The Pillars of Peer Support Services Summit IV

Establishing Standards for Excellence

The Carter Center

Atlanta, GA

September 24-25, 2012

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Background and Introduction

The fourth Pillars of Peer Support Services Summit was held at the Carter Center in Atlanta, GA on September 24th and 25th, 2012. The goal of the Summit was to build on the work of the three previous summits and to focus on two topics, which were selected in the spring of 2012 using a qualitative survey of previous Pillars summit participants. Those two topics included the issues of *Establishing National Standards/Credentials for Peer Support Services* and *Creating Recovery Cultures that Support Peer Specialists*. This meeting again convened peer and other representatives from states, with invitations sent to all State behavioral health authorities, and participants accepted based on those whose States expressed the most interest by responding first. There were 70 total participants, including individuals who came from 36 different states. This summit was made possible from the generous support received from the Substance Abuse and Mental Health Services Administration (SAMHSA), Optum Health Behavioral Solutions, the National Association of State Mental Health Program Directors (NASMHPD), and logistical support provided by the Carter Center, the Georgia Mental Health Consumer Network, and the Appalachian Consulting Group.

The structure of this meeting was similar to the previous Pillars of Peer Support Summits, and included a series of keynote presentations, panel discussions, and participant working groups. Keynotes were presented by Larry Davidson, Professor of Psychiatry, Yale School of Medicine – *Harnessing the Power of Peer Support Services*; and John O'Brien, Senior Advisor, Innovation Center CMS – *Authenticating Peer Support Services through Sound Funding*. The two panels held discussions on the two summit topics of *Establishing National Standards/Credentials* and *Creating Recovery Cultures that Support Peer Specialists*. Overviews of the keynote presentations, panel discussions, and workgroup reports are included in this report. Power Point presentations from these reports are included in the appendices.

Keynote Presentations

Harnessing the Power of Peer Support Services
Larry Davidson, Professor of Psychiatry, Yale School of Medicine

This presentation focused on four key areas. These included: Historical precedents and the overlooked role of peer support in the past; peer support in its contemporary form; evidence to date; and promising directions for the future.

Davidson traced the beginnings of peer support to the 1790's in France and noted that in asylums the role of mutual support was well documented. He also noted that this pattern has been traced through history and that the role of advocacy is based on the principle of people with lived experiences of mental illnesses benefitting others.

In reviewing the evidence base for peer support services Davidson presented a generational approach. This included:

- First generation (early) studies showed that it was feasible to hire people in recovery to serve as mental health staff
- Second generation (later) studies showed that peer staff could generate equivalent outcomes to non-peer staff in similar roles

- Third generation (recent) studies are investigating whether or not there are unique contributions that peer support can make

Recovery services are described as a complement to treatment which aims to reduce or eliminate illness, symptoms, and relapse, and to increase "recovery capital." Recovery capital is the total of all resources, including personal, social, and community supports a person can draw on to build and sustain recovery.

Davidson noted that recovery services include outreach, engagement, case management (recovery coaching or mentoring), and other strategies and interventions that assist people in gaining the skills and resources needed to initiate and maintain recovery, and in establishing a social and physical environment supportive of recovery. Recovery services seek to:

1) Enhance the person's "recovery capital" (e.g., by assisting people in addressing their basic needs, gaining employment, going back to school, forming sober social relationships, etc.)
2) Remove personal and environmental obstacles to recovery (e.g., through the provision of child care or transportation)
3) Enhance identification of and participation in the recovery community (e.g., through connecting people to treatment and to 12-step and other mutual support/recovery-oriented groups)

Davidson stated that when these services are provided by someone with lived experience of an illness and in recovery, they promote such positive experiences and benefits as: Hope and positive role modeling; recovery education and mentoring; assistance in navigating social service and recovery service systems; and assistance in asset mapping and connecting with community resources, welcoming community destinations, and informal community associations that support recovery.

In a review of the overall outcomes of peer support services, Davidson reported that they promote improved health behaviors, improved clinical outcomes, and improved quality of life. Complete slides for this presentation are included in Appendix A.

Authenticating Peer Support Services through Sound Funding
John O'Brien, Senior Advisor, Innovation Center CMS

John O'Brien presented the keynote session on the role of funding to support peer support services. He noted that Medicaid will be expanding to provide coverage for more people, and it is anticipated that many of these newly enrolled individuals will have significant behavioral health issues. This new coverage will have a focus on primary care coordination and an increased emphasis on home and community based services. Early identification, preventing chronic illnesses, and promoting wellness will be essential.

The development of benefit plans that promote both evidence based practices and the provider workforce will also be important issues. The services will need to support guiding principles that focus on preventing and treating mental illness as integral to overall health. Services should be

quality focused and consistent with clinical guidelines, they should be consistent with community and consumer needs, and they should be recovery and resiliency focused.

In this keynote John O'Brien also outlined five key goals for behavioral health. These include:

- Effective use of screening for mental health and substance use disorders, including strategies to refer and effectively treat individuals with these conditions
- Increased access to behavioral health services for persons with serious and/or chronic disorders
- Improved integration of primary care and behavioral health, and in some instances long term services and supports to obtain better health outcomes for individuals with mental health and/or substance use disorders
- Better availability of Evidenced Based Practices to enhance recovery and resiliency and to reduce barriers to social inclusion
- Strategic development, implementation, and testing of new benefit designs, and service delivery with models that are taken to scale

A number of opportunities for the Center for Medicare and Medicaid Services (CMS) to support peer support services were also noted. These include providing vision, guidance, and leadership to states to support the roles of peer support service providers. As a part of this CMS can also ask states to outline their workforce plans for these services and how they might continually support new opportunities. Furthermore, they can continue to provide guidance on the role of peer and family support specialists to the states. CMS also recognizes the important role for peer support services in health homes, and expects that they will be included in all new proposals. Complete slides for this presentation are included in Appendix A.

Panel Presentations

Two panel presentations were held to inform participants and provide a baseline to use as a framework for the work groups. These included: 1) Establishing National Credentials/Standards; and 2) Creating Recovery Cultures that Support Peer Specialists. Panel members used a combination of Power Point presentations and talking points for these sessions. Complete slides and materials for these presentations are included in Appendices B and C for panels 1 and 2 respectively (Note not all presenters had Power Point slides, and so there are fewer than four presentations in the Appendices for each panel).

Panel # 1 – Establishing National Credentials/Standards

Sue Bergeson – VP, Consumer Affairs, Optum
Wilma Townsend – Substance Abuse and Mental Health Services Administration
Pam Werner – Michigan DCH, Bureau of Community Mental Health Services
Tom Gibson – Interim CEO, US Psychiatric Rehabilitation Association

In the first panel session Sue Bergeson presented the key issues for why a national set of credentials and standards is important for managed behavioral healthcare organizations. She noted that the development of standards would put peers on a level playing field with other professionals, and is consistent with the operations of other professional organizations. Having national credentials/standards would also support the ongoing opportunities for the peer workforce to maintain a key role in the changing healthcare delivery system.

Wilma Townsend presented on the important distinction among terms that are regularly used in discussions around establishing credentials and standards. She focused on the differences between standards, certification, accreditation, and licensing. Standards are described as rules or principles that are used as a basis for judgment established by an authoritative entity. Certification is a process of completing technical, educational and practical requirements defined by a profession that qualifies an individual to practice that profession. Accreditation is a Status of certification and authority meaning that someone has met all formal official requirements of technical and educational standards which reflect standards that define competency and authority for a professional program. Licensing is a formal permission from an authoritative entity to practice within a particular profession. Examples of how other professions address these issues and current activities to support the peer support field were presented.

Pam Werner described some of the benefits of a national credential for peer support services. These include opportunities to work in different states, uniform standards of ethics, supported career ladders, and recognition for an established training level. Challenges that were noted for the development of a standard credential include building consensus, qualifying trainers with quality peer review and mentoring, CEU processes to maintain credentials, meeting various state requirements, and financing the development and implementation of a body to administer a program.

Tom Gibson presented an overview of the United States Psychiatric Rehabilitation Association (USPRA) national credential program. He noted benefits that include the assurance that providers have met an independently created set of criteria for knowledge, skills, and services that support recovery. He reported that the development of this program required an investment of about $750,000 (in present dollars), and there were also ongoing recurring costs. The organization is committed to continuing their program and finds that it is receiving increasing recognition.

Panel # 2 – Creating Recovery Cultures that Support Peer Specialists
Lori Ashcraft – Recovery Opportunity Center at Recovery Innovations
Lisa Goodale – VP of Training, Depression and Bipolar Support Alliance
Leo DeLaGarza – Director of Special Projects, Bluebonnet Trails Community Services
Bill Gilstrap – Certified Peer Specialist, Bluebonnet Trails Community Services

The Pillars of Peer Support Services Summit IV also included a panel of presenters discussing the importance of Creating Recovery Cultures that Support Peer Specialists. Lori Ashcraft distributed two handouts that she used for her remarks. These documents included *What a Recovery Organization Looks Like* and *How Recovery Happens*, and are included as Appendix D. The key theme of these remarks focused on the need for organizations to convey a welcoming environment, and to have staff that is recovery minded, empowers people, and focuses on strengths.

Lisa Goodale presented the work of the Depression and Bipolar Support Alliance (DBSA). She focused on Peer Specialists training, and reported on benchmarks established by the Veterans Administration. In addition she addressed the Recovery to Practice initiative and illustrated the

range of professional disciplines that are involved in this program. Eight key curriculum elements were presented and include:

- Recovery Principles and Self-Care
- The Complex Simplicity of Wellness
- The Effects of Trauma on Recovery
- The Influence of Culture on Recovery
- From Dual to Whole Person Recovery
- Recovery Roles and Values
- Strengthening Workplace Relationships
- Recovery Relationships

Representatives from the Bluebonnet Trails Community Services (Leo DeLaGarza and Bill Gilstrap) presented a case example of how organizations can embrace recovery and build recovery-oriented cultures. They discussed their programs, how they were developed, and the importance of building recovery into all aspects of the program.

Work Groups

For this Summit the two key areas of *Standards and Credentials for Peer Support Services* and *Building Recovery Cultures* were reviewed by working groups. In order to accommodate the number of attendees, the work groups were divided into two sub groups for each topic. There were a total of three work group break-out sessions, during which work groups were able to discuss and contemplate the issues, and then report back to all Summit participants on their discussions. For the first two break-out sessions, participants for each key area/topic were subdivided into two groups (for a total of four groups) to facilitate greater participation by all group members. The third session had all members on each topic work together (for a total of two groups) in an effort to create consensus. Each of these two groups then provided a final consensus report to the full group of Summit participants.

Standards and Credentials

The participants in the Standards and Credentials work group determined that their best focus would be to begin by addressing the issue of standards as a baseline for any additional work on credentials, certifications, or licensing/accreditation of peer support services. They were able to identify a number of key issues and recommendations as a result of their discussions.

Several themes emerged from the Standards and Credentials group. These included:

- Education and awareness
  The groups reported that it would be necessary and helpful to have some more background information on the processes that have been used in other disciplines on the development and implementation of standards. They were curious to know more about the process for how these were developed and how stakeholder groups were represented in the process.

- Inclusiveness
  There was a strong sense among the participants that any process for the development of standards must be inclusive and representative of the notion of "nothing about us without us." This includes the full spectrum of stakeholders and organizations. Both mental health

and addictions peer support services must be included. An additional caution was made that any process needs to be careful not to lose the grass roots representation of the peer community.

- Values
  The workgroup identified that there are strong values at the core of peer support services, and these would need to be fully represented in any process that would develop standards. In particular this included the recovery and strength-based focus of peer services, and values of choice and self-determination.

- Representation
  Along with the principles of inclusiveness, the development of standards requires fair representation among stakeholders and organizations. Not only does this include mental health and addictions, but also a variety of advocacy and service organizations. Additionally, there was discussion about how individuals could participate and be represented in the process.

- Leadership
  The issue of who should lead a process for the development of standards for peer support services received a lot of attention. There was concern that in order to be successful there needs to be a clear process with effective leadership. Yet who should provide that leadership remained uncertain. There was discussion about a possible role for SAMHSA in this, but there was some hesitation expressed about a federal organization providing central leadership. There was also discussion about the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and/or the National Council on Community Behavioral Health (NCCBH) providing leadership roles. Again, concerns were expressed about these organizations being able to be neutral and unbiased. The notion of a coalition of leaders was also discussed.

- Strategies and plans
  The work group identified that in order for there to be any progress on the development of standards for peer support services there would need to be a strategy and plan for its achievement. There was consensus that the Pillars of Peer Support Summits have been effective in the promotion of the field. Additionally there was a consensus that a set of recommendations would be helpful to direct future work towards the development of standards.

Recommendations

The work group on the development of standards for peer support services provided a set of recommendations. The general consensus of the group was that while it is important to establish core national standards, there were questions about moving beyond this to core curriculums, and that it is important to recognize that most states will want to retain responsibilities in the content design and delivery of trainings. The recommendations included:

- The Pillars of Peer Support Services Steering Committee should develop a two page summary of key issues that describes the issues, concerns, and recommended processes

from the work group discussion. This should include a definition of key terms including: Standards, certifications, accreditation, peer specialist, peer support, recovery peer support services, and other terms relevant to the process

- Identify a process and vehicle to bring all of the relevant and existing peer services standards (mental health, addictions, State, Medicaid, other) together and create multiple matrixes to describe them

- The Pillars Steering Committee should include in its two page key issues summary a proposed outline and strategy for building the coalition and process for the development of standards for all peer support services

Moving Towards a Recovery Oriented Culture

The work group *Moving Toward s a Recovery Oriented Culture* focused on a range of issues related to the roles of funders, service providers, peers, and recipients of care. This included background discussion on the elements of a recovery culture, key barriers and opportunities to support their development, and overall strategies to promote recovery.

Several themes emerged from the work group dialogue and report and include:

- Assessing current initiatives
  There was broad discussion on developing an inventory of what is currently being done at the state and federal level to build and promote recovery cultures. In particular this should focus on funders and service providers. Additionally this inventory should include what SAMHSA, NASMHPD, NASADAD, and others are doing

- Stakeholder engagement
  The work group recognized that there is a broad group of stakeholders that needs to be engaged in any programs to support the development of recovery cultures. Specifically this needs to branch out beyond the mental health constituencies and include both addictions and physical health. Key leaders and organizations from these groups need to be identified and engaged in projects in this area

- Planning
  In order to support the development of recovery cultures it will be important to recognize the key partners that need to be involved and engage them in a planning process. This includes those identified in the stakeholder engagement and others who can help support the development of plans and strategies. It was also noted that the state representatives who have been involved in the Pillars Summits can be a good grass roots group to keep involved in the process

- Training and education
  The training and education of the service delivery workforce does not currently support recovery in all disciplines. The work group advocated for expanded curriculum development in this area, and outreach to each of the behavioral health clinical disciplines plus primary care

- Next steps and recommendations
  The work group came up with a series of next steps and recommendations. They identified that it is a difficult goal to pursue without a designated lead, and recommended that a national lead be appointed

Recommendations

The work group recommendations established a list of key stakeholders that should be included in all discussions about advancing recovery cultures. They include (not in priority order): SAMHSA; the Office of National Drug Control Policy (ONDCP); the NASMHPD Research Institute (NRI); CMS; NASMHPD; the SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS-TACS); the National Association of Peer Specialists (NAPS); State Behavioral Health Authorities; and others.

The recommendations from the work group are divided into different categories. These include:

- States – The role of State authorities for mental health and substance abuse is paramount in promoting recovery cultures. This includes increased dialogues with these organizations and their roles. It is important for planning councils to work together. National organizations that support State operations (NASADAD and NASMHPD) can also take a significant lead in promoting and supporting the development of recovery cultures. These systems should conduct needs assessments for the status of recovery culture development

- Integration of care – There is a need to promote better integration between mental health and substance abuse care, as well as the Whole Health approach across all levels of care. This includes better combined leadership that addresses these needs. Additionally, there is a need for improved education and cross training between professional disciplines

- Policy – There is a need for better information on the status of recovery and transformation to inform the decision process. This includes the staffing ratios for emerging health providers (e.g. health homes and accountable care organizations) and the role of peer support services in these systems. Working with HRSA and others to hire peer Whole Health wellness coaches into the Federally Qualified Health Care (FQHC) workforce and other public health entities will also support recovery cultures. This includes the development of language for strength-based peer services that can be funded by health insurances including Medicaid

- Advocacy and leadership – There is an absence of leadership on the development of recovery cultures across organizations. This shortage is seen at all levels and there is a need to develop a network of local and national champions. One idea discussed included the creation of a recovery czar position at the federal level. There was also discussion about fostering and supporting advocacy and leadership roles at the state, local, and provider system levels. The use of social media was also seen as a valuable tool to promote advocacy

- Quality and accountability – In order to promote recovery focused cultures, it is important to establish quality indicators. The group noted the absence of useful data to

evaluate and track progress. This includes the need for developing state and provider system assessment tools and benchmarks. One of the work group's recommendations includes the creation of standards for accreditation of Recovery Oriented Systems of Care (ROSC) to be considered by the Commission on the Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and CMS

Conclusions and Next Steps

The participants in the Pillars of Peer Support Summit IV were consistently favorable in their assessments and reviews of the progress made in this meeting. The design of the Summit was developed on two tracks including standards/credentials and recovery cultures. Those attending noted that these two tracks worked well together and need to have continued focus and attention. However it was also discussed that there is not currently an identified organization that will be responsible for the formal advancement of these issues.

The Pillars Steering Committee is well aware of these needs, but recognizes the limitations of its ability and mission to take a leadership role beyond its convening functions. This is an important role, but it is recognized that there are gaps in the integration of peer services across the mental health, substance abuse, and general health fields. Additionally there are gaps between state, federal, and commercial funders of care. The Pillars of Peer Support Services Summit reports are continually published through the www.pillarsofpeersupport.org site and this can continue to be a resource for additional dissemination of materials and resources.

The Pillars Steering Committee is continuing to look for support for future summits and welcomes the ideas and input of broad groups of stakeholders. The committee also recognizes the significant contributions of its funders and supporters.

Appendices – Keynote Speaker and Panel Presentations

A. Acronyms and Organizational Resources
B. Keynote Presentations,
C. Standards and Credentials Presentations
D. Recovery Cultures Presentations and Documents

Appendix

A. Acronyms and Organizational Resources

BRSS-TACS: Bringing Recovery Supports to Scale Technical Assistance Center – see www.samhsa.gov

CARF: CARF International (formerly: Commission on Accreditation of Rehabilitation Facilities) accredits health and human services organizations – see www.carf.org

CMS: Center for Medicare and Medicaid Services – see www.cms.gov

DBSA: Depression and Bipolar Support Alliance – see www.dbsalliance.org

FQHC: Federally Qualified Health Center – see www.cms.gov

HRSA: U.S. Department of Health and Human Services Health Resources and Services Administration – see www.hrsa.gov

JCAHO: The Joint Commission – see http://www.jointcommission.org/

NAPS, International Association of Peer Support (formerly National Association of Peer Specialists) – see http://na4ps.wordpress.com/

NASADAD: National Association of State Alcohol and Drug Abuse Directors – see www.nasadad.org

NASMHPD: National Association of State Mental Health Program Directors – see: www.namshpd.org

NCCBH: National Council for Behavioral Health – see http://www.thenationalcouncil.org/

NRI, NASMHPD Research Institute, Inc – see http://www.nri-inc.org

ONDCP: Office of National Drug Control Policy – see www.whitehouse.gov/ondcp

POPS: Pillars of Peer Support – see www.pillarsofpeersupport.org

ROSC: Recovery Oriented Systems of Care – see http://partnersforrecovery.samhsa.gov/rosc.html

SAMHSA: Substance Abuse and Mental Health Services Administration – see www.samhsa.gov

USPRA: United States Psychiatric Rehabilitation Association – see www.uspra.org

B. Keynote Speakers and Presentations

- Larry Davidson, Ph.D.
  Professor of Psychiatry and Director
  Program for Recovery and Community Health
  Yale University School of Medicine and
  Institution for Social and Policy Studies
  www.yale.edu/prch

- John O'Brien
  Senior Policy Advisor
  Disabled and Elderly Health Programs Group
  Center for Medicaid and CHIP Services

C. Standards and Credentials Presentations

- Sue Bergeson
  VP Consumer Affairs,
  OptumHealth

- Wilma Townsend, MSW
  Associate Director for Consumer Affairs
  Center for Mental Health Services (CMHS)
  Substance Abuse and Mental Health Services Administration (SAMHSA)

- Pam Werner
  Michigan Department of Community Health
  Lansing, MI

- Tom Gibson
  Interim CEO
  United States Psychiatric Rehabilitation Association – USPRA

D. Recovery Cultures Presentations and Documents

- Lori Ashcraft
  Recovery Opportunity Center
  Recovery Innovations

- Lisa Goodale
  VP of Training,
  Depression and Bipolar Support Alliance

Slide 1

yale program for recovery and community Health

Harnessing the Power of Peer Support

Larry Davidson, Ph.D.
Professor of Psychiatry and Director
Program for Recovery and Community Health
Yale University School of Medicine and
Institution for Social and Policy Studies
www.yale.edu/prch

Slide 2

What is "Peer Support"?

Dr. Philippe Pinel at the Salpêtrière, 1795 by Robert Fleury. Pinel removing the chains from patients at the Paris Asylum for insane women

- History extends back to Philippe Pinel at the end of the 18th Century
- In contemporary form, emerges from Mental Health Consumer/Survivor Movement
- Resurrected as a strategy for addressing the gap between treatment and "a life in the community"
- Is now reimbursed by Medicaid in many states

Slide 3

Today's Agenda

- Historical precedents and the overlooked role of peer support in the past
- Peer support in its contemporary form
- Evidence to date
- Promising directions for the future

Slide 4

The Creation of Peer Support in the 1790's in France

"In lunatic hospitals, as in despotic governments, it is no doubt possible to maintain, by unlimited confinement and barbarous treatment, the appearance of order and loyalty. The stillness of the grave, and the silence of death, however, are not to be expected in a residence consecrated for the reception of madmen. A degree of liberty, sufficient to maintain order, dictated not by weak but enlightened humanity, and calculated to spread a few charms ever the unhappy existence of maniacs, contributes, in most instances, to diminish the violence of the symptoms, and in some, to remove the complaint altogether.

Slide 5

Jean Baptiste Pussin

Such was the system which the governor of Bicetre endeavoured to establish on his entrance upon the duties of his present office. Cruel treatment of every description, and in all departments of the institution, was unequivocally proscribed. No man was allowed to strike a maniac even in his own defence. No concessions however humble, nor complaints nor threats were allowed to interfere with the observance of this law. The guilty was instantly dismissed from the service.

Slide 6

In might be supposed, that to support a system of management so exceedingly rigorous, required no little sagacity and firmness.

The method which he adopted for this purpose was simple, and I can vouch my own experience for its success. His servants were generally chosen from among the convalescents, who were allured to this kind of employment by the prospect of a little gain. Averse from active cruelty from the recollection of what they had themselves experienced;—disposed to those of humanity and kindness from the value, which for the same reason, they could not fail to attach to them; habituated to obedience, and easy to be drilled into any tactics which the nature of the service might require, such men were peculiarly qualified for the situation. As that kind of life contributed to rescue them from the influence of sedentary habits, to dispel the gloom of solitary sadness, and to exercise their own faculties, its advantages to themselves are equally transparent and important" -- Pinel, 1801

Slide 7

Jean Baptiste Pussin

Dr. Philippe Pinel at the Salpêtrière, 1795 by Robert Fleury. Pinel removing the chains from patients at the Paris Asylum for insane women

Slide 8

Earlier in the 20th Century

Harry Stack Sullivan

People with psychosis are much more fundamentally human than otherwise

Suffered from psychosis himself, and hired recovered and recovering patients to be staff

Slide 9

The Role of "Peers" in Moral Treatment and beyond

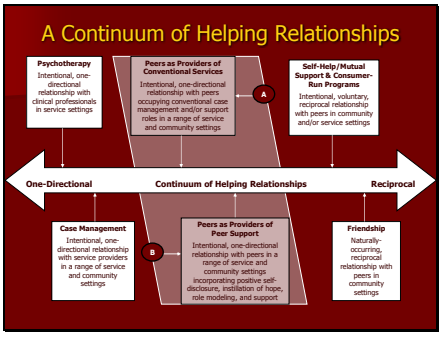
- Pinel did not remove the shackles from the inmates at the Bicetre, Pussin did
- Pinel observed and described Pussin's approach
- Pussin's approach relied heavily on peer workers (convalescing patients, which is what Pussin was when he was hired)
- Dorothea Dix's crusade was fueled by her own experiences of psychosis as well as her sense of social justice
- Role of peers in "therapeutic communities"

Slide 10

Empirical Evidence to Date

- First generation studies showed that it was feasible to hire people in recovery to serve as mental health staff
- Second generation studies showed that peer staff could generate equivalent outcomes to non-peer staff in similar roles
- Third generation studies are investigating whether or not there are unique contributions that peer support can make

Slide 11



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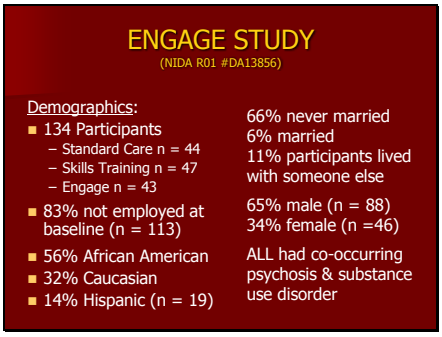

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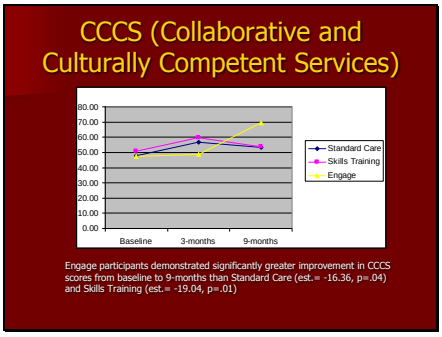

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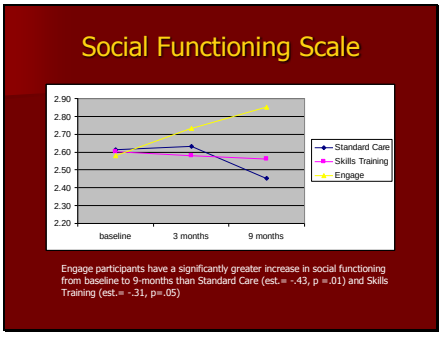

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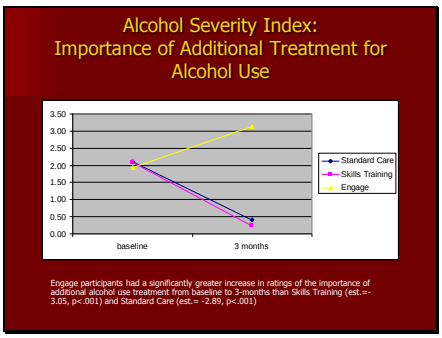
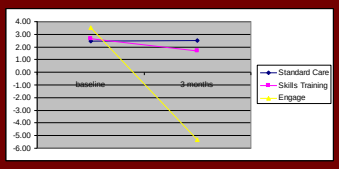


Slide 16

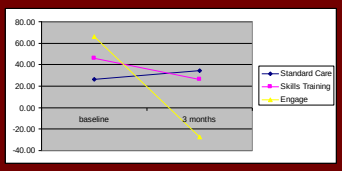
Problems with alcohol in last 30 days



Engage participants demonstrated a significantly greater reduction in problems with alcohol use in the past 30 days from baseline to 3 months than Standard Care (est.= 8.84, p<.001) and Skills Training (est.= 7.89, p<.001)

Slide 17

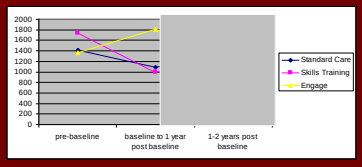
$ spent on Alcohol in last 30 days



Engage participants had a significantly greater reduction in spending on alcohol than Standard Care (est.= 101.49, p =.04)

Slide 18

Total Duration of Services during 1st and 2nd year post-baseline



Engage have a significantly greater increase in time spent in services from before baseline to the first year after baseline than Standard Care (est.=-765.26, p = .04) and Skills Training (est.= -1183.19, p<.001)

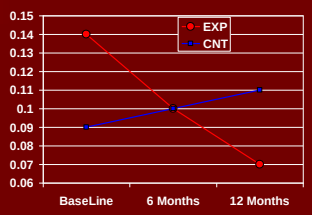
Slide 19

The Citizens Project

- Emerged from work of the CMHS ACCESS (Outreach & Engagement) Project.
- The Premise: Treatment and services alone can't help people become full citizens, i.e., to have a strong connection to the rights, responsibilities, roles, resources, and relationships available to people through public and social institutions and associational life in communities.
- Started as system-level effort of homeless and formerly homeless people, services providers and other community members.
- Now an individual intervention—classes and valued role projects with peer mentor support for persons with SMI & criminal justice charges.
- Was tested through an RCT with DMHAS program funds and Yale Institution for Social and Policy Studies research funds.

Slide 20

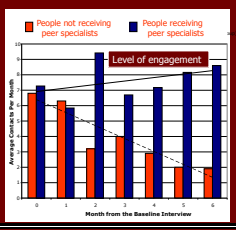
Citizens: Reduced Alcohol Use



Slide 21

Peer Engagement Study

Randomized, controlled trial of assertive outreach with and without peer specialist staff for people who would be considered eligible for outpatient commitment in other states.



Slide 22

Culturally-Responsive Person-Centered Care for Psychosis

(NIMH #R01-MH067687)

Demographics:

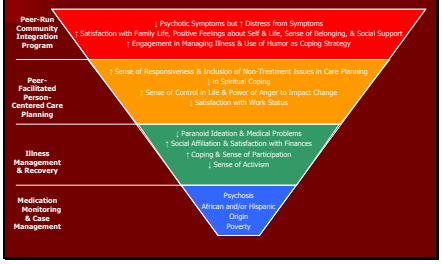
278 participants
- 143 Hispanic origin
- 135 African origin

Conditions
- IMR = 84
- IMR & Peer Advocate = 94
- IMR & Peer Advocate = 100 and Connector

Mean age 44
Average education level 11 years
15% employed
57% male (n = 88)
43% female (n =46)

Slide 23

6-Month Process and Outcome Data



Slide 24

Recovery Mentor Study

- Randomized controlled design
- Inpatients 18 years and older, with a diagnosis of:
  - Schizophrenia
  - Schizoaffective disorder
  - Major depression
  - Bipolar disorder
- Follow up
  - 3 and 9 months

Slide 25

Experimental Condition

"Usual care" plus:

Community-based interactions with recovery mentor as desired by participant

Mentors were trained in
- Engaging people in trusting relationships
- Using positive self-disclosure to instill hope
- Role modeling of adaptive problem solving
- Motivational interventions

Slide 26

Demographics

	Experimental (n=38)	Control (n=36)	
Characteristic	% or Mean (SD)	% or Mean (SD)	P (two-tailed)
Age	42.37 (11.47)	38.69 (8.35)	.12
Male Gender	17 (44.7%)	21 (55.3%)	.24
Race			.37
African-American	12 (32.4%)	9 (25.0%)	
Caucasian	19 (51.4%)	24 (66.7%)	
Hispanic	4 (10.8%)	3 (8.3%)	
Other/Unknown	2 (5.4%)	0 (0%)	
Currently Married (yes)	8 (21.1%)	1 (2.8%)	.02
Number of Hospitalizations in Prior 18 months	3.76 (1.08)	3.94 (1.31)	52
Number of Hospitalization Days in Prior 18 months	40.0 (20.70)	42.31 (19.69)	.63
Diagnosis			.92
Mood Disorder	12 (31.6%)	11 (30.6%)	
Psychotic Disorder	26 (68.4%	25 (69.4%	

Slide 27

Admissions & Days

Condition	Peer Mentor	Usual Care
Participants	38	36
Hospitalizations		
Mean (SD)	.89 (1.35)	1.53 (1.54)
Significance: F = 2.90, df = 1, p = .05 (one tailed) Partial Eta Squared = .04		
Hospital Days		
Mean (SD)	10.08 (17.31)	19.08 (21.63)
Significance: F = 3.63, df = 1, p = .03 (one tailed) Partial Eta Squared = .05		

Slide 28

Admissions & Days by Diagnosis

	Average Hospitalizations				Average Days in Hospital	
Condition	Mentor		Usual Care		Mentor	Usual Care
	N	Events	N	Events	Days	Days
Psychotic	26	.92 (1.41)	24	1.80 (1.68)	11.30 (18.05)	17.39 (21.41)
Non-psychotic	8	.83 (1.27)	6	.91 (.94)	12.13 (20.07)	10.0 (15.46)
Significance: ANCOVA, p (one tailed)	Condition: F = 1.47, p = .12 Partial eta squared=.03 Diagnosis: F = 2.22, p = .07 Cond. X Dx: F = 1.28, p = .13				Cond. F = 1.51, p = .12 Dx. F = 3.96, p = .025 Cond. X Dx: F = 1.23, p = .14	

Slide 29

Significant Differences between Conditions over Time for Intervening Variables

Condition	Drug Use		Hope		Depressed		Poor Self-Care		Well-Being	
	Base-line	9 Mos.	Base-line	9 Mos.	Base-line	9 Mos.	Base-line	9 Mos.	Base-line	9 Mos.
Usual Care	.54 (1.23)	.53 (1.17)	39.03 (11.45)	38.63 (7.75)	4.21 (2.06)	3.20 (1.91)	2.04 (1.40)	2.80 (1.36)	43.56 (28.20)	53.65 (19.76)
Mentor	.85 (1.52)	.05 (.21)	43.467 (12.52)	45.68 (10.59)	4.03 (2.28)	2.64 (1.99)	2.09 (1.69)	1.68 (1.04)	44.70 (29.41)	61.40 (28.41)
Significance	p = .004		p = .04		p = .002		p = .02		p = .016	

Slide 30

Summary

- Addition of peer mentors reduced:
  - readmissions by 42% and
  - days in hospital by 48%
- Addition of peer mentors:
  - Decreased substance use
  - Decreased depression
  - Increased hopefulness
  - Increased self-care
  - Increased well-being

Slide 31

Peer-Delivered Services and Supports in

the Current Health Care Environment

Slide 32

Recovery Support Services in Addiction

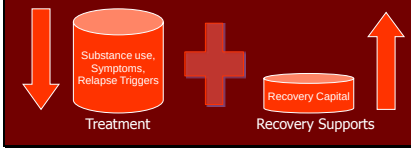
"You need a little love in your life and some food in your stomach before you can hold still for some damn fool's lecture about how to behave"

–Billie Holiday

Slide 33

What are Recovery Support Services?

As a complement to treatment—which aims to reduce or eliminate illness, symptoms, and relapse— recovery support services aim to increase recovery capital.



Slide 34

Recovery Capital is . . .

"the quantity and quality of both internal and external resources that a person can bring to bear on the initiation and maintenance of recovery" (White, 2006)

In contrast to people who achieve "natural" recovery (without care), many people with addictions entering treatment have never had much recovery capital or have dramatically depleted such capital by the time they seek help.

Slide 35

Recovery Support Services include

outreach, engagement, case management (recovery coaching or mentoring), and other strategies and interventions that assist people in gaining the skills and resources needed to initiate and maintain recovery and in establishing a social and physical environment supportive of recovery.

Slide 36

What Recovery Support Services do:

1) enhance the person's "recovery capital" (e.g., by assisting people in addressing their basic needs, gaining employment, going back to school, forming sober social relationships, etc.)
2) remove personal and environmental obstacles to recovery (e.g., through the provision of child care or transportation)
3) enhance identification of and participation in the recovery community (e.g., through connecting people to treatment and to 12-step and other mutual support/recovery-oriented groups)

Slide 37

Recovery Support Services include:

- Recovery guiding or coaching and assistance with addressing basic needs
- Transportation to and from clinical, rehabilitative, and other recovery-oriented, community-focused activities
- Sober and supported housing options such as transitional housing, liaison with landlords, etc.
- Post-treatment monitoring and support designed to assist people in establishing and/or maintaining engagement in services and positive activities
- Social support and community engagement services, such as recovery community centers or recovery groups designed to assist people in building positive community connections, discover positive personal interests, give back, and take on valued social roles
- Educational and vocational supports
- Legal services and advocacy

Slide 38

When provided by people in recovery, recovery support services also offer:

- Hope and positive role modeling
- Recovery education and mentoring
- Assistance in navigating social service and recovery service systems
- Assistance in asset mapping and connecting with community resources, welcoming community destinations, and informal community associations that support recovery

Slide 39

That all sounds nice, but …

… especially in times of budget constriction, when we don't even have enough funding for "core clinical services," aren't these luxuries we can't afford to provide?

… and even if we could, wouldn't this just enable the person to continue to use?

… or aren't these just for people with (co-occurring) serious mental illnesses?

Slide 40

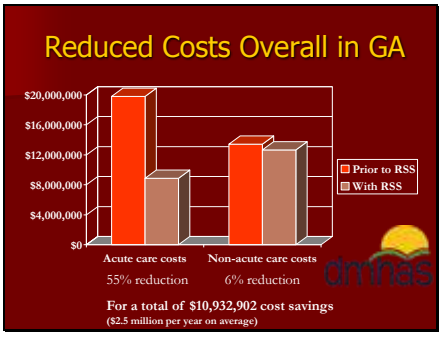
And the answers are:

- No
- No

And

- No

Slide 41



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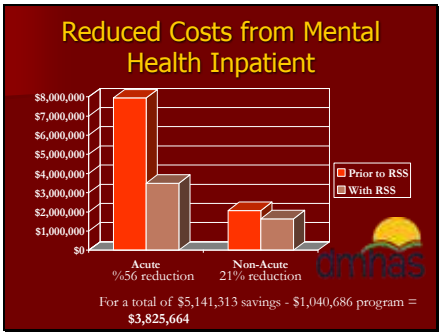

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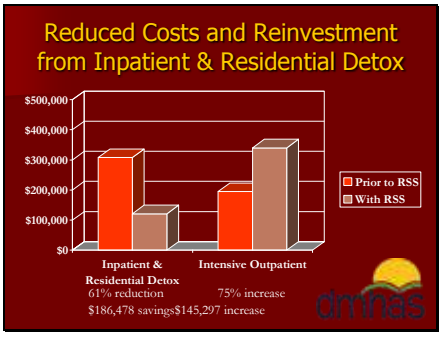

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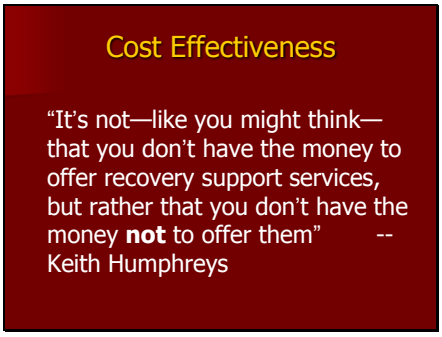

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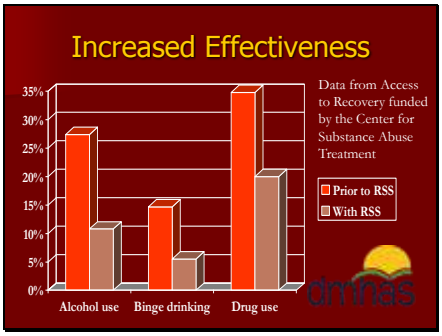

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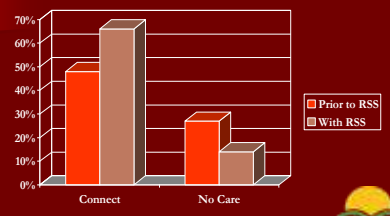
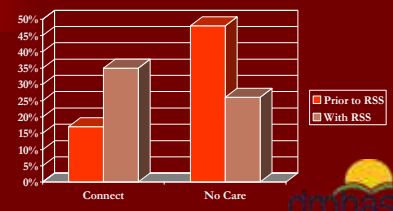
Connection from Acute Care



37% increase %49 reduction

Slide 47

Connection from Non-Acute



105% increase 45% reduction

Slide 48

Effectiveness

"… at times described as people with 'refractory' addictions or as 'unresponsive' to treatment (or castigated with such stigma-laden labels as 'frequent flyers' or 'retreads'), such individuals may perhaps be better understood as being in need, not of more addiction-related losses in their lives (their capacities for such pain are often immeasurable), but of additional recovery capital. Put simply, the major obstacle to recovery may be more the absence of hope than the absence of pain"

-- Bill White

Slide 49

Health Care Reform

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

Slide 50

Navigation

- scheduling appointments
- arranging for child care
- reminding people of appointments
- providing transportation to and/or accompanying people to appointments
- providing information, education, support, and encouragement

Slide 51

Outcomes

Navigation services have targeted underserved populations, and have led to increased rates of engagement and retention, as well as improved trust and communication between patients and health care providers, both of which have contributed to improved adherence and self-care.

Slide 52

Examples

- Decrease in high-risk behaviors for HIV
- Decreased infant mortality
- Decreased psychiatric symptoms
- Significant decreases in HbA(1c), body mass index, total cholesterol, LDL cholesterol, and systolic and diastolic blood pressure among persons with diabetes

Slide 53

Patient (behavioral) Activation

- helping people prepare for health care visits and ask questions;
- identifying and setting health-related goals;
- planning specific action steps to achieve goals;
- encouraging exercise and good nutrition;
- assisting in daily management tasks;
- problem solving;
- providing social and emotional support and feedback;
- and following up with people over time

Slide 54

Outcomes

- improved health behaviors
- improved clinical outcomes
- improved quality of life

Slide 55

Discussion

- Evidence base is growing along with expansion of peer workforce
- Health care reform represents an unprecedented opportunity to solidy the role of peers in mental health
- What needs to be done to take advantage of this opportunity?
- The need for self-care for peer staff

Medicaid and Behavioral Health – New Directions

John O'Brien
Senior Policy Advisor
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services

September 24th, 2012

Role of Medicaid with Behavioral Health

- Major Drivers
  - More people will have Medicaid coverage
  - A significant number of those individuals will have behavioral health issues
  - Medicaid will play a bigger role in MH/SUD than ever before
  - Focus on primary care and coordination with specialty care
  - Major emphasis on home and community based services and less reliance on institutional care
  - Early identification, preventing chronic diseases and promoting wellness is essential

What's on Our Radar Screen?

- Ensure that people understand and have the opportunity to enroll in the Medicaid program
- How to best encourage benefit designs that promote or test evidenced based practice
- How to address provider capacity issues to promote access to services
- Ensuring that approaches look at the whole person—primary care, behavioral health and long term services and supports

Issues

- States may lack the capacity to provide mental health and substance abuse to individuals with behavioral health disorders
- States will need to understand the requirements set forth in MHPAEA
- Increasing pressures to promote community integration in community-based settings for individuals with mental illness, substance use disorders and other disabilities.
- Behavioral health providers often do not have access to emerging health information technology capability to better integrate primary and behavioral health care for the Medicaid population.
- Without adequate integration, mental and substance use disorders will continue to be major drivers in the cost of health care.

Guiding Principles

- Preventing and treating mental illness and substance use is integral to overall health.
- Services and programs should support health, recovery and resilience for individuals and their families who experience mental or substance use disorders.
- Individuals and families should have choice and control over all aspects of their life, including their mental health and substance use disorder services.
- Services should be of high quality and consistent with clinical guidelines, evidence-based practices or consensus from the clinical and consumer communities.
- Services should maximize community integration

Goals for Behavioral Health

- Goal One: Effective use of screening to mental and substance use disorders, including strategies to refer and effectively treat individuals with these conditions.
- Goal Two: Increased access to behavioral health services for persons with serious and/or chronic disorders.
- Goal Three: Goal: Improved integration of primary care and behavioral health, and in some instances, long term services and supports to obtain better health outcomes for individuals with mental and substance use disorders

Goals for Behavioral Health

- Goal Four: Better availability of Evidenced Based Practices to enhance recovery and resiliency and reduce barriers to social inclusion
- Goal Five: Strategic development, implementation and testing of new benefit design and service delivery with models that are taken to scale.

Vehicles for Implementing Goals and Strategies

- Efforts underway to implement new opportunities created under the Affordable Care Act
  - ✓ Health Homes for Individuals with Chronic Conditions
  - ✓ Community First Choice State Plan Option
  - ✓ Balancing Incentive Program
- Expansion and increased flexibility of current Medicaid programs
  - ✓ Money Follows the Person
  - ✓ 1915(i) State Plan Option

Balancing Incentive Program

- Enhanced FMAP to increase diversions and access to HCBS, effective October 1, 2011
  - ✓ 2% if less than 50% LTSS spending in non-institutional settings
  - ✓ 5% if less than 25% LTSS spending in non-institutional settings
- SMD letter and application published September 12, 2011
- User Manual released October 14, 2011

Money Follows the Person

- Affordable Care Act extends and expands through 2016
- Offers States substantial resources and additional program flexibilities to remove barriers
- 43 States plus District of Columbia participate
- More than 20,000 transitioned from institutional settings to home and community based settings
- Enhanced match used to build HCBS capacity and create infrastructure necessary to help sustain rebalancing long-term care systems

1915(i) State Plan Option

- Section 1915(i) established by the DRA of 2005
- State option to amend the state plan to offer HCBS as a state plan benefit; does not require institutional LOC
- Modified under the Affordable Care Act effective October 1, 2010 to allow comparability waivers, add "other services"
- States cannot waive statewideness or cap enrollment

What Are The Workforce Implications?

- Increasing demand for LTSS services, especially mental health and substance use (MH/SUD) disorder
- Supply of MH/SUD workers not growing fast enough to keep up with demand
- Trend toward home and community-based services raises new challenges
- Quality of services depend on quality and stability of workforce
- Cost of turnover

What Are We Concerned About?

- Isolation/limited supervision/ limited peer support
- Limited availability of training/credentialing systems
- Part-time work
- Lower wages and fewer benefits compared with other health care jobs
- Higher transportation costs

What Else Are We Seeing?

- Lack of education and supports for peer specialists
- Skepticism of the organization and staff in recovery concepts and the value of peer supporters.
- Confidence of peer supports who have been disenfranchised for so long.
- Education and clear job expectations.
- Role confusion (am I a staff, am I consumer).
- Peers trying to direct or "do for" their peers.

Good News

- Peer specialists are included in all health home proposals that include individuals with a significant MH condition
- Peer Specialists/Caregiver to Caregiver supports were included in 4 or the 9 PRTF Demonstrations (started in 2007)
- Peer supports is included in many State Plan Amendments (2007 SMD Letter)

Good News

- BIP allows and encourages states to include peer specialists and recover services when calculating the balance
- Most recent 1915is include peer specialists as distinct serve or as one of the provider qualifications
- Additional guidance regarding peer specialists and family support specialists forthcoming

What Can CMS Do?

- **Provide vision, leadership and guidance to states on workforce development, especially development of peer support opportunities.**
- **Ask states about their plans for workforce development and improvement every time they apply for a discretionary grant, submit a SPA or waiver application, propose other kinds of program changes.**

What Can CMS Do?

- Ask states if their workforce policies (e.g., service rates, training programs, quality improvement initiatives) are consistent across settings and across populations. Are inconsistencies causing disincentives to rebalancing?
- Promote data collection about workforce status and outcomes of workforce improvement initiatives (e.g., NBIP and PHI State Data Center)
- Refer State Medicaid staff to the DSW Resource Center for technical assistance and provide expert feedback on DSW Resource Center

Sue Bergeson – VP Consumer Affairs, Optum

Credentialing: Why having a state or national credential supports the growth and sustainability of peer programs from a MCO perspective

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Some of us might see having a national or state credential for peer services as confusing

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Some might see it as obvious

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Some might see it as painful

Others might see it as sending the wrong message

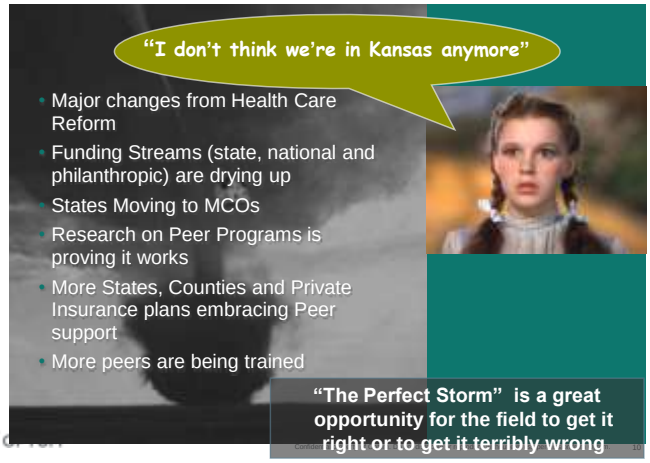
But no matter how you see it, I think we can all agree that if it is going to happen, it should not occur through an automatic process without us

Because sometimes automation can lead to unexpected outcomes

And sometimes automation can lead to unwelcome outcomes

So why do Managed Care companies care if peer services are credentialed and why do we care if they notice whether they are or are not?

The World is Changing and Creating the "Perfect Storm"



- Major changes from Health Care Reform
- Funding Streams (state, national and philanthropic) are drying up
- States Moving to MCOs
- Research on Peer Programs is proving it works
- More States, Counties and Private Insurance plans embracing Peer support
- More peers are being trained

"The Perfect Storm" is a great opportunity for the field to get it right or to get it terribly wrong

With apologies to David Letterman, here is my top ten list of why the field might consider adding a national credential

Reason #10: Accreditation Creates an Even Playing Field among all peer programs and across all locations

Reason #9: Accreditation communicates the value of what Peers are offering in terms others understand

Reason #8: Right or wrong, like it or not, change is occurring. Many states are moving to MCOs so if we want to receive state funding for peer services, we will likely need to figure out how to work with MCOs

How Does Managed Care Work?

- The Managed Care Organization and the employer/state/government purchaser agree to a contract, which outlines benefits and limitations of services.
- MCO seeks certified/credentialed providers for a network based on the needs outlined in the purchaser contract, checks the credentials and engages them in the network
- Providers agree to a contract with the MCO that sets the fees
- Consumers/families are referred to providers within the network
- Some services require authorization before access, based on the purchaser contract
- Consumers who are more intensive users of services may be offered enriched services (based on the purchaser contract, level of care guidelines and evidence that the service works)
- Providers submit payment for the services using the federal codes and modifiers agreed to for the services
- MCO reviews submission to ensure it is within the contracted services for each employer contract
- Checks are cut
- Quality and compliance audits are done
- Consumer and provider satisfaction and utilization tracked and trended

Reason #7: The MCO Network is built based on expected supply and demand as well as accepted quality standards

Reason # 6: Accreditation is important to MCOs to ensure quality standards

Reason #5: MCOs can provide sustainable income that allows peers and peer programs to work instead of exhausting themselves trying to raise funds to keep their doors open

Reason #4: Peers can be paid for services using their hard earned skills. Payment for services allows many to raise their quality of life, perhaps making purchases they otherwise might not be able to afford - like going out to dinner.

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"All I want is a chance to prove money can't make me happy."

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Reason #3: It opens up the care system to more creative options when we can offer peer services as a routine service for millions and not just an important services accessed by thousands who are lucky enough to find us

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Reason #2: It puts peer runs services on the same playing field as provider run services.

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"Somebody has to do something, and it's just incredibly pathetic that it has to be us."

--the late Jerry Garcia of the Grateful Dead

Reason #1: If we don't someone else will

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So as our community tries to understand what the signs reveal about the future

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We might find them confusing

We might hope the signs are wrong

We might wish the signs mean something else

We might consider whether they have different meanings

At the end of the day, we need to do what we have always done: we need to face our obstacles, and turn them into opportunities so we can grow

OPTUM

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential**.**

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Slide 1

Slide 2

Pillars of Peer Support Summit
Atlanta, Georgia
September 24, 2012

Wilma Townsend, MSW
Associate Director for Consumer Affairs
Center for Mental Health Services (CMHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)

Slide 3

Definitions and Distinction Among Terms

- Standards
- Certification
- Accreditation
- Licensing

Slide 4

Standards

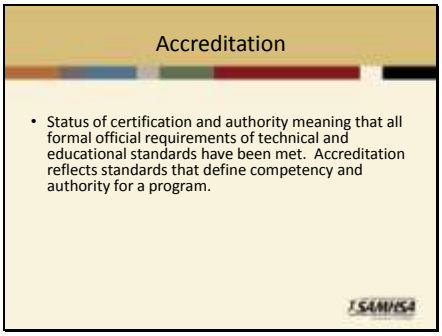
- Rules or principles that are used as a basis for judgment established by an authoritative entity
- Based on values, ethics, principles and competencies

Slide 5

Certification

- Process of completing technical, educational and practical requirements defined by a profession that qualifies an individual to practice that profession.

Slide 6



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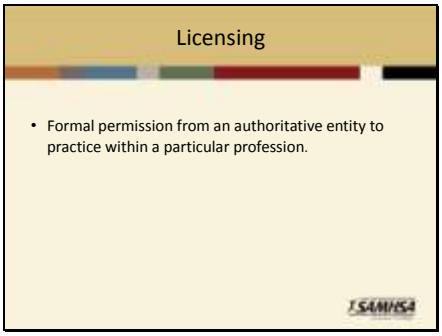

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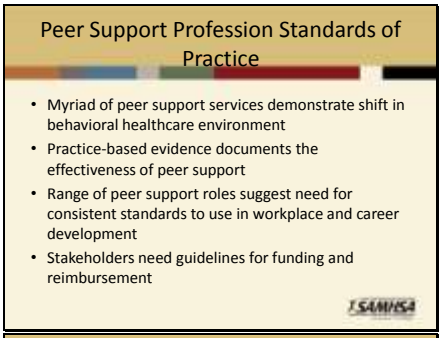

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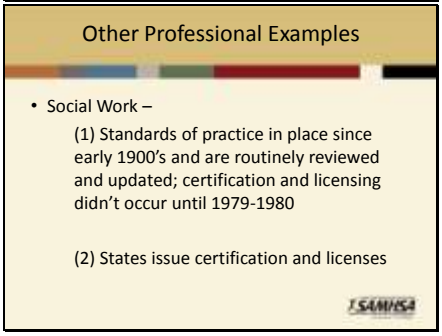

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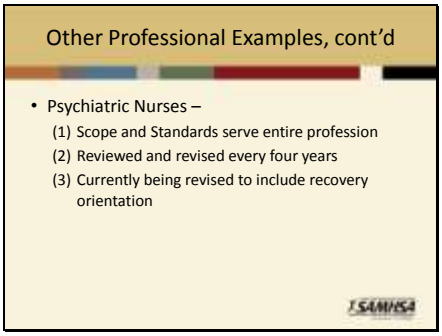

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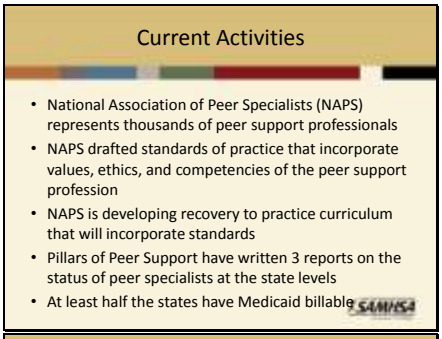

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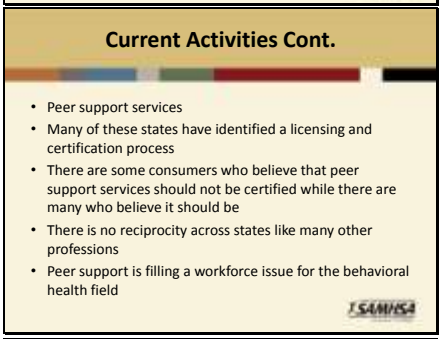

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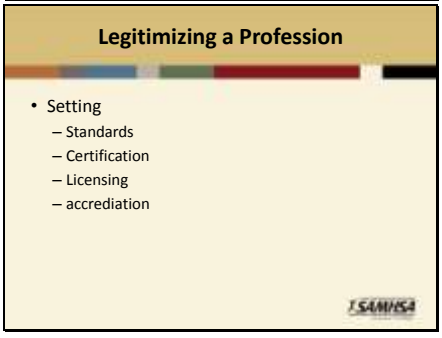

Developing National Credentialing and Standards for Peer Support Specialists
Benefits, Challenges and Opportunities

Pillars of Peer Support
September 24 – 25, 2012
Atlanta, GA

Pam Werner
Michigan Department of Community Health
320 S. Walnut
Lansing, MI
48913
wernerp@michigan.gov

Benefits of National Credentialing

- Opportunity to work in multiple states
- Uniform standards of ethics
- Career ladder
- Recognized in states who do not have defined criteria and an established training program
- Developed by peers in partnership with stakeholders

Challenges and Opportunities

- Developing a credentialing process with consensus
- Qualifying trainers requiring continuous quality peer review
- Implementing a model for mentoring, coaching, supporting national trainers
- CEU process to maintain credentials
- Meeting individual state requirements
- Financing the development, implementation and ongoing activities

Michigan Certified Peer Support Specialists 1027 Strong!

USPRA US Psychiatric Rehabilitation Association

Pillars of Peer Support Services Summit IV

Panel #1: Establishing National Credentials/Standards

Tom Gibson

Interim CEO

United States Psychiatric Rehabilitation Association - USPRA

USPRA US Psychiatric Rehabilitation Association

About the Presenter

- CEO, Coulter
  - Award-winning, nationally accredited Association Management Company headquartered in McLean, VA with 85 staff managing 17 nonprofits
  - Focused on fueling relevance & sustainability for high potential nonprofit organizations that help drive social and societal purpose
  - Former federal lobbyist
  - 25+ years executive experience in helping move nonprofits from *good to great*
  - Heavy focus on enhancing the *business model* and *business performance* of nonprofits as the most direct path to doing "good"

www.uspra.org

USPRA US Psychiatric Rehabilitation Association

About USPRA

- Core Mission: Supporting Recovery Through the Development and Empowerment of a Recovery-Oriented Workforce & Implementation of Evidence-Based Practices
- How?
  - National Certification Program
    - CPRP – Certified Psychiatric Rehabilitation Practitioner, the Standard for the Professional Provision of PSR Services
  - Knowledge dissemination and exchange
    - Online and in-person trainings
    - Annual Conference
    - Psychiatric Rehabilitation Journal and associated publications
    - Peer-to-Peer networking through a nonprofit membership framework
  - Federal and State Advocacy
    - Expanding the knowledge and embrace of the Workforce of Recovery by federal and state policymakers

www.uspra.org

USPRA US Psychiatric Rehabilitation Association

USPRA's CPRP Credential

- Benefits:
  - Assures practitioners have met independently developed criteria to ensure knowledge, skills and experience in the provision of psychiatric rehabilitation services that support recovery
  - Protocol for candidate evaluation, exam development, administration and recertification is consistently updated
  - Currently in excess of 2,600 CPRP's worldwide with an estimated 15% - 20% of CPRP's being peers in recovery
  - In the United States, 15 states recognize and/or endorse CPRP as Medicaid reimbursable

USPRA US Psychiatric Rehabilitation Association

Establishing a National Credential and Related Standards

- Minimum Requirements
  - Clear, compelling marketplace need
    - Thousands of persons have obtained, and a near majority of states have recognized the CPRP, a ratification of marketplace need
    - Today, CPRPs worldwide are helping drive affirmative recovery outcomes
  - The framework and related superstructure to accomplish these goals is steeped in 40 years of science and practice
    - The USPRA Certification Commission for Psychiatric Rehabilitation provides an existing, organized and experienced operating structure, supported by professional full-time staff management, all operating under the aegis of a national nonprofit organization
  - Initial funding and an ongoing economic model which supports the validity and sustainability of the credential
    - Successful credentialing program launch requires significant initial funding coupled with considerable year-over-year investment. CPRP Year 1 startup costs were close to $750K in present value dollars and in 2012, the CPRP program will incur $400,000+ in total expense. A self-sustaining economic model is essential … absent a compelling business model, the program will lack the resources required for launch and sustainability
  - Solid Partnerships which Advance Objectives
    - As an example, USPRA recently executed a new partnership relationship with the American Psychological Association to further expand and enhance the Psychiatric Rehabilitation Journal, the leading publication on recovery and recovery-oriented services and a valuable tool in advancing recovery outcomes

www.uspra.org

USPRA US Psychiatric Rehabilitation Association

Where You Stand Depends on Where You Sit …

- Where USPRA Sits in RECOVERY
  - Shared desire for high-quality recovery outcomes, delivered in an intelligent, efficient and results-driven way
  - USPRA deeply supports the principles and values of recovery
  - The CPRP Credential has set the standard for the professional provision of psychiatric rehabilitation
  - The CPRP Credential is uniquely situated to provide career pathways designed to meet the unique needs of peer providers while supporting workplace integration and equity
  - The CPRP is the only professional credential in mental health that meets the needs of the entire behavioral health care workforce to support the role of recovery and enhanced functioning for persons in recovery

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The Path Forward …

- USPRA's Offer
  - Ensure the CPRP credential continues to embrace and provide clear and compelling career paths for people in recovery
  - Serve as a convener, bringing the parties together in the refinement and enhancement of a prospective peer provider credential that delivers tangible, measurable improvements in recovery
  - As appropriate, assess if and how USPRA's established superstructure and credentialing expertise may assist in the leveraging of peer support credentialing
  - Advanced credentialing opportunities to the behavioral workforce in critical areas of service need - children's mental health, the integration of physical and mental health care, and elder wellness management of persons in recovery

USPRA US Psychiatric Rehabilitation Association

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www.uspra.org

HOW RECOVERY HAPPENS

Personal moments can motivate people in recovery and behavioral health professionals

BY LORI ASHCRAFT, PhD, AND WILLIAM A. ANTHONY, PhD

The road to recovery looks different for each person—it is a very personal experience. However, some common occurrences often are shared by most people who choose this path. Over the past few years leaders in the recovery movement have identified several common steps along this path. Among them are LeRoy Spaniol, PhD, and his colleagues at Boston University, who have been conducting several qualitative, longitudinal analyses of individuals' recovery experiences.[1-4]

Dr. Spaniol and colleagues have identified four broad, overlapping phases of recovery that people move between: overwhelmed by the disability, struggling with the disability, living with the disability, and living beyond the disability. Furthermore, they have identified three factors associated with the degree of challenge to recovery: comorbid substance abuse, environmental context, and age of disability onset.

Mark Ragins, MD, medical director at The Village Integrated Services Agency in Long Beach, California, is another leader in this area (The Village offers a comprehensive program for people with serious mental illnesses). Dr. Ragins describes four fluid stages of recovery: Hope, Empowerment, Self-Responsibility, and Meaningful Role in Life.

Similarly, recovery services provider META Services, Inc., in Phoenix calls for an attitudinal prerequisite of love and identifies five recovery pathways: hope, choice, empowerment, environment, and spirituality.

These three models and others have a lot in common. So many of us try to use models to describe recovery because it gives us a map we can follow and redraw for each person who comes down the recovery path, thereby establishing an approach that works for most people. Models can be useful but are limited in their ability to accommodate subtle internal shifts that define the process of recovery on a personal level.

Let's examine the personal process of recovery and what happens "in the moment" as the process unfolds. In interviews with people in recovery and employed at META Services, we often hear interviewees describe a moment of choice—an opportunity to choose a new way to respond. They describe a brief, unfamiliar mind-space in which they see a glimpse of themselves from a new perspective, not reacting in familiar ways to external and internal stimuli. The moment they describe is the moment immediately preceding a trigger or symptom. In that moment, there is a *split* second when they can either surrender to the symptom, reacting in habitual ways, or they can choose a new path leading to further recovery.

IN THIS DEPARTMENT
Behavioral Healthcare **provides guidance on operational transformation to meet the increasing call for recovery-based systems.**

When asked how they felt in that moment, interviewees often said, "I don't know. I've never been here before." However, they found that if they could stay in that moment long enough to get their bearings, they could make some choices about how to respond—follow the familiar path or choose a new path leading them further along their journey to recovery. Dr. Spaniol refers to these latter times as "upward turning points" which, as they accumulate over time, represent an awakening sense of self and agency and a growing awareness of one's own ability to develop a satisfying and contributing life.[4]

Here's how Lori describes her own internal process during these moments:

> There have been times when I haven't been able to stay in that moment and have found myself so overwhelmed by a symptom that I didn't have any choice but to surrender to it. When I have been able to stay in that moment, I've been able to choose other options that have helped me grow and learn new ways of moving ahead.... There is something seductive about symptoms—they are familiar ground, they give definition to who we are and what we're experiencing, and they usually cause others to either excuse us, or try to help us. So when we don't surrender to them, we're on

new ground—unfamiliar, undefined, and while it feels unreal, in fact, it is what's really real. With it comes a feeling of being free from the mind-prisons that previously limited our ability to respond in new ways and recover.

As you might have suspected, this process is not unique to people with mental illnesses. It is the process by which most of us learn and grow. Perhaps those pursuing recovery are more acutely aware of it because they are usually highly motivated to regain parts of themselves temporarily lost during their illness. The journey back to wholeness often requires attention to this level of detail if recovery is to unfold.

If you are interested in furthering the transformation that recovery can bring to your program, we suggest you also consider this as a path that can further your own professional transformation. The next time you have a choice to do things the way they always have been done or to do them in ways that would further the recovery opportunities for people using your programs, stay in that moment long enough to get inspired. Gather the courage to step out onto new ground, and take a stand for doing things in ways that really provide recovery options. It's in those unfamiliar, undefined moments that *you* emerge. You'll know you're there because you'll feel somewhat lonely, and at the same time connected to something beyond yourself. Just remind yourself that a lot of us have stood there before, and we're sending you courage and hope.

People recovering, as well as behavioral health professionals and administrators, must take the opportunity to realize the possibilities the recovery movement is providing, or we will lose the momentum to improve the way we deliver services. This is a cause we all have to get involved in; we can't pretend to be a player just by changing the sign on our door. This transformation calls for a change of heart, a change in power structures, and a change in the way we heal together. ■

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. To send comments to the authors and editors, e-mail ashcraft0906@behavioral.net.

New Professional Association for Peer Specialists

Stakeholders in recovery-based psychiatric services created the National Alliance of Peer Specialists at a Philadelphia meeting in July. The professional association aims to promote the emerging profession of certified peer specialists—people in recovery from psychiatric disabilities who are employed to help their peers work toward their own recovery.

"Peer specialists offer hope because they're walking, talking examples of recovery," said Joseph A. Rogers, president and CEO of the Mental Health Association of Southeastern Pennsylvania (MHASP), which organized the meeting and is advancing the peer specialist initiative in Pennsylvania. Peer specialist services are expected to be Medicaid reimbursable in the Keystone State beginning next month. Other states, including Arizona, Georgia, Iowa, Michigan, and Washington, along with the District of Columbia, already pay for such services.

For more information, visit www.mhasp.org/presspeer.pdf.

Douglas J. Edwards

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CIRCLE 6 ON READER SERVICE CARD

Issue Date: June 2009

What a recovery organization looks like
Targets you should aim for to promote people's healing

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

In your quest to make your organization recovery oriented, you may feel like you are boldly going toward something, but aren't sure what. What does recovery look like? What does it feel like? How will you know when you get there? Perhaps a more controversial question is, How do we measure it?

We think these are pretty good questions. If you've been asking them, you probably are on the right track. So this month we describe some outcomes for you to aim for as you hurtle headlong toward that often elusive target called “recovery.”

Before we get started, you may be interested to know that several evaluation instruments have been developed to measure recovery in behavioral healthcare organizations. Bill and his team at Boston University have created some very helpful tools, and Priscilla Ridgway and Larry Davidson, both at Yale, each have developed sophisticated ways of measuring an organization's recovery progress. This article is not in that league. Its purpose is to provide you with sort of a *Reader's Digest* version of recovery targets you can take aim at within your organization.

A welcoming environment

First, it's important to realize that becoming a recovery-based organization involves a lot more than adding the word “recovery” to your front door. This has happened not infrequently across the country and has become a major disappointment to a variety of funding sources and service participants alike. Unfortunately, having “recovery” on the front door has become meaningless.

What we would look for instead is a *welcome sign*. Yes, a welcome sign-imagine that! What if your organization had a big welcome sign on the front door? A subtitle might be, “Thanks for giving us an opportunity to partner with you on your recovery journey!” Such a sign commits the organization to being welcoming and friendly, as well as sets the stage for a recovery partnership. If we saw a sign like this on your front door, we would know you are willing to step out and create opportunities and environments that support recovery.

A welcome sign would tell us that your organization is committed to shifting its culture toward recovery-not just for participants, but for your staff and the entire organization. Once we got inside, we would look for a comfortable setting that was not intimidating and that reflected respect and dignity for those who receive services. Ideally, it would be clean and fresh, and there would be greeters instead of security guards, friendly and respectful receptionists, and positive signs on the walls that don't start with the word “no” (as in no smoking, no loitering, and so on).

Recovery-minded staff

Next, we would check out the staff. Here are some questions we would ask ourselves as we talked to them:

- Are they welcoming and friendly? What do they do to connect with people?
- Do they understand and practice the importance of developing real relationships with people?
- Are they hopeful and excited about each person's plans and goals?
- Do they have high expectations for themselves and for the people they are serving?
- Are they inspiring and encouraging?
- Do they treat each other and the people they serve with dignity and respect?
- Do they have knowledge of recovery values?
- Do they use recovery language?
- Do they offer people choices and avoid force and coercion?
- Are they willing to partner with the person in “risky” choices?
- Are service users trained and hired as peer employees?

In addition, we would look for shifts in practice. From what we can tell, most staff have not been trained to elicit recovery responses, although some of them do it despite their training. Teaching staff recovery practices should be a high priority for a recovery-oriented organization. Answers to four broad questions would give us an idea of practice priorities:

- Have staff been trained in recovery practices, and is there a way for them to continue learning new recovery skills?
- Do staff have confidence in their ability to help a person recover, as well as confidence in the person's ability to recover? If not, this is a major cause of burnout that can be addressed, usually through interesting and provocative training.
- Are staff able to use negative or challenging circumstances as learning opportunities for both themselves and for the service user, instead of experiencing them as failures?
- Is there an attitude of mutuality and partnership?

Inclusive documentation

Then we would take a look at the organization's paperwork and documentation. We would hope it wouldn't be boring and/or complicated. We would look for signs that the service user was the primary participant in the planning process, as well as that attention had been given to involving family and friends as supporters. Beyond this, we would ask ourselves these questions:

- Does the treatment plan aim for self-determination?
- Who seems to “own” the treatment plan? Is it the person? If so, does he/she know what is in the plan? Does it have any meaning for him/her? Or is it owned by the staff? The organization?

- Is there an expectation that the person will recover and not just become “stable”?
- Has the person been given information about the organization and its goals so he/she understands what is supposed to happen and what to expect?
- Do forms use recovery language, and are they written in first-person language?
- Is there a plan to periodically review the person's plan and measure accomplishments and progress toward goals? (This is about accountability for both the person and the staff.)

Empowered people

We also would examine the organization's distribution of power. Where is it? Who has it? How is it used? These are some of the most important questions to ask when determining the extent to which recovery is present in an organization. Since the person has to take the lead in his/her recovery process, he/she is the one who needs the power. The organization's job is to ensure it transfers power to the person. Here are some signs we would look for in a power shift:

- Have staff been trained in transferring power to service participants? Are they skilled and knowledgeable in ways of empowering people to take the lead in their recovery process? Are they reluctant to give over the power for fear of creating risk?

- Has the “agreement” to “fix” people been changed to an agreement to empower people so they can be instrumental in their own transformation?
- Have participants been trained to recognize their own strengths and potential? Are their strengths and potential reinforced constantly by organizational interventions?
- Have people been informed about their rights and responsibilities in the recovery partnership?

Focus on strengths

In addition, we would look for the organization's focus. Here are some clues we would look for:

- Is the organization, through staff, documentation, and orientation, focusing on what is strong or what is wrong with each person? Obviously, we would want to find a focus on what is strong in both the staff and people being served. This also would give us a glimpse of the “spirit” of the organization.
- Is there a focus on each person's abilities and accomplishments-a “whole person” focus instead of a singular focus on challenges?
- Are challenges viewed through the lenses of potential instead of past disappointments?
- Is the focus on the person rather than his/her problems?

Talking recovery

Since recovery is mobilized through conversation, we would look for a dialogue with people that promotes recovery. Here are some specifics we would look for:

- Is the conversation among staff, and between staff and people served, carried out with recovery language and not jargon or clinical/illness-based language?
- Is the conversation more about listening instead of directing?
- Is the conversation inspiring instead of controlling and managing the person?
- Is there a lot of talk about choices and options?
- Is there an absence of threat and coercion?
- Is there talk about recovery instead of just stability?
- Is the conversation sequenced to build self-confidence?

Recovery-oriented policies and procedures

Finally, we would be remiss if we didn't bring up issues related to policies and procedures. Since most policies were developed before we knew recovery is possible, they tend to get in the way of the recovery process, instead of enhancing it. So we would check out your policies. Do they promote recovery, or do they hold it back? You may be tempted to put off rewriting policies since it's a tedious task, but try to make it fun. Ask your service participants and staff to get involved in rewriting them. Use action-oriented language. You may need to pay attention to staying out of your own way by not letting your own fears about the barely visible course you've charted worry you.

Conclusion

Remember that setting targets is a way of making a commitment and creating some accountability. We often are reluctant to set targets (even though we insist on making the people we serve do so) because once we do, our success can be measured (Some rationalize that it's better to be vague in case we fall short). But transformation requires courage, guts, and risk taking, so we encourage you to go for it. As Ralph Waldo Emerson pointed out, “When skating on thin ice, our safety is in our speed.”

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Behavioral Healthcare 2009 June;29(6):10-13

Creating Recovery Cultures that Support Peer Specialists

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It all begins with HOPE

HOPE

It started with a little understanding
Then came a little compassion...

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No more seeing myself
Through the eyes of others
Or walking a path not of my choosing...

Excerpt from "Hope" by Kim Cowgar

OUR MISSION

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Taking a national look at

- Culture shift in a large system
- Enhancing knowledge and skills to create recovery cultures

2012 VA PEER SPECIALIST BENCHMARKS

2004: VA strategic plan agenda recommendation: "Hire veterans as Peer-Mental Health Paraprofessionals" (Commission Rec. 2-3.18 & 19, Appendix 1)

2008: *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics* states that "all veterans with SMI [serious mental illnesses] must have access to Peer Support" (2, pg. 28)

Source: Mark Salzer, PhD – Temple University Collaborative on Community Inclusion

UNIFORM MENTAL HEALTH SERVICES IN VA MEDICAL CENTERS AND CLINICS, VHA HANDBOOK 1160.01 September 11, 2008

(1) All medical centers and very large CBOCs must provide individual or group counseling from peer support technicians for Veterans treated for SMI when this service is clinically indicated and included in the veteran's treatment plan.
(2) Other CBOCs must make peer counseling available for Veterans with SMI when it is clinically indicated and included in the veteran's treatment plan. Peer counseling may be made available by telemental health, referral to VA facilities that are geographically accessible, or by referral to community-based providers using contract mechanisms.

Contracts for peer support services must ensure that peer providers have competencies and supervision equivalent to those required in VA facilities.

Commitment to trained/certified peer staff

- VA values peer support certification
- If not already certified upon hiring, peer support staff must demonstrate competency in the principles of peer support by the end of their first year of employment
- Volunteers are also required to demonstrate the same competencies
- VA Peer Support Training Manual was developed and released in June 2011; provides training on the skills, knowledge, and abilities needed to be competent in the provision of peer support
- National VA Peer Specialist training/certification contract will be implemented in 2012-13

2012 Expansion of VA peer support positions

500 new peer staff to be hired by December 2013; total # of peer support staff to reach 800 nationally

3 peer staff at each VA Medical Center and 2 at each very large Community-Based Outpatient clinic (CBOC)

New staff must meet qualifications outlined in PL 110-387:
- have a lived experience/be in recovery from mental health condition or substance use disorder
- be a Veteran
- be certified through a VA-approved or their state-approved certification process

2010 VA PEER SPECIALIST SUPERVISION SURVEY

"We are just like everyone else working at the VA … everyone has issues that they deal with. We just talk about ours a little more."

(VA peer support provider)

""[Peer support providers] are like you and me, and they are bright [and] intelligent, and we could learn so much from their first-hand experience."

(VA Supervisor)

2010 VA PEER SPECIALIST SUPERVISION SURVEY

DBSA Consumer and Family Survey Center

- N = 44 Peer Support Providers & 33 Supervisors

Key result areas addressed:

- Supervisor role knowledge
- Advocacy and trust
- Peer Provider ethics
- Elements of supervision

2010 VA PEER SPECIALIST SUPERVISION SURVEY

***PSPs*: "I believe that my supervisor received needed information and training before beginning his/her role as a supervisor of a peer support service provider."**

- Agree strongly: 52%

***Supervisors:* "I received needed information and training before beginning my role as a supervisor of a peer support service provider."**

- Agree strongly: 39%

Supervisor Role Knowledge

2010 VA PEER SPECIALIST SUPERVISION SURVEY

PSPs:

"My supervisor understands my role as a peer support service provider."

- Agree strongly: 64%

Supervisors:

"I understand the role of the peer support providers I supervise."

- Agree strongly: 94%

Supervisor Role Knowledge

2010 VA PEER SPECIALIST SUPERVISION SURVEY

PSPs:

"I trust my supervisor."

- **Agree strongly: 55%**

Supervisors:

"I believe that the peer support provider(s) I supervise have trust in me."

- **Agree strongly: 94%**

Advocacy and Trust

2010 VA PEER SPECIALIST SUPERVISION SURVEY

PSPs:

"I believe that my supervisor has trust in me."

- **Agree strongly: 59%**
- **Agree somewhat: 18%**
- **Disagree somewhat or strongly: 23%**

Supervisors:

"I trust the peer support provider(s) I supervise."

- **Agree strongly: 73%**
- **Agree somewhat: 27%**
- **Disagree somewhat or strongly: 0%**

Advocacy and Trust

2010 VA PEER SPECIALIST SUPERVISION SURVEY

PSPs:

"I behave ethically in the workplace."

- **Agree strongly: 89%**

Supervisors:

"The peer(s) I supervise behave ethically in the workplace."

- **Agree strongly: 82%**

Peer Provider Ethics

2010 VA PEER SPECIALIST SUPERVISION SURVEY

PSPs:

"My supervisor does a good job of supervising me."

- **Agree strongly or somewhat: 75%**
- **Disagree strongly or somewhat: 25%**

Supervisors:

"I do a good job of supervising peer support service provider(s)."

- **Agree strongly or somewhat: 97%**
- **Disagree strongly or somewhat: 3%**

Elements of Supervision

2010 VA PEER SPECIALIST SUPERVISION SURVEY

PSPs: **"It's important for my supervisor to monitor my mental health as well as my work performance."**

- **Agree strongly or somewhat: 59%**
- **Disagree strongly or somewhat: 41%**

Supervisors: **"It's important for me to monitor the mental health of the peer support providers I supervise as well as their work performance."**

- **Agree strongly or somewhat: 82%**
- **Disagree strongly or somewhat: 18%**

Elements of Supervision

2012 Recovery to Practice

RECOVERY TO PRACTICE
Resources for Behavioral Health Professionals

Incorporating the vision of recovery into the concrete and everyday practice of mental health professionals in all disciplines

Disseminating training strategies for professional disciplines

samhsa.gov/recoverytopractice

2012 Recovery to Practice

Enhancing recovery knowledge in

- *Addiction Profession*
- *Nursing*
- *Occupational Therapists*
- *Peer Support*
- *Psychiatry*
- *Psychology*
- *Psychiatric Rehabilitation*
- *Social Work*

2012 Recovery to Practice

1. *Recovery Principles and Self-Care*
2. *The Complex Simplicity of Wellness*
3. *The Effects of Trauma on Recovery*
4. *The Influence of Culture on Recovery*
5. *From Dual to Whole Person Recovery*
6. *Recovery Roles and Values*
7. *Strengthening Workplace Relationships*
8. *Recovery Relationships*

Working Peer Specialist training curriculum modules