiar you may want to start by asking them about their familiarity with people’s ability to recover from mental illness.
7. A person should never be asked, nor expected to answer intrusive questions about their life history or their mental illness. It would not be appropriate to ask someone if they take medication, for example.
8. Developing a five to six person interview committee that is representative of different levels of administration, staff and including service recipients is strongly suggested.

Suggested Interview Questions

1. Tell us about your background and experience.
2. What is your experience in the mental health system? Did your experiences take place in this state?
3. What is your experience with individuals with mental illnesses?
4. What do you think are your greatest strengths?
5. What interests you in working in this job role?
6. Have you had Peer Support Specialist training? What additional training do you think would be helpful?
7. What do you know about “recovery” as a concept? Describe some of your personal experiences and turning points from your own life.
8. Do you have any experience being a member of or delivering services to peers in a consumer-operated program?
9. How would you use your personal “life story” while working with other peers also diagnosed with mental illnesses? Are you comfortable self-disclosing and sharing your story with peers?
10. What might be the greatest challenges you might face working with clinical team members in a hospital setting? What kind of support might you need?
11. Working includes time when all of us are experiencing increased stress. What would you do to take care of yourself? What might you need from your supervisor or team members?
12. An additional complex problem solving question might be added. An example might be, “What would you do if someone told you that they had thoughts of suicide? Make sure your own answer is well thought out and consistent with state laws. You may want to take some moments to think about it.
13. End on a positive note. You might use an open ended closing question such as, “Is there anything that we didn’t get a chance to talk about that you would like to add to the discussion?” A final thank you, and when a response might be expected is helpful.

First Day(s) Experience

First day (s) of employment for new peer providers can be awkward and uncomfortable depending on how much thought was given to welcome them and orient them to the job. Here are some suggestions that may be helpful:

1. Plan for a celebratory event that involves all levels of staff and administration. This can be a great way to introduce the peer provider(s) to staff and provide information about what they will be doing. Invite local peer providers from the community as well as other community partners.
2. Include information in agency newsletters and other forms of circulating information such as internal email distribution, announcements at staff meetings, special bulletins, etc.
3. Arrange for new employees to spend time formally and informally with the supervisor. Discussions might include things like work styles, special skills, special needs or concerns and a schedule for regular meetings. Written materials of policies and guidelines should be made available so that the new employee understands hospital standards, etc.
4. Arrange for a tour of the hospital or institutional organizational setting, including areas for recreation, employee health, lunch and break rooms, special departments, etc.
5. Schedule a meeting with other peer providers that might be on staff.
6. Invite family members, external advocates and interested community participants to participate in the orientation and celebration.
7. Encourage informal contact with people receiving services in the hospital (this may take place during first few weeks). You may want to schedule special luncheons, pizza parties or create other special events at which time new peer provider (s) are introduced. Similar meetings and events can be arranged for groups of staff.
8. Arrange for new employee to review hospital policies and procedures.
9. Have a supportive person (may be supervisor or could be other) accompany/shadow the new employee on first day, and make introductions to staff and service recipients in their natural settings. Allow for more freedom and flexibility on subsequent days. Make sure that same individual is available for questions at all times.
10. Make sure that the person has necessary equipment, keys, name badge, safety responder, etc.
11. Information regarding safety and security should be explained. What is peer provider's role in emergencies? (though this may change over time)
12. Make sure there is a specific office space (in contrast to a cubicle) for peer providers with computer and internet access. Make sure that access to the office includes after hours access.

Typical Duties and Responsibilities

Duties and responsibilities will vary in each facility, even between state hospital facilities within the same state. This is because some facilities provide different types of services or may be short-term or longer term. Peers working in forensic areas of the hospital will also have a different set of responsibilities as may be true of other special populations. After speaking with many peer providers and visiting them in their settings the following are some of the common duties and responsibilities that are shared by all:

- Participation in orientation and training of new employees
- Assisting and orienting people who are being admitted
- Providing individual peer support and counseling
- Attending treatment team meetings at request of individual
- Facilitate WRAP (Wellness Recovery Action Planning) Groups (also other types of support groups)
- Working with service recipients on their Personal Safety Plans
- Serving as members of crisis teams or providing special support to individuals who are frequently in crisis
- Administering consumer satisfaction surveys and suggestion boxes
- Addressing minor complaints and grievances
- Attendance at hospital committee and policy meetings.
- Involving service recipients at all levels of decision making including hiring of new employees
- Participation in organizing special events
- Reviewing and helping to develop hospital policies with language that is sensitive to recovery
- Being a member of a clinical team (not consistent for all positions)
- Helping people advocate for themselves
- Conducting surveys on special issues
- Documentation on records: This may be limited to new admission; recipient's perspective on incidents, individual's progress.

The following are some of the favorite chosen activities of peer providers:

- Newsletter production
- Jokes and humor
- Creative and Artistic Projects
- Developing a Consumer Advisory Council
- Decorating the environment to promote well being.
- Leading groups on relaxation, meditation
- Creating "Comfort Rooms" and "Comfort Kits"
- Journaling groups
- Pet therapy
- Organizing Talent Shows
- Exercise programs (indoor and outdoors)

Helping Peer Providers to be Successful and Satisfied

The following are a compilation of some of the ideas received from peers in the narratives as well as from other sources about their work as a peer provider. Careful attention to these examples suggests what makes for a satisfied peer provider of services. The list is by no means complete but it does paint a partial picture of what might be helpful.

1. **Access to a well developed support system:** Both on site and with other peer providers in the state. In some states there is a statewide consumer organization or a Director of Office of Consumer Affairs who offers outreach and support to fellow peer providers. Generally, attendance at these peer support meetings is expected as part of the job duties.
2. **Flexible duties and responsibilities:** Support for creativity and special interests.
3. **Open communication between the supervisor and the peer provider:** This might include scheduling meetings on a regular basis with an established agenda that is maintained and updated.
4. **Reasonable accommodations when needed:** This may include flexible work hours, working part time, shared positions, and time off when requested.
5. **Participation in staff career ladders to advance in position:** Annual salary increases with adequate benefits, etc.
6. **Expressions of appreciation, rewards:** These are necessary for all employees but especially important for peer providers to receive regular feedback and occasional special recognition.
7. **Minimizing committees to those that are essential:** Maximizing contact with service recipients.
8. **Make sure that peer providers are treated equally to other employees:** If not, the position can be construed or regarded as tokenistic. The best way to stay honest is to keep communication lines open. Evaluations should be two-way with supervisor and employee evaluating each other, both written and verbally.
9. **Respect for and allowance for peers to try new ideas:** To make changes and introduce new concepts despite old paradigms and rules that might have prevented them from being implemented in the past.
10. **Make sure that all staff receives ongoing training:** Training on a variety of subjects that are related to recovery oriented care and particularly new employees who may come into an environment knowing nothing about recovery or how to work with peer employees.

Common Hurdles

1. **Peers gaining the trust of staff.** This hurdle will probably be experienced by most peer providers, even when staff has been adequately prepared. Not all staff will embrace the concept of peer provided services. The Planning and Advisory committee can provide support to the peer provider. This committee can also identify ways to work with resistant staff. Peer employees may learn to work closely with staff that are supportive and wait for others to follow when they are ready.
2. **Working alone.** Peers working alone without other peer providers can be a challenge for many. Consequently, it is always advisable to have more than one peer provider on staff whenever possible.
3. **Overworked, Overtired, Over-extended.** Many peers work too many hours and do not take enough time to rest and relax. Often peers take on too many responsibilities or they don't know how to pace themselves. It will be important for supervisors to assist individuals with their workload and help a peer provider that might be experiencing difficulties such as "letting go" of a situation or person.
4. **Serving on too many committees.** Peer employees are often asked to be part of every committee, which prevents them from interacting with people whom they are serving. It is important that they not be asked to be on every committee but that other peers in the community could also be invited to serve in this way.
5. **Inflexible job duties.** It is recommended that a job description include basic duties but that after someone is on the job for a sufficient time period, a work plan can be developed jointly by the peer provider and supervisor and reviewed periodically. A work plan should allow for flexible duties involving the peer employee's special interests, skills, and creativity.
6. **Keeping one's eye on the Prize.** Occasionally peer providers become too comfortable in their positions as equal members on clinical teams and forget to maintain their focus on peer support.
7. **Fear of speaking up:** Peer providers may not always feel safe to speak up about observed mistreatment or abuse for fear of retribution or losing status. It is for this reason that there must be an administrator with whom they have easy access and can report problems confidentially.
8. **Stuck: No way to move up the ladder:** People often are unable to move higher in their careers or receive salary increases. Whenever possible, there should be a means of career advancement, with the understanding that some positions require specialized training and medical degrees. Making scholarships available for advanced education is one way to help people advance in their careers.

Basic and Continuing Education

1. Peer employees should be invited to attend any training that is offered at the hospital facility when the peer provider and supervisor determine jointly that subjects are relevant. It will be helpful to invite peer providers to be speakers at any opportunity to integrate the consumer experience but be sure not to use the same peer provider continuously.
2. Make sure peer employees receive the standard training that all employees receive on legal issues, safety, HIV, domestic violence, mandated reporting laws, ethics, etc.
3. The following is a recommended list of some of the basic topics and skills that are important for all peer providers working in inpatient settings. It will be helpful if the peer employee has been trained prior to accepting employment; however, many peer providers develop skills while working on the job and acquire training after employment through workshops or peer specialist certification programs.
 - Basic Recovery Concepts
 - Assessment for crisis and risk of suicide; legal ramifications
 - Ethics and Boundaries (can sometimes be more flexible for peer providers)
 - Confidentiality
 - Seclusion and restraint prevention
 - Rights and Responsibilities
 - Active listening and communication skills
 - Reasonable Accommodations (ADA)
 - Basic advocacy skills—helping an individual to self-advocate
 - Medications, diagnoses, and treatments
 - Group facilitation skills
 - Understanding peer support, concepts and skills
 - Cultural Competency
 - Telling your story effectively and when appropriate (self-disclosure)
4. The following is a recommended list of some of the topics that are important for continuing education: (Some of these skills may be learned on the job; others will require specialized training.)
 - Trauma Informed Care
 - Self Injury training
 - Wellness Recovery Action Plan (WRAP) Facilitator Training
 - Conducting dialogues and role play skills
 - Substance abuse issues
 - Spirituality vs. religion
 - Working with special populations, e.g., forensic, substance abuse, cultural differences, language barriers, gay and lesbian and transgender
 - Learning about community resources
 - Personal Safety Plans

5. Develop training that uses peer providers' expertise to train other staff on issues of recovery, trauma informed care, advocacy, wellness promotion and other related topics.
6. Encourage peer employees to participate in conferences that relate to consumer perspectives outside of the hospital, local, state and national. Often, peers will be asked to be workshop presenters; the facility can help by providing resources and support for them to develop their technical presentations (such as Power Point) or materials for this purpose.

Resources



Resources

Comfort Rooms

Bluebird, G. (Summer/Fall 2002). *Comfort and communication help minimize conflicts*, Networks, p.18. Alexandria, VA: National Technical Assistance Center, National Association of State Mental Health Program Directors

Bluebird, G. (Spring 2005) *Comfort Rooms: reducing the need for seclusion and restraint*, *Residential Group Home Quarterly* Vol. 5 No.4, p5

Champagne, T., & Stromberg, N. (2004) *Sensory Approaches in Inpatient Psychiatric Settings: Innovative Alternatives to Seclusion and Restraint*. *Journal of Psychosocial Nursing* 42, (9) pp 35-44

Consumer Roles in Mental Health Settings

The President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: U.S. Department of Health and Human Services

Ralph, R. O., Lambert, D., & Kidder, K. A. (2002). *The recovery perspective and evidence-based practice for people with serious mental illness*. University of Southern Maine. <http://bhrm.org/guidelines/mhguidelines.htm>

Bluebird, G. (2004). *Redefining Consumer Roles: Changing culture and practice in mental health settings*. *Journal of Psychosocial Nursing and Mental Health Services*, 42(9), 46-53

Clay, S.; Schell, B.; Corrigan, P.W.; Ralph, Ruth O. (Eds.) (2005). *On our own together: peer programs for people with mental illness*. Vanderbilt University Press: Nashville

Hutchinson, D.S., Anthony, W.A.; Ashcraft, L., Johnson, E., Dunn, E.C. Lyass, A. & Rogers, E.S. (2006) *The personal and vocational impact of training and employing people with psychiatric disabilities as providers*, *Psychiatric Rehabilitation Journal* 29, (3) 20-213

Mead, S; Hilton D. & Curtis L.; (2001) *Peer Support: A theoretical perspective*, *Psychiatric Rehabilitation Journal*, 25, 2 134-141

Prescott, L. (2000). *Veterans of abuse and daughters of the dark: The politics of naming and risk of transformation in building partnerships for change*. *Perspectives in Psychiatric Care*, 34(2)

Ridgway, P. (1988, December). *The voice of consumers in mental health systems: A call for change*. Center for Community Change through Housing and Support. National Institute of Mental Health

Solomon, M.L.; Jonikas, J.A.; Cook, J.A.; Kerouac, J. (1998). *Positive Partnerships: How consumers and non-consumers can work together as service providers*. Chicago: National Research and Training Center on Psychiatric Disability, The University of Illinois at Chicago

Solomon, P. (2004). Peer Support/Peer Provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, 27. 392-401

Van Tosh, L., & Del Vecchio, P. (2000). *Consumer-operated self-help programs: A technical report*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services

Dialogues and Communication

SAMHSA, (2000). *A Participatory Dialogue Report—Consumers and Psychiatrists in Dialogue*. website: <http://store.mentalhealth.org/consumersurvivor/publications.aspx> (Other reports of dialogues between consumers and providers also available on this site.)

SAMHSA, (2000). *Participatory Dialogues, A guide to organizing interactive discussions on mental health issues among consumers, providers and family members*, On line: [http://store.mentalhealth.org/consumersurvivor/publications.aspx \(SMA\)\)-3472](http://store.mentalhealth.org/consumersurvivor/publications.aspx (SMA))-3472)

Public Conversations Project, *Fostering Dialogue across divides: A nuts and bolts guide from the public conversations project*. www.cafepress.com/pcp_press

Guidelines for Hiring Peer Specialists

Ralph O. Ruth, (2002). The Dynamics of Disclosure: Its Impact on Recovery and Rehabilitation. *Psychiatric Rehabilitation Journal*, 26. 165-172

Salzer, M.S., & Mental Health Association of Southeastern Pennsylvania Best Practices Team (2002). Consume Delivered Services as a Best Practice I Mental Health Care and the Development of Practice Guidelines. *Psychiatric Rehabilitation Skills*, 7, 355-382. (Available by contacting penrrtc@mail.med.upenn.edu)

Peer to Peer Resource Center: Promoting peer support and recovery for people living with mental illness www.peersupport.org/LatestNews.htm

Legislation and Advocacy

Centers for Medicare and Medicaid Services: Medicare Hospital Conditions of Participation on Patients' Rights, www.cms.hhs.gov/cop/2b.asp

The National Disability Rights Network web page on Seclusion and Restraint: www.ndrn.org/issues/an/rs.htm

Consumer Committee on National Resource Center on Psychiatric Advance Directives (NRC-PAD) at www.nrc-pad.org

Joint Commission on Accreditation of Healthcare Organizations (2004). *Standard for including consumers in training*, Standard PC.12.30. PP. 211-212. JCAHO. (2005). The Joint Commission's sentinel event policy: Ten years of improving the quality and safety of health care. *Joint Commission Perspectives*. 25(5): 1-5

National Association of Protection and Advocacy Systems. (2003). *Restraint and Seclusion: Overview of federal laws and policies (2003)*. Retrieved January 15, 2004, from <http://www.napas.org/AbuseNeglect/Restraintoutline03.htm>

Shared Visions – New Pathways: The Joint Commission's Redesigned Accreditation Process (Behavioral Health Care) Video Length: 52 minutes. Video clip. <Http://www.jcrinc.com/media/DEP/behavioral-shared-NTSC.wmv>

Peer Specialists Training

Collins, A., Kobzar, S., & McDiarmid, D. (2002) *Consumer as Provider Project*. Lawrence, KS: The University of Kansas School of Social Welfare

Georgia Certified Peer Specialist Project, website: www.gacps.org/home.html

Harrington, S. (2007). National Association of Peer Specialists Training Manual, National Association of Peer Specialists, Ada, MI. www.naops.org
(This organization puts on an annual national conference for peer specialists (check the website for information))

Illinois Model for Mental Health Certified Recovery Support Specialist, Illinois Certification Board, Inc.: A provision of competency-based credentialing of Certified Recovery Support Specialists, www.iaodapca.org

META Peer Employment Training Program, Recovery Innovations, Inc., Phoenix, AZ, website: www.metaservices.com

Mead, S. *Peer Support training manual*. Albany, NY: New York, Association of Psychiatric Rehabilitation Services. Retrieved 2004 from: www.mentalhealthpeers.com/trainings.html

Peer to Peer Resource Center, (2006) sponsored by Depression and Bipolar Support Alliance: Retrieved 2006 from: www.peersupport.org

The Institute for Recovery and Community Integration, Mental Health Association of Southeastern Pennsylvania, Call 1-800-688-4226 Ext. 288.

Peer Support Resources

Mazelis, R. *The Cutting Edge: A Newsletter for People Living with Self-Inflicted Violence*. www.sidran.org

Copeland, Mary Ellen, MS, MA. *Wellness Recovery Action Plan*. Online at: www.mentalhealthrecovery.com

Deegan, P. (1998) *Recovery as a self-directed process of healing and transformation*. Online at <http://intentionalcare.org/articles/trans.pdf>

NASMHPD/NTAC. (2004)/Fall). E-Report on recovery. *Networks*. Retrieved from the Internet on November 12, 2004 at http://www.nasmhpd.org/spec_e-eport_fall04intro.cfm

Personal Safety Plans

Cook, J.A., Jonikas, J.A., & Laris, A. (2002). *Increasing self-determination: Advance crisis planning with mental health consumer inpatient and other settings*. Chicago, IL: University of Illinois at Chicago Mental Health Services Research Program

Bluebird, G. (2001). *Personal Safety Plan*. South Florida State Hospital. Retrieved May 2, 2004 from http://www.nasmhpd.org/general_files/publications/ntac_pubs/networks/De-EscalationForm.pdf

Stromberg, N.; LeBel, J.; Bluebird, G.; Huckshorn, K. & the National Executive Training Institute (2004) Seclusion and Restraint prevention tools module. In Training curriculum for the reduction of seclusion and restraint, Alexandria, VA: National Association of State Mental Health Program Directors

Seclusion and Restraint Reduction (Children and Adults)

Huckshorn, K.A. (2004). Reducing seclusion and restraint use in mental health settings; Core strategies for prevention. *Journal of Psychosocial and Mental Health Services*. 42 (9). Pp. 22-23

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., et al. (2004). Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based Care. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 37-45

Murphy, MS, Bennington-Davis, MD. (2005) *Restraint and Seclusion: The model for eliminating their use in healthcare*. (A Manual), Marblehead, MA., HCPPro, Inc.

National Executive Training Institute (NETI). (2005). *Training curriculum for reduction of seclusion and restraint. Draft curriculum manual*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC)

SAMHSA, (Ed. Jorgenson, J), A Roadmap to Seclusion and Restraint Free Mental Health Services for Persons of All Ages. [Http://www.mentalhealth.samhsa.gov/publications/allpubs/06-4055](http://www.mentalhealth.samhsa.gov/publications/allpubs/06-4055)

Stories and Experiences

Bassman, R., (2007). *A Fight to Be: A psychologists experience from both sides of the locked door*. Albany, New York, Tantamount Press

Martinez, R., Grimm, M., & Adamson, M. (1999). From the other side of the door: Patient views of seclusion. *Journal of Psychosocial Nursing*, 73(3), 3-22

National Executive Training Institute (NETI), Lane, T. (editor): *Speaking Out: Personal Experiences of Seclusion and Restraint*. A resource compendium toward culture change and best practice. 2005, Alexandria, Virginia

Ray, N.K., Myers, K.J., & Rapport, M.E. (1996). *Patient perspectives on restraint and seclusion experiences: A survey of former patients of New York State psychiatric facilities*. *Psychiatric Rehabilitation Journal* 20(1), 11-18

Trauma Informed Care

Bloom, S. (Summer/Fall 2002). *Creating Sanctuary, networks*, p.1. Alexandria, VA: National Technical Assistance Center, National Association of State Mental Health Program Directors

Ford, J. (2003, January 17), *Trauma Adaptive Recovery Group Education and Therapy (TARGET)*. Retrieved from www.traumamatters.org/documents/TARGET--JulianFord.pdf on January 17, 2003

Giller, Esther. (Spring 2005) *Sidran Bookshelf: Trauma and Dissociation*. Information and Resource Newsletter, (listing of publications). On line: www.sidran.org

Harris, M. (1998). *Trauma recovery and empowerment: A clinician's guide for working with women in groups*. New York, NY: The Free Press

Herman, J. (1992). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York, NY: Basic Books

Hodas, G.R. (2004). *Understanding and responding to childhood trauma: Creating trauma informed care*. Unpublished paper. Pennsylvania Office of Mental Health and Substance Abuse Service

Levin, Bruce, Blanch, Andrea, Jennings, Ann, *Women's Mental Health Services: A Public Health Perspective*. (1998). Sage Publications. Thousand Oaks

Najavits, L. (2003, January 17). *Seeking safety*. Retrieved from www.seekingsafety.org/3-02%20arts/training%20in%20SS-s.pdfZ