



**New York State Office of Mental Health
Transformation Transfer Initiative
2009 Project**

Center for Mental Health Services

Substance Abuse and Mental Health Services Administration
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NASMHPD

Final Report

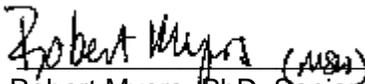
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Table of Contents

Project Description..... 2
Phase 1 - Dartmouth PRC Study: 2
Phase 2 - Peer Forums 7
Phase 3 - Supported Employment..... 9
Appendix #1: Recovery Centers in NYS Consensus Paper.....12
Appendix #2: List of Organizational Contacts.....17
Appendix #3: Introduction and Questionnaire Used by Dartmouth Psychiatric Research Center
.....19
Appendix #4: Programmatic topics suggested by the participants of the Peer Forums.....26
Appendix #5: Peer Forum Meeting notes27
Appendix #6: Peer Forum PowerPoint, Lindy Fox.....77
Appendix #7: Peer Forum PowerPoint, John Allen.....77

Project Description

As part of the transformation effort in New York State, the NYS Office of Mental Health, applied for and received a 2009 Transformation Transfer Initiative Grant in the amount of \$221,000 to explore the idea of “recovery centers” in order to bring the mental health system closer to one with a recovery focus. Our initial thinking related to recovery centers was to expand peer support assistance to more of a focus on supported education and employment, including benefits counseling, crisis resolution services, all with a strong focus on health, wellness and recovery. In addition to mutual support, Recovery Centers would be places that consumers could go to get information, and to get assistance with the topics they care most about, such as housing, jobs, illness/wellness management, and benefits counseling. Consumers could also get assistance with crises access to good treatment for physical as well as mental health concerns and access to community resources. OMH used this transformation grant to bring consultation and expertise to the system to identify what best practices elsewhere look like and to determine how to incorporate these into the New York State system. Currently, there are no definitive models or information sources that exist for such Recovery Centers.

Phase one of the project was designed to gather information on innovative peer programs, develop recommendations regarding best practices in peer support, and obtain recommendations on how to move forward with implementation of a Recovery Center model.

Phase two built on the information and recommendations obtained from the peer organizations who were contacted and surveyed in phase one. In phase two, 6 Peer Forums were held across the State to share information on innovative practices with peers/consumers/ex-patients/survivors and to discuss what peers would like to see in a Recovery Center. The Peer Forums were conducted to solicit input into redesign, with a particular emphasis on identifying what services peers would be most eager to access (e.g., jobs) and what routes they would most like to use. A consultant was hired to (a) assist in the development of a structured approach to guide these sessions, (b) facilitate each of the groups, and (c) produce a public report summarizing the recommendations which are contained in this report.

In Phase three OMH obtained consultation in order to increase access to supported employment services, particularly those run in peer-operated centers and promote best practice on how to convert traditional employment programs to evidence based supported employment.

Phase 1 - Dartmouth PRC Study:

The NY State Office of Mental Health (NYS OMH) intends to establish Recovery Centers across the state. As part of a larger planning and development process for the establishment of these Recovery Centers, NYS OMH engaged the Dartmouth Psychiatric Research Center (PRC) to interview a variety of consumer operated programs identified both nationally and internationally by NYS OMH. There were 39 organizations identified by NYS OMH to be contacted (attachment #2). A questionnaire (attachment #3) was developed by NYS OMH and PRC to guide the conversation with these organizations. Staff members of the PRC, including both consumers and professionals, were involved in talking with these organizations and summarizing that information. Dartmouth PRC summarized those findings in the following of an outline of the major mission and operational elements that characterizes these organizations and includes discussion points for further consideration.

Phase 1 – Data Gathering

Over the course of 2009, the New York State Office of Mental Health (NYS OMH) initiated a process to gather information needed to facilitate a transformation process that would lead to the establishment peer-operated Recovery Centers. The focus of Recovery Centers would be to support individuals who are working towards defining and achieving their personal recovery goals and connecting to their communities. The first step in this process was to gather information from peer lead organizations in the US, Australia, New Zealand, Canada, and the United Kingdom. The intention was to learn from these organizations how they achieved success in working with individuals to achieve their recovery goals, if and how they measured that success and what they had learned from programs and interventions that were not successful. The Transformation Transfer Initiative (TTF) funds were used to engage the Dartmouth Psychiatric Research Center (PRC) to complete and summarize these findings.

Dartmouth Survey Responses from Consumer and Peer Support Services:

The organizations that were interviewed described a significant number of variables that have shaped their development. Among these variables are:

- Location: Urban, suburban, or rural character of the community;
- Identified community needs,
- Financing opportunities, and
- Interchange with sponsoring organizations.

Basic to all of these organizations, however, is the mission and vision that drive the organization. Each of the organizations articulated a mission/vision that evolved over time with a basic philosophy of mutual support, in that through the process of peer support, all peers are on common ground. These mission and vision statements often included:

- Assuring a welcoming and accepting environment for consumers,
- offerings of individual and group peer support,
- activities to empower consumers on their recovery journey,
- educational opportunities to develop personal and systemic advocacy skills,
- developing a knowledgeable staff who are able to provide consumers with information about supports available in their community, and
- establishing structures that assure consistent and continued consumer input into the organization and its operations.

Dartmouth PRC comment: NYS OMH may share examples of mission/vision statements that can then be particularized to the local circumstance of these developing organizations.

History of Peer Centers:

The emerging Recovery Centers are a result of a more than thirty year history of the development of the Consumer and Peer Support (CPS) movement in the United States. The recovery center of the future will build on the principles that have driven these organizations throughout many years of growth and change. The rich history of the consumer movement and peer support will provide a firm foundation for the further growth and development of these organizations into recovery centers of the future.

The centers contacted in Dartmouth's survey can be categorized as two separate groups: those with long histories of offering peer support, often developing as a drop-in center, and those centers established more recently. Not surprising is the fact that the centers established more recently tend to have a wider array of services reflecting where the field is today. Those with longer histories seem to take longer in developing and adding new services to their original program offerings.

Dartmouth PRC comment: NYS OMH needs to be aware of the histories of the developing consumer organizations and work with that reality as organizations transform into recovery centers.

Domains of Services and Supports:

The centers that were contacted present a remarkable variety of services that they offer to consumers. These services generally fall into four categories:

- 1) traditional peer support,
- 2) educational opportunities,
- 3) employment, and
- 4) social activities.

As a reflection of their historical success, the core of these organizations is individual and group peer support. For many years, organizations have experienced success with mutual support as the cornerstone of recovery: helping people begin, develop, and continue their recovery journey.

Educational services in these organizations take many forms. Some organizations offer seminar programs within their organization to address an educational need that has been identified by the consumers. Others have developed a partnership with a community college to offer programs requested by consumers for college credit. All of the programs contacted in this study are involved with some form of recovery planning process. The educational programs are an important vehicle that can bring consumers into the community by participating with other citizens in adult education.

Surveys show that up to 70 percent of people with mental illnesses want to work. Drake and his coauthors say that a national "supported employment" program would help people in recovery. Several peer organizations surveyed developed employment supports as a core function of their program.

Finally, these organizations almost always have a formal social dimension to their programs. Center-based programs often have dinners, and social gatherings offered by the organization or social programming that introduces consumers to community based functions. The goal of these activities ultimately needs to enable the consumer to participate actively in their own community.

Dartmouth PRC comment: Recovery Centers need to be focused on community participation and integration. This needs to be considered as one of the basic standards employed in measuring the success of the recovery center over time.

Program Participation:

All of the CPS organizations that were contacted have active outreach programs. Many of the programs are involved in outreach to inpatient units, to homeless shelters, to jails and prisons. Their purpose is to make their services known and available to consumers as they transition from hospitalization/incarceration to community living. Among the organizations surveyed, their

association with traditional mental health providers is uneven. Some organizations reported excellent cooperation and communication with traditional mental health providers in their community while others indicated that the relationship was not a positive one. This often appears to be a function of the capacity of staffs of each organization to relate positively to one another in the common interests of the consumer.

Dartmouth PRC comment: Active outreach is another of the basic building blocks of many CPS organizations. Of special importance is the link that needs to exist between these organizations and the traditional mental health service delivery system. NYS OMH needs to be actively involved in assuring that these relationships are established and nurtured in the developing recovery centers. Regular meetings of the leadership and staff of these respective organizations will help that building process.

Outcomes:

The CPS organizations surveyed present a wide variety of approaches to measurement of their performance. Those organizations with a specific focus on employment (e.g. Laurie Mitchell Employment Center, a consumer-run and operated employment and empowerment and training center located in Alexandria VA) measure consumer success in gaining and keeping employment. Many of the organizations when asked about outcomes pointed to satisfaction surveys as their primary outcome measure, however other organizations have certain outcomes that they report are dictated by their funding organizations (e.g. state, HUD, etc). A small number of respondents are CARF accredited and track outcomes demanded by that accrediting organization.

Dartmouth PRC comment: Recovery Centers will need to report certain outcomes. Many respondents indicated that they felt that they had much work to do in this area in order to be satisfied with their performance. These outcomes should be identified in a mutual process between the developing recovery center and the State. On-going technical assistance will be vital if the measurement of outcomes is going to be successful.

Governance/Organization/Operation:

The vast majority of the CPS respondents are either an independent non-profit or part of a larger organization that is a non-profit. Only one organization, Mind and Body Network in New Zealand, is a privately held company. Regarding the make-up of the governing boards, all have consumer membership with the variable being the number of consumers on the Board. A significant number of the organizations reported having a majority (51% or greater) of consumers on their Boards. The staffing of these organizations, and hours of operation varied widely and appear to be a function of the focus of the services the organization provides. A significant number of the organizations have regular business hours with some evening and week-end availability.

Dartmouth PRC comment: As the NYS OMH continues to plan for the implementation of Recovery Centers, the issues of governance and organizational structure need to be carefully considered. It is recommended that the Recovery Center have a preponderance of consumers in positions of governance, leadership, and staff for the Recovery Center in order to be accepted in a positive manner by the consumer community and reflect the operational model most in use among the survey participants. For this to be successful, however, NYS OMH has to be prepared to provide regular, ongoing technical assistance to these organizations such that these structures will be successfully implemented and utilized over time.

Financing Models:

The CPS organizations receive funding from a variety of sources including the state, province, and federal governments. HUD and Medicaid in the United States are the principal sources of funding. Although very limited, a small number of the respondents are involved in fund raising. Grant funding is also a vehicle used to fund peer organizations. The grant funding mechanism is often contingent on certain deliverables in order to receive funding. It is significant, however, that the use of Medicaid funds is increasing as a source of financial support for peer organizations. This is a result of two trends: the Peer Certification process, originating in Georgia, and the movement of several of the respondent organization to the provision of traditional mental health services such as case management e.g. 'Recovery Innovations' in Arizona. The Peer Certification process or a similar training process is growing across the United States and is often a prerequisite for a CPS organization to be able to access Medicaid funding.

Dartmouth PRC comment: NYS OMH needs to address the issues of training and credentialing of staff in the Recovery Center programs. If NYS OMH wants to access Medicaid funds for the support of this development, a credentialing process will be necessary. In any event, a formal training process for staffs of recovery centers will be every helpful in the process of assuring quality and fidelity to the recovery center model. Finally, any funding mechanism needs to be closely tied to the measurement of the outcomes of the recovery center organization.

The Future:

When asked about the future of CPS organizations and what is needed for them to continue to grow and flourish, among the responses were: "develop a wellness city," "a wellness coaching center," "more room," "more funding," "more affordable housing," "health care delivery," "voice in state policy," "close to public transportation." From the very practical: "more room" to the visionary: "a wellness coaching center" the breadth of thoughts about the future was impressive. In the midst of this development, there are trends that seem to be emerging:

1. A movement of CPS organizations toward providing a wider variety of services and activities e.g. food pantries, employment coaching, career clubs, housing.
2. Some organizations are contracting for more traditional mental health services e.g. psychiatry. **Dartmouth PRC comment:** There is concern that following this path and incorporating traditional mental health services that the original philosophy driving the consumer movement will get abbreviated or lost.
3. There is a growth in the number of CPS that focus just on one population and/or issue. For example, 'Sound Times' in Toronto, Ontario focuses on those people with mental illness in the judicial system and their transition from that system into the community.
4. The development of certification processes for the staffs of CPS organizations such as the Peer Certification Process developed in Georgia.
5. The emergence of Medicaid as a source of funding of CPS.
6. The recognition by a majority of the stakeholders in the mental health service system that all of these approaches employed by CPS and traditional systems of care present unique and useful services to offer to consumers in their recovery journey.

Phase 2 - Peer Forums

The second phase of this project involved gathering foundational information from consumers through a series of regional forums that were held throughout the NY State in the fall of 2009. Notes from these meetings can be found in attachment 5.

This summary, provided in collaboration with Dartmouth PRC is intended to consolidate the themes and issues that emerged during these listening sessions. The following is a list of locations, dates, and some approximate attendance information from this process.

<i>Site</i>	<i>Date</i>	<i>Approx Att.</i>
Brooklyn, NY	Aug. 27, 2009	28
Hauppauge, NY	Aug. 28, 2009	30
Newburgh, NY	Oct. 8, 2009	27
Saratoga Springs, NY	Oct. 9, 2009	40
Syracuse, NY	Oct. 14, 2009	10
Batavia, NY	Oct. 15, 2009	35

Each meeting began with PowerPoint presentations (appendix 6 & 7) provided by Lindy Fox of the PRC and John Allen, OMH Director of Recipient Affairs. The presentations shared the results of phase one of the project, the PRC study of peer organizations, how the process conversations were conducted with the peer centers, initial findings, common elements, key components, and innovative practices. This was done to inform the discussion with peers around what they, the peers, would like to see in the development of recovery centers. Common elements of peer organizations and highlights of innovative programs were also discussed as follows:

Dartmouth Survey findings:

The mission of all of these peer programs is based on the philosophy of recovery, that recovery from mental illness is a goal. Their history and origin is often based on the recognition by an individual or a group regarding the gaps in the service system that needed to be filled. These program pioneers stepped in and began to fill those identified gaps. A picture emerged of two types of programs: established peer programs that developed as a typical “drop in” peer support center model and more recent programs that evolved to incorporate a wellness focus, an employment program, outreach activity, an educational program perhaps associated with a community college, parent training, justice diversion program, a course in recovery strategies or service in addition to empowerment and support. In addition to the basic mission of all of these programs (i.e. to give support to people as they undertake and pursue their recovery journey), there is an evident movement in many newer centers to structure their programs in an educational context. Among the challenges that were identified were leadership and succession planning for ongoing solid leadership of the organization, interfacing with the community, and placing the organization in the context of other service providers within the community served.

The Phase 2 forums were designed as an information gathering process that involved OMH staff listening and recording consumers responses’ regarding the outline of the proposed recovery center ideas. A list of topics common to all sessions was generated (attachment 4). Major themes emerged from these meetings. The following is a summary of those themes.

The response of peer organizations interviewed and the comments of consumers present in the meetings indicated recognition of the fact that peer operated organizations are at another phase in their development.

These organizations, in addition to their basic function of peer support, need to look at an expanded menu of services that might include: skill building, wellness, employment and education.

Dartmouth PRC comment: There needs to be recognition in these organizations that success is, in part, defined as people getting the skills they need to achieve their goals and moving on into full community inclusion. People may from time to time need the peer organization active in their lives. However, they should move away from these organizations as they begin to achieve their own goals and life aspirations.

The Recovery Center is a means to move forward, not necessarily an end or goal in itself. It was noted that the Recovery Center should link consumers to already existing community groups and educational opportunities rather than replicating them at the Recovery Center. In this sense the Recovery Center becomes a locus of information for the consumer.

Consumers spoke of the need to help people find their passion in life and develop a plan to realize that passion. The issue of stigma was raised as a barrier force to be reckoned with as the person seeks to realize his/her goals. The process of helping people identify their interests and pursue them was a recurring theme in each meeting.

In almost all the meetings the need for informed benefits counseling was underscored. The difficulty that consumers have navigating the benefits structure is clear. Concise and understandable benefits counseling for the consumers is necessary especially as they develop their career goals.

A list of services was generated by peers at the forum held in Newburgh, NY. This list presents a possible expanded menu of services that could be offered in the Recovery Center. This list included:

- career clubs,
- supported employment services,
- internet access,
- crisis “warm line”,
- food pantries,
- forensic services,
- “home of your own” program, partnership with “Habitat for Humanity”,
- parent training and support,
- speaker’s bureau such as “In Our Own Voice” of San Diego CA,
- transportation,
- availability of a recovery mentor,
- safe houses,
- family education,
- substance abuse programs,
- role modeling, life coaches, a course in confidence building including hearing from consumers who have been successful in moving on.

The following statement with or without attribution was recorded in the minutes of the Newburgh meeting: “The mental health system creates dependency; a Recovery Center is a vehicle of transformation to independence.”

One of the basic values in the peer support movement is the conviction that outreach and engagement with people is essential. This value was repeated again and again in these listening sessions.

As a result of the Peer Forums, OMH will continue to gather information from the community. OMH will offer technical assistance to the consumer community as the process of development proceeds. The goal is to build consensus around the model of the Recovery Center and, where consensus is not achieved, continue the dialogue.

Following the Peer Forums, a Consensus Paper (see attachment 1) was developed by OMH that reflects key components of Recovery Centers that peers could agree on, areas where there was disagreement and need for further refinement. This paper has been used to set up discussions throughout OMH, with executive staff, Recipient Advisory Counsel and will continue to inform and advise OMH on the conceptual framework of Recovery Centers.

Conclusion

Recovery Centers of the future in NY State will build on mutual support and existing peer run activities but have an outward focus. Recovery Centers will be a resource to “get on with life” provide avenues for transformation from dependency to self-reliance. The center will build on the existing best practice of mutual self-help and assisting people to access the most integrated setting possible (Olmstead). Key elements are an expanded menu of services that will include assistance with life skill development, help with accessing resources and supports related to housing education, employment, integrated social and recreational opportunities and greater participation in the community. Many participants described this as “taking back your life with supports”, and “claiming independence and having the skills and tools to go on with life”. Recovery Centers of the future will not be a destination but a place to go through to make connections to someplace else. In summary, we are talking about an asset based community development project, creating opportunities for social entrepreneurship and interconnecting social networks. As an outcome the Consensus Paper has sparked dialog within OMH, with providers, and consumers that will help to refine and revise the conceptual framework for Recovery Centers.

Phase 3 - Supported Employment

Phase three of the Transformation Transfer Initiative provided consultation that will enhance access to supported employment services, particularly those run in peer-operated centers, and provide strategies to convert traditional employment programs (e.g., workshops and enclaves) to supported employment.

This phase included staff training in evidence-based supported employment through the IPS (Individual Placement and Support model) and the use of fidelity measures.

In late October 2009, we enlisted Columbia University EBP Center and Paul Margolies, PhD. to implement regional forums on technical assistance in evidenced base supported employment. Raymond Gregory (IPS trainer) and Steven Baker (part-time IPS expert consultant) both began in November 2009 at the Columbia University, EBP Center.

Six (6) ISP regional forums were held from December 2009 through March 2010:

Location	Date	Approx. Attendance
Buffalo	12/8/09	8
Rochester	12/9/09	24
NYC	12/15/09	50
Suffolk	1/4/09	35
Westchester	1/11/10	26
Albany	3/8/10	25
Total		168

The agenda for the regional forums included:

- NYS OMH emphasis on supported employment within PROS programs (Personalized Recovery Oriented Services programs) a new recovery orientated licensed program funded under the Medicaid Rehabilitation Option and other program models as well.
- Supports available to PROS programs for IPS (using additional funds, Employment Networks, Ticket-to-Work, etc.)
- Employment Networks, NYAPRS technical assistance, Coalition training, NYSPI EBP Center training and support.
- What is IPS (Individual Placement and Support) and why is it important? What's the evidence for its effectiveness?
- Implementing IPS within a PROS environment, technical assistance supports available through the NYSPI EBP Center.
- How to engage important stakeholders in this initiative (including use of an exercise).

The response to the regional forums has been strong, with considerable interest expressed by many of the agencies at each forum. Participants were engaged, asked many questions during the forums, and requested further technical assistance from the EBP Center. Raymond Gregory has begun his targeted technical assistance with Suffolk County providers, and on-site visits have begun at FECS, Federation of Organizations, and Clubhouse of Suffolk. His first visit to Hands Across Long Island was on March 12, 2010.

Technical assistance focuses on agency leadership, employment supervisors, employment specialists (the staff members who focus on competitive employment) and other treatment team members as well. The focus is on how leadership can support the implementation process, how supervisors can coach staff in this practice, and how staff can provide this service in a competent manner. Technical assistance may happen on site, and through webinars and other distance learning forums that also may be used.

Mr. Gregory is working with program leaders and staff at these agencies to begin the implementation process, and will soon do baseline fidelity assessments at these sites. Fidelity measures will be adapted from scales developed by Dartmouth University.

Conclusion

OMH used the Transformation Transfer Grant to bring consultation and expertise into the system, to identify what best practices exist elsewhere, what they look like, and to effectively determine how to incorporate these into the New York State system. The interviews conducted

by Dartmouth helped to expand our ideas around Recovery Center. At present no definitive models or information sources exist for such Recovery Centers. What we discovered is that the range of peer support services is enormous, however, a full menu of services does not exist in any single program entity.

In addition to the study on innovative practices, we were able to have meaningful dialog with approximately 170 recipients/consumers/ex-patient/survivors who attended statewide forums. These peer forums were critical in creating and refining the OMH's Consensus Paper.

The Consensus Paper on Recovery Centers (appendix 1) has brought us closer to realizing the key elements that will drive the Recovery Centers of the future. As a result of this project, NYS OMH has allocated \$1.5 million, in FY 2009-2010 and \$4 million in FY 2010-2011 to develop training and technical assistance that will provide organizational assistance to these evolving centers. An RFP for organizational training and technical assistance to support the infrastructure of recovery centers will be released in the spring of 2010.

In terms of developing evidence based supported employment, OMH successfully contracted with Columbia University, Psychiatric Institute, EBP Center to provide access for 168 individuals through statewide forums on Individual Placement Support. The focus was how to convert traditional employment programs (e.g., workshops and enclaves) which do not use an evidenced based approach. In addition to the forums, consultants have begun to provide technical assistance and staff training in evidence-based supported employment and the use of fidelity measures on Long Island.

The materials from each of these initiatives will be made available to consumers and providers throughout the state via the OMH website or the website of its partner, the Evidence-Based Practice Technical Assistance Center at the New York State Psychiatric Institute. In addition, all materials posted online will be sent directly to the consumers, consumer organizations, and providers participating in their development.

The resources made available through this SAMHSA TTI Grant provided the front-end focus to begin the development of Recovery Centers and to introduce evidenced based supported employment to NYS providers and consumers. The Grant funds were put to good use and have lead to targeted funding in the OMH budget to develop Recovery Centers and IPS (Individual Placement Support) focused employment programs. The ongoing support and technical assistance provided by NASMHPD throughout the Grant period was helpful and appreciated.

Appendix #1: Recovery Centers in NYS Consensus Paper

March 5, 2010

**Suzanne Gurrán
Assistant Director
of the Adult Community
Care Group**

“We are human beings with souls, in progression, and not an illness in remission” – anonymous

Introduction

Many consumers credit self-help and peer support as influential in their transformation along the continuum of going from passive and dependent recipients of mental health services to active community participants. Self-help is a unique form of social organization where "helping" takes on new form and meaning when compared to the more familiar and accepted tradition of receiving assistance from specially trained "experts." It is estimated that during any one year, 3% of the population of the United States participates in self-help groups (Lieberman & Snowden, 1994).

In the United States during the 1960s and 1970s, the organizing efforts of former psychiatric patients are identified as the birthing era for the active involvement of consumers in so many aspects of the public mental health system. During the 1980s Federal and State governments recognized the value of consumers empowering themselves and other consumers utilizing self-help. Government funding for consumers to develop services and to participate at various levels of policy decisions attributed new value to the experience-based expertise of consumers. Today, more than 200 self-help groups and peer-run programs /organizations throughout New York give testimony to the importance of self-help and empowerment in the recovery journey. Many of these groups will be expected to transform into Recovery Centers over the next ten years.

2009 Peer Forums

In the fall of 2009, the NYS OMH held a series of listening forums in 6 regions throughout the State to gather input from peers on the idea of developing a new program type called “recovery centers.” Approximately 170 recipients and recipient family members attended the “Peer Forums”. These forums were supported by a Transformation Transfer Initiative Grant funded by SAMHSA and, awarded through NASMHPD. This grant gave NYS the unique opportunity to dialog with individuals representing the peer/consumer/ex-patient community regarding what they would like to see in the design of a recovery center. Using the feedback gathered from the “Peer Forums”, we will attempt to capture the themes relative to the development of recovery centers.

Executive Summary

Person Centeredness

Throughout each of the forums there was general agreement that the spectrum of needs of people living with mental illness include: a home of their own, employment, social relationships, romantic relationships, community participation, advocacy and support.

Participants in the forums were generally enthusiastic about the concept of recovery centers and particularly liked the fact that the center of the future would focus on individuals’ strengths and interests rather than labels and diagnoses. Recovery centers of the future will focus on supporting individuals who are in the process of working towards defining, empowering and achieving their personal recovery goals.

Mutual Help

Knowing that people are “in your corner, keeps you grounded”. The core of peer run organizations is individual and group peer support. Mutual help and member-run, voluntary organizations are cornerstones and building blocks for the recovery centers of the future. Feedback from peers indicated support of both traditional and new alternatives to recovery support. There was consensus on the need for place-based centers where members could connect with each other for mutual support as well as providing a place to facilitate an outward focus and enable individuals to look, discover and connect with community resources and opportunities outside of the mental health system. In the continued mission to provide self-help and mutual support, recovery centers of the future might offer more in the area of the addiction-type support groups including Personal Advance Directives and Wellness Recovery Action Plan groups.

Menu of Services

Many individuals affirmed that self-help groups and active outreach to others are core functions of a center. Some programs are involved in outreach to inpatient units, homeless shelters, jails and prisons to connect with recipients as they transition into the community. Participants felt that outreach was essential to marketing the program and gaining new members.

Some participants suggested more of a focus on wellness, health, family supports around parenting and self-help that is trauma informed. The availability for support on weekends and holidays was seen as essential whether it be through “warm lines” or direct access to the center. Rather than low-demand drop-in centers, in all of the forums participants supported an expanded menu of options at centers, however people made it clear that they do not want to have groups “for the sake of having groups” or “babysitting”. There was agreement on the concept of “recovery taking place in the community” and “not getting stuck in programs”. Centers should be places where “the expectation is that people will move on” to and participate in their community. Most attendees were receptive to the idea that centers could function as clearing- houses for information, resources and opportunities available in the community. Centers that focus on community information will have better outcomes in community participation. In addition, there was support for the idea of recovery mentors/life coaches to link people with experiences that connect peers to their communities.

Many participants shared the experience that the “system makes you forget your dreams” In support of an outward focus, most individuals liked the idea of helping each other to “find the spark” or “passion” in life and then discovering ways to connect with like-others in the community, but they unsure how to accomplish this. Recovery centers of the future are about finding and rediscovering passions or as one person so eloquently stated: “it is never too late to do what you want to do”. The idea is “discovery through exposure”.

Housing

Most forum participants would like to change the process of accessing housing and have the opportunity to live in areas of their choice. Several centers assist members with locating apartments; however we are looking at housing from a home ownership perspective as something the recovery centers of the future should be involved with. Participants were open to the idea of using their time to support Habitat-like programs such as the “Jerome’s Home” project and developing IDAs (individual development accounts) and as pathways to homeownership.

Education & Employment

Literacy training and educational supports need to be expanded on recovery centers. Recovery centers need to be equipped for on-line learning opportunities as well as connecting with community colleges. Centers could assist peers to link to college courses, supports and access to financial aid.

Currently some peer organizations help individuals who want to return to work find employment. Expanding on this, centers may want to reach out to employers through peer bridges and assist peers' access employment or develop employment networks. Participants agreed that employment as a big part of recovery. If recovery centers wish to grow in this area, they will need to have a dialog with the community around work opportunities.

In addition, recovery centers of the future could assist in developing peer-run businesses, facilitating apprenticeships with skilled crafters or builders, or develop on-site work experiences by connecting peers with volunteer opportunities or externships. Participants agreed that peer-run career clubs can play an important function with individuals returning to work. Many peers can know how to do a job or work, however not how to be successful in a work environment. Career clubs can assist peers in developing social skills, relating to co-workers and support success on the job.

Benefits Advisement

There was agreement that the more resources (money) a person has, the more choices are open to them. Many individuals felt information on benefits advisement would be a critical part of the new recovery centers.

The recovery center of the future will need to address economic issues in order to help people have more choices and employment supports. Career clubs, employment coupled with benefits advisement could serve as a new direction for many centers.

Collaboration with the Mental Health System

OMH wants recovery centers of the future to be part of a network of mental health services as both a provider and advocate. Reactions varied in regard to working closely with the larger mental health system. Many individuals viewed the consumer/ex-patient/survivor movement as historically outside of the mental health system. Some participants felt that they had excellent communication and cooperation with traditional mental health providers, however there was an uneven response regarding centers working with the larger mental health system. One participant suggested that a center having an MOU with a provider to supply on-site services would be beneficial. The participants had concerns about being co-opted by the larger system. If recovery centers will be working with an outward focus, they will need to develop relationships with the larger community such as police, food pantries, employers, including mental health providers.

Peer Run Organizations

At peer centers everyone has a common background and the majority of participants agreed on the definition of "peer owned" as: 51% or greater of peers serving on the board of directors. Recovery centers of the future should continue to build on peer owned and staffed models. There was initial lack of consensus around the idea of non-peer programs converting to a peer model, however after some discussion, there were those who thought that if non-peer agencies wanted to convert they should be allowed to try, as long as there was adequate oversight to ensure that decisions would be made by peers. There was concern that non-peer providers would have fidelity issues related to the core concepts of recovery and peer support. There was

general agreement that peers needed training to undertake new operational and administrative roles as well as learn how to support and outward focus and community participation. Overall, participants commended the concept of recovery centers as a means to move forward to a more integrated life.

Appendix #2: List of Organizational Contacts

	List of Contacts	Contact
1	Peer Operated Self Help Center Hackensack NJ	Yes
2	Voices, Opportunities, and Employment Club Ontario, Canada	Yes
3	Laurie Mitchell Employment Center Alexandria, VA	Yes
4	Recovery Innovations/META Arizona	Yes
5	Hands Across Long Island Central Islip, NY	Yes
6	MHA of Nebraska Supported Employment Project	Yes
7	Georgia MH Consumers Network	Yes
8	The Village Integrated Service Agency, Long Beach, CA	Yes
9	Wellness Management and Recovery Columbus, OH	Yes
10	SIDE Kansas City, KS	No Response
11	Kansas Peer to Peer Services	Yes
12	Consumers as Providers (CAP) Program Kansas	Yes
13	Brook Red Brisbane, Australia	Yes
14	Our Consumer Place North Melbourne, Victoria, Australia	Yes
15	Recovery Devon, Devon, England	No Response
16	YALLA MEVALIM ACHERET, Israel	No Response
17	ASHNAV, Israel	No Response
18	Peer Support Whole Health, Georgia	Yes
19	Advocacy Unlimited. CT	Yes
20	Focus on Recovery-United (FOR-U) Connecticut	Yes
21	Housing Options Made Easy, Gowanda, NY	
22	People, Inc., Poughkeepsie, NY	
23	Howie the Harp Peer Advocacy Center, New York, NY	
24	Baltic Street , Brooklyn, NY	
25	The Main Place, Newark, OH	
26	Thomas M. Wernert Center For Mental Health Recovery and Support Toledo, Ohio 43604	
27	Gathering Hope House, Lorain, OH	
28	Peer support and Wellness Center Decatur, GA	Yes
29	Metro Boston Recovery Learning Community, Boston MA.	No Response
30	Family Options, Marlboro, MA	Yes
31	Mind and Body, Auckland, New Zealand	Yes
32	Sound Times Ontario Canada	Yes
33	CAN Mental Health	Yes

	List of Contacts	Contact
34	Thresholds, Chicago, IL	Yes
35	Pat Deegan Common Ground, Byfield, MA	Yes
36	Mind Freedom International Eugene, OR	Yes
37	Community Works	No Response
38	Florida Self-Directed Care Program, Ft. Myers, FL	Yes
39	Vin Fen, Boston, MA	No-Peer Support Program

Appendix #3: Introduction and Questionnaire Used by Dartmouth Psychiatric Research Center

Introduction: The New York State Office of Mental Health is developing a concept of a peer-operated “Recovery Center.” We imagine these centers as outward-focused, where peers may come and get assistance in achieving their goals. We view these centers as helping people to move forward with their lives, and will therefore assist individuals with issues such as housing, employment, wellness, parenting, empowerment, mutual decision-making related to treatment planning, and avoiding and managing crises (for example, using WRAP plans and peer crisis alternatives).

Your organization has been identified as a peer-operated program – or one that has a strong peer component - that has introduced innovative approaches to assisting people in their recovery. We would like to interview you to determine what you offer to people, how you do it, what results you have achieved (that is, what outcomes you have reached) and what ideas you have for the future. Thank you for agreeing to speak with us.

Recovery Center Descriptive Questionnaire
Dartmouth Psychiatric Research Center

RC#.....

Name of program.....

1. Philosophy

Please tell me in a few words the mission of your organization.

.....
.....
.....

Please describe any overall vision driving the organization.

.....
.....

What do consumers feel is unique about the program compared to the traditional service system?

.....
.....
.....

Has the overall philosophy changed over time? If so why?

.....

.....

.....

2. History of organization

Can you briefly describe how the center came into existence?

.....

.....

.....

3. Domains of services/supports

Please tell me about the different elements/programs that are provided at the center?

.....

.....

.....

What is the role of self help support in the program? How does this happen specifically in your program?

.....

.....

.....

What is the relationship with 12 step and other self help models?

.....

.....

Do you offer person centered planning? (If yes, describe how this is working)

.....

RAP plans? (if yes, describe how this is working).

.....

Advance directives? (if yes, describe how this is working)

.....

Is there an emphasis on health? (Describe)

.....

A focus on wellness? (describe)

.....

Do you offer services to assist people to avoid crises? (If yes, what are they and how are they delivered?)

.....

.....

Do you have a focus on employment and education in your program?

If yes, how does the program support this? What specific services related to employment or education are offered and how are they delivered?)

.....

.....

.....

If no, do you refer and/or work collaboratively with an agency? (describe)

.....

How do you approach benefits assistance? For example, do you work directly with individuals or refer them for assistance?

.....

.....

.....

How does your program coordinate with the broader mental health treatment and rehabilitation programs, as well as other community programs in your area?

.....

.....

.....

4. Program participation

How do people usually learn about your program and its services?

.....
.....
.....

Are there any criteria for people being involved in your program?

.....
.....

Do individuals leave the program or use it as a touchstone over time?

.....
.....

How do you help people from getting “stuck” in your programs and keep the focus on community integration and outward focused goals?

.....
.....

5. Outcomes

Do you measure outcomes? If so, what do you measure?

.....
.....

Do you have any outcome data for the past year? If so, please describe it.

.....
.....
.....

6. Organizational

What is the legal status of the program?

.....
.....

Is the center free standing or a component of a larger program or agency?

.....
.....

7. Operational

What are the center opening hours?.....

Which days of the week does it open?.....

Is there a capacity for off-site services? Is so, what do you provide off-site?

.....
.....

How do you address cultural competence?

.....
.....

8. Governance

Is there consumer input into program governance, service menu and format? Please describe:

.....
.....

9. Describe the background of the members of the board of directors. (e.g. legal, fiscal, peer, business)

.....
.....
.....

10. Staffing

Does the center have peer and non-peer staff?.....How many of each?.....

How many paid staff work in the program? FTE?

How many volunteer staff works in the program? FTE?

Are the peer staff credentialed?.....

What is the extent and role of peer staff?

.....
.....
.....

Please describe the management structure of the program.

.....
.....
.....

11. Oversight

Is your program reviewed regularly by the funding source or other governmental agency?..... If so, by whom and how often?

.....
.....
.....

12. Financing

What is the budget of the program?.....
Please identify the different funding streams that support your program.

.....
.....

Do you have to apply to these funding sources annually?.....

.....

Does your program receive Medicaid funding? If so, how are services billed? (e.g., fee-for-service, case payment)

.....

Are you part of a managed care network?.....

13. Demographics

How many people does the program serve in a year?.....

Do you serve families?.....

If so how many?.....

Do you serve adolescents?If so, how many?

Are there any other special populations you specifically serve in this program, e.g. the homeless, dual diagnosis, people with criminal justice issues, etc.? If so please describe.

.....
.....

What is the ethno-racial diversity of the clientele served?

.....
.....

What is the gender distribution? % men.....%women

What is the age range and distribution?

.....

14. Vision for the future

What kind of assistance would consumers like from the program that may currently be unavailable due to funding or other factors?.....

.....
.....
.....

If you could design an ideal recovery center, what would it include?

.....
.....

What would it take to turn your program into an "ideal" center?

.....
.....

Are there any materials from your program you could send us that touch on any of the things we've talked about?

If yes, email or mail to: [*insert contact]

Appendix #4: Programmatic topics suggested by the participants of the Peer Forums

The following is a list of programmatic topics suggested by the participants that were recorded in the summaries of the five meetings. This inventory does not include comments made by the meeting facilitators: Lindy Fox and John Allen. The figure refers to the number of meetings where this topic was raised.

Educational Programs	2
Stigma	3
Housing/Safe Houses	3
Employment Services	3
Social Relations	1
Romantic Relations	1
Transportation	4
Internet Access	3
Addiction Support Grps	2
WRAP	1
Career Club	1
Food Pantry	2
RC Public Relations	2
Hospital Outreach	2
Parenting Class/Support	3
Spirituality	2
Physical Health Care	2
Art Class	1
Social Skills Tr.	1
Benefits Counseling	2
Speaker's Bureau	1
Listening Skills	2
Peer Life Coaches	1
Crisis Support	2
Social Events	1
Jail Diversion	1
Trauma Informed	2
Peer Role Model	1

Appendix #5: Peer Forum Meeting notes

Transformation Transfer Initiative Peer Forums 2009 St. Francis College, Brooklyn, NY August 27, 2009 Executive Summary

Background: The Office of Mental Health is exploring the possibility of developing peer-led Recovery Centers that would offer focused supports to individuals who are in the process of working towards defining and achieving their personal recoveries. One aspect of this process has been work done by experts at Dartmouth's Psychiatric Research Center to interview peers across the country who are currently involved in such Centers. This will provide OMH with some perspective on what seems to work (and not work) in other locations. A report summarizing this process will be issued in the near future. Another aspect of this process consists of holding a number of regional forums with consumers throughout NYS, asking for their input into the planning process. This is one such forum. Participants attending this forum identified the following themes:

Need to Address Stigma in Community

Forum participants expressed unanimous concern about stigma experienced by consumers who integrate into the mainstream community. Recovery Centers need to make de-stigmatizing public education a major priority. Participants strongly encouraged educational efforts to inform the community about the capabilities of consumers in recovery, including the development of better marketing tools. Participants supported establishment of speaker's bureaus. Flyers could be distributed in the community, for example, in Social Security, welfare, and Medicaid offices. Participants suggested using the word "wellness" rather than "recovery." Participants felt that "recovery" is a stigmatizing word. Recovery Centers will need to do more outreach to make recovery-oriented services known.

Spectrum of Needs for People with Serious Mental Illness

Recovery can be divided into five main areas:

- Housing
- Employment
- Social Relationships
- Romantic Relationships
- Transportation

Recovery Centers need to focus on access to comprehensive health care, not just mental health care. Recovery Centers should provide links to resources for free health screenings.

Consumers also need supported employment services and training services for people with jobs. Recovery Centers should offer advice on benefits, with explanations about mental health coverage provided by different health plans.

Psycho-education and support for families was another topic of interest. Often families do not know how to help family members with mental health diagnoses. Family members would benefit from training in learning to communicate with their loved ones. Self-help groups for family members (e.g., Al-Anon) can be useful.

Culture often impacts perceptions of health and mental illness. Staff training can address understandings of different communities and how people view and want to engage in services.

Recovery Centers should balance both traditional and alternative options, including psycho-education, aroma therapy, pet therapy, and other approaches. Recovery Centers also should help peers access spiritual retreats, which can be inexpensive, relieve stress, and provide a path to self-awareness.

Recommendations about Operations of Recovery Centers

- Both a permanent location and a way to be mobile are needed. Consumers must have a place where they can be connected to services.
- Availability on weekends and holidays is essential.
- Non-peers on the Recovery Center staff will allow positive interactions that reduce stigma.
- A peer council with no outside agenda can keep the Recovery Center focused.

OMH Presentation:

OMH is committed to restructure care in NYS. Our goal is to increase the role of peers in all aspects of services. We hope for better accountability and coordination of care to ensure getting services they need. In an effort to assist states in transforming their mental health systems of care, OMH applied and received a grant from SAMHSA. OMH wants to look at the idea of Recovery Centers. OMH contracted with Dartmouth University to do a search of best practices and to look at innovative practices around the world – mostly peer-oriented programs. Dartmouth did interviews with 30 high-quality programs around the world, and Dartmouth is putting together a paper. We are here because we wanted to know what our New Yorkers think of this.

Lindy Fox – I am a trainer and consultant at Dartmouth, I've been with Dartmouth for 21 years, but longer than that I have been a recipient of services. There are 39 peer programs that we contacted. 30 programs responded to us. You guys have a copy of the questionnaire that was used when talking to these programs (See Questionnaire). There were different elements that those questions covered. John [Allen] and I were talking over dinner, and there really weren't any surprises from the questionnaires. Some interesting findings, but no surprises. The mission of the programs were driven by where programs were located – rural or urban – but certainly the mission, the recovery-oriented mission that drives your programs was part of all of their missions. That mission was there everywhere. Same thing about their vision. We called it “rules of the road”, empowering people on their road to recovery. I talked to lots of program, in Arizona, California, Canada, their underlying values are very much the same everywhere we go. I actually read all 30 questionnaires, and although they began to mush together, the underlying values were still there. The history was kind of fun to read about. Recovery Innovations was started by a husband and wife team. It was driven by somebody being unhappy with what they are getting.

There were two categories of peer programs – older peer programs developed with the typical “drop-in” center model, and then the newer programs with a wider array of services which have wellness centers, outreach to hospitals and jails, employment. The more traditional center had a harder time developing an array of services. I'm sending electronically all of the questionnaires, and we will figure out a way to disseminate the agency responses to everyone.

Many programs are offering the array of services that you would get (e.g., WRAP, employment services). The value of “consumer managed” services is there. There are a lot of programs with a mix of peer and professional staff out there. I didn’t really count, but there is still a mix of some that have professional staff mixed in.

Comment from the group: If I am supplying services then I want to provide Lamborghini services, but in reality we are only delivering smart cars.

Lindy Fox – the leadership is a central issue. People are attracted to charismatic leaders. I talked to some people who started programs, and some were very passionate and charismatic. Passing the baton is a very big concern – who will take over their place? Who will carry on that mission and vision? That issue needs to be tackled.

Recovery and “giving back” was a central theme. I heard many organizations saying they don’t want to duplicate services that already exist. Many peer programs have a huge emphasis on wellness. Recovery Innovations was one of the peer programs. Recovery Innovations has a “wellness city” with a complete focus on health and wellness. The Village has a wellness center where wellness is a huge focus. Most did have some wellness component being incorporated into the programs. Some programs had positive relationships with mental health services in the community. Outreach was often a big part of peer programs. Some did outreach to hospitals and jails. Programs varied in how positive they viewed traditional mental health services. One program had staff working within the mental health center to work directly with staff in the mental health center to develop WRAP plans, which I thought was a really good effort. I think that peers can have a great impact if mental health professionals are willing to listen.

Comment from the group: If you are a survivor of services, you look at certain things. I’m focused on poverty, moving towards guaranteed income and into alternative treatments, making sure their rights are protected.

Comment from the group: At Baltic Street, we came out of the state hospital, so our peer run programming is directly linked to the hospital. The peer run program is meant to offer an alternative and to serve as role models. We can’t do everything, but we try to connect people and to show them that there is a transformation, there is a change. Now we are also dealing with the overflow from prisons coming into the psychiatric centers. They are a whole different population, but we still have to deal with them. I was looking at community relationships. Programs that are most successful are those that look outside of their discipline. They look at churches and community centers, but you have many people who use alternative services. It’s important that outreach goes out to the alternative organizations. We are finding lots of people who need treatment that aren’t part of any traditional program.

Comment from the group: I do agree with thinking outside of the box, but as far as reaching out, my program has done outreach to programs in the community, and we have developed a wonderful relationship with the providers. We are able to say, “you know, that’s not our area of expertise, let me refer you to such and such.” Peers are experts in how to navigate the system. We’ve survived the experience, and are helping others to survive it also.

Comment from the group: In my work at Bellevue Hospital, a big barrier that I had to work with was the lack of education that people had. In my personal view, part of recovery is taking responsibility to giving hope to others. Once we reduce the stigma, all of these barriers will go

away. Stigma is upheld by ignorance. I didn't hear the message for a long time, but now I do hear it.

Comment from the group: If you think this system is going to change quickly, and power concedes, but I would never surround myself with people who just "yes" me to death. This is a multimillion dollar business brought on by the pharmaceutical industry.

Lindy Fox - Domains of supports: There are a lot of elements to these peer support programs, and there is a lot that these people offer. Peer support groups we interviewed were lead by peers, provided information on what's available in the community and what resources are available, did outreach to hospitals, jails, shelters, and all had a variety of educational opportunities. Some had links with community colleges and people could earn college credit there. Some could take classes for college credit within the center. They partnered with community colleges and had artistic and spiritual programs. Many had some kind of emphasis on employment, housing supports, and advocacy support. One program only did computer education classes. Many offer some kind of social aspect within the drop-in component or linking with some kind of social aspect in the community, some had apartments for people, and offer some kind of advocacy programs. Many have WRAP within the program, social activities, health and wellness component. Much of my work is in the co-occurring domain, and I was excited that many peer programs who offer groups for co-occurring disorders (e.g., "double trouble").

Comment from the group: The peer groups are doing outreach to hospitals. I hope that the state-funded programs can have something on the admission form where we can put the information on the peer recovery. It's hard to get into some of these peer places and people don't know they exist.

Lindy Fox - Yes, there are some barriers to finding out about peer programs.

Comment from the group: We try to get consumers in systemic advocacy, whether through consumer committees, regional advisory committees, or getting them involved in local government. We do have a voice and are a voting block. Remind people that you are a constituent and show that you have more power. I'm a homeowner and a person with a mental illness. I want to see how consumers can get more involved in the community. Can you have a mental health program in the community? They can help with the elections. I pay taxes, I pay your job.

Comment from the group: Employment is a big part of recovery, and have seen many people feeling despondent until they got a job. It helps people have something they can take pride in, gives them a wage, and gives a sense of self-worth. If you have depression, one of the things to combat the triggers – you get up and take a shower, and you'd be surprised that once you get up and do something, you begin to feel better.

Comment from the group: You need to provide an employee assistance program. I mean a fully working EAP. Supports for medical and mental health. It's also where realistic ideas of what an accommodation is and disclosure is discussed, but kept private.

Comment from the group: I ran a program for 7 years called PALS and it was really unique because most of the staff were part-time on call. It gave people the confidence that they could do something. It was a peer support line, and people would call about their problems. When someone would call up we could assign them to a person who can help them.

John Allen – Let me tell you what we are thinking about Recovery Centers, and then want to get your input as the experts. We have \$1.4 million dollars to support the development of Recovery Centers. We are looking at what is the next generation of self-help/peer-support groups. Much hasn't changed in 30 years, and so part of what we are looking to do, we want to leap forward to what the next generation will really be.

Let me start with what we are talking about. In NYC what you have here is some of what peer support offers but not all of what peer supports offer. What do we mean? There are four characteristics of peer support – mutual help, member-run, composed of peers, voluntary non-profit organization. Mutual help is the fundamental basis of peer run. Member-owned (51% of board of directors) and a significant number of staff. The preponderance of staff should be peers. If you need an accountant, you hire an accountant, and if they happen to be a peer, then great. When programs are funded they have to be defined as voluntary non-profit. Mutual help typically occurs when you have peers together offering peer support. This is the basis of self help and peer support – people helping one another. Everyone there has a common background. I don't need to explain what it's like to be a consumer because we have a common understanding. We are talking about member owned. If a preponderance of staff are not peers, then you are not peer-run. To be peer-run you have to be both peer-owned (at least 51%) and peer-staffed. The peers all have to be "out of the closet" as peers. These definitions come from the American Self-help Clearinghouse. Peers are professionals in recovery. Voluntary-run, or at a minimum voluntary participation, people may pay dues. Peer support groups have often begun with a single individual or small group wanting to meet their own specific needs. Usually the group starts out very informally. Peer-run organizations are the outgrowth of these groups as they grow. Drop in centers have been the basis of peer groups. Drop-in centers are low or no demand, with no expectations, and no scheduled activities, but lots of activities and supports for when you do drop in. With recovery centers, the idea is to move toward more options on the "menu" and then adding some additional things. In New York State, drop-in centers are a certain kind of funded activity, but not necessarily peer-run. NYS is the only exception to this. Anywhere else, at a drop in center there are lots of volunteers, someone greets you at the door, offers you coffee and asks you what supports you need. Some offer supports to people who are homeless. We want to talk about how to make some of these drop-in centers become funded recovery centers. Traditional array of services include support group meetings such as AA, PADS (advance directives) and WRAP(wellness recovery action plans), advocacy training and advocacy, benefits advisement (the "jingle" factor.; one of the requirements will be to offer benefits advisement. We need to address economic issues in order to help people have more choices), employment supports (not always peer work, as we are aging, we want to begin having a meaningful role in the community), clothes closets, food pantry, peer bridging, etc...[see slides].

There are a variety of addiction-type support groups. We might offer one or more of these on a regular basis. PAD/WRAPS historically became one tool for advocating for wishes. Career clubs – employment coupled with benefits advisement. When you get me housing, now I have a lot to lose, and I get anxious. When people take on new roles (e.g., employment), there can be anxiety about the new role; "I know how to be crazy, but I don't know how to be the employee". Changing the role also means changing how we talk to ourselves. Clothes closets offer clothing to those who need it. Coats are offered in winter, and so are socks and shoes. Almost all the original peer support groups offer community meals. I know that if we want to convene a meeting of peers, all you have to do is offer them food, and they will come. Food is a commonality for us, and a matter of survival; it's difficult to live on SSI; having options about food help engage people.

If you want to teach life skills, you need to engage people in a different way. To normalize this, food is the center of the activity for everybody. Food is a communal thing where we congregate around and it's an incentive to come together. Talking about "community" meals not just feeding people. Coming together over a meal is not just about socialization but planning learning experiences that connect us to the broader community.

The recovery centers have to be fun, and a place to enjoy myself, and being a human being, not just a place about learning stuff.

Computers and internet access are links to many things. Warm lines and crisis support are opportunities for peers to help each other. People sometimes just need someone to talk to.

We die 25 years younger than the rest of the country. Food pantries are good ways to provide for our "brothers" and "sisters." We are looking at cost effective approaches (e.g., Cornell cooperative extension), to offer nutritious foods to consumers. Recovery Centers can play a role in jail diversion. As there are cut backs on community supports, many may be at risk to end up in jail or prison. I do not just mean outreach, but developing relationships with police so that when appropriate, consumers can be referred to a provider or a peer-run organization to provide support, as alternative to jail.

"Housing Options Made Easy (HOME)" in NYS is an example of a peer run organization that is focused on housing. In Georgia, one group partnered with Habitat for Humanity to develop "Jerome's Home" which helps create home ownership opportunities for individuals in the mental health system. There are Individual Development Accounts in New York State which allow people to build a savings that is matched 4:1, and can be used to buy a house, start a business. Laundry services help people to have clean clothing. Many programs have basic literacy training. Many people with SMI have a 6th grade reading level, possibly because of medications, and because of disruptions during formative years – we help people develop skills to compensate. If you have SSI and have student loans, ask them to forgive the loans, and many times they will. Many peer-run programs do newsletters for getting information out to members. Reaching out to people not currently part of the system and engaging people not currently in services is important. There is going to be a new funding mechanism for peer-run programs around outreach and engagement. Clinics will subcontract with peer agencies to provide outreach and engagement. Parenting support to support parents. Around 60% of women with SMI of childbearing years have children; 85% of those do not have custody of their children. Almost half of men in the system are also parents, and we also need to think about ways to support parents, both mothers and fathers, around child custody issues. Peer bridging helps inpatients and inmates navigate the community upon discharge. Budgeting and money management support by offering courses and offering rep payee services.

Speaker's bureaus are part of outreach programs and stimulating membership. Social recreation events are important to engage people in ways to include fun and not just training. Support groups, psycho-education and self-management are offered. Many traditional providers do this already and do this well, but can teach about managing one's own life; managing my own weight and health, preventive care; empowering them to be able to talk to their own doctors, or talking about "personal" medicine. We can link consumers with volunteer opportunities since many communities have a clearinghouse for volunteer opportunities.

So, all of these things have been there in parts in peer run programs, but we want to get all of these to the entire state.

What do we mean by a Recovery Center? I think about self-help peer-run group “on steroids” but like Olmstead. It’s not a place where you will get supports forever; it is focused on helping people to have a life outside of the center. We want to get away from the “rehab van” that takes consumers to all of these non-integrated services in the community. So, recovery services are about helping people get into “regular” things in the community, and in regular ways. It will be a clearinghouse of opportunities for things in the community which incorporates the principles of Olmstead. Think about assisting people in using their own community, as opposed to having the recovery center be their community. Discovering your own passions in life is the theme. Many people I speak to have been in the program so long that they have killed off all memory of what was important to them. If all I think I can do is sit in a day treatment program all day, I forget about my passions as a survival mechanism. It is the “spark of life” that we are looking for. What is the passion in your life, something you can talk for hours about? It might be children, hobbies, an organization, cultural heritage. If I can find passion, then I can find hope. If there is no passion, there is no expectation of something different. Centers need to help people remember what their passion is – help them find their “spark of life”. There was a resident of adult home for 38 years, and in her youth, she had been a flamenco dancer, and never had the opportunity to dance. She forgot that she used to enjoy that. At a party she asked me to dance and remembered how much she loved it. We want to think about helping people figure out what they are zealots about, and help them find a lot of other zealots. If I am a computer geek and I am around other computer geeks, then there is less emphasis on how we are different from each other, to more of how we are similar. In the “Cheers phenomena” – “where everybody knows your name” we want to use the Cheers concept within the recovery center where people can connect to community member (another zealot) so that it’s not so scary to leave the center and try something new. We want to develop groups around topics that they are passionate about that don’t include mental illness groups. Mental illness isn’t life. We want people to celebrate their lives.

There are naturally occurring communities such as faith-based organizations with lots of ways to be involved, parks and rec, libraries, schools, arts councils, community centers. If I am passionate about baseball, I may not be able to pay to go to the Yankees game all the time, but I can go to the park and be a coach or umpire. Doing that allows me to develop that passion in an environment that has nothing to do with mental illness and passions get reinforced. Involvement in political organizations, civic organizations, red cross, SPCA (lots of contact with pets), co-ops - food, housing and products – safety concerns (neighborhood watch), museums, spirituality; places where people can get supports that aren’t in the recovery centers – it is just about linking people with things outside of the recovery center. Feeding my passions.

Not all of us have people that we can call when I need them, so virtual groups can be useful because there is always someone to talk to. With virtual groups you can’t exhaust all of the people there.

So what are the next steps? Gathering input and direction from peers (what we are doing today). How to transition from where we are to where we want to be? We want you to transition from what you currently offer to also offer and expanded menu of other things. We will contract for technical assistance center as a lot of peer groups fail because they don’t understand the “business” of managing a not-for-profit organization. We will be issuing an RFP for ; the TAC and we will be looking for an organization that can help these small non-profits with the business ends of things. We will also use the TAC to drive the programmatic end of the process (peer steering committee, peer mentoring opportunities, distance learning opportunities). If you have a particular specialty (e.g., know how to operate a co-op), and then we want to identify

who you are and link others to you. The main concept is community linkages and participation, not the place where the passion happens.

Participant Feedback:

You mentioned a non-profit peer-run process, it's a big mental process, confronted by a lot of new things like being monitored by government, and there is no mentoring. We had to rewrite a mission statement and create a board of directors. We had no emotional support. For those peers who want to move on, they need emotional support. Peer mentors who can tell us what to do and provide emotional support.

John Allen – remember that we are going to have the TAC support center to help with this. This is already built in. What we need to know is whether we are on the right track.

Can the TAC group provide training to project director?

John Allen – it doesn't exist today, but we are going to build it.

I like the idea of a mobile unit. I don't want to see any provider organization getting the funding. As a peer, the minute larger organizations get any peer funding, we know what is going to happen with it. We should get it. For example, as the mobile unit, we are going to visit several different homes. If I see lots of CD's, I would think to ask, "do you like music". The conversation may continue "Yeah, I used to be a DJ"; These interactions will help identify passions. Doing outreach is important.

I'm a licensed clinical social worker and a consumer, just because you have a mental illness does not necessarily mean that you can provide good services. More training is important. There are good people who have a mental illness but would provide bad services, and people without mental illness who can provide good services; recovery is a personal thing – your journey in life, dealing with the cards you have been given; so, training is important.

I think an actual location is really needed. One of the major obstacles to integration is not having computer skills, so partnering with an organization for cheap laptops, or even providing payment plans for laptops could work. Then, people would have access to a lot of information. Employment website; and, I'm concerned about stigma out in the community, and should provide peer crisis diversion services.

So, what has prevented consumers from accessing these organizations already? The answer is probably stigma. When people try to fit into a mainstream group, they experience stigma. Part of the Recovery Center process might be to go into those organizations and provide information to help them address the stigmas attached to these labels. When working one on one with individuals, we can help to make those links.

There is a certain element of us talking to ourselves, but I worry about the person who has a first time psychotic break. How much quicker would have my recovery have been if I had known about these Recovery Centers, as opposed to the ER? We may want to think about advertising and marketing for these recovery centers.

Lindy Fox – across the board, what he discovered in our interviews was getting the word out about their organization. I was one of their biggest challenges

Is it even possible for someone to just walk into a RC- would you need a diagnosis to enter a recovery center?

We need to engage community services like Central Park maintenance, Bronx Zoo maintenance and get them involved. When people have a passion it is great to use volunteer match- but sometimes people are dismissed once they do something unpalatable to the general public. It would be great to engage a program where people can gain skills- targeted and focused skills in something they are passionate about. If we don't get rid of the stigma, this isn't going to happen.

For the population who has been in traditional services for many years, I was thinking about the kind of flexibility we need to engage the service providers. Some doctors won't even let you in the door. Instead, we need to ask them, what kind of training can I help provide? This will help the relationship between RCs and traditional providers. The Centers could help develop training that providers can offer themselves. Flexibility is important so that if a provider comes in and asks us to help in some way or provide a service, we can meet that need (e.g. advocacy training- this would help partner with clinicians since it is something that they can't bill for anyway). Therefore, providers won't be threatened and may feel that the service we provide is something that they can use.

If we want outsiders to respect us, we need to respect each other- we are all professionals and need to act like professionals.

It's important to train the personnel. From my own personal experience, when I have gone to someone who claims to have expertise in helping, they couldn't help me, and I had to figure it out on my own. If we want outsiders to respect us, we need to respect each other.

It's really important at these Recovery Centers to have employment services, referrals to job training centers, lists of places to get training. They might want to have an employment specialist on hand that can refer people to important resources.

Certification for peer specialists is needed because people should be on the same page- you should get a consistent philosophy. People come from all different backgrounds and bring diversity which is good, but for certain information; everyone should have a similar understanding and knowledge base.

There needs to be a centralized location for the RCs. With a mobile unit where peers go to the individual's day treatment program or residence, you are keeping people in their own comfort zone and they end up interacting with the same people over and over again. There is a need to integrate into the larger peer community.

I think the concept of the RCs is good and will work, but we often forget about weekends/holidays. People often have stuff to do during the week, but don't have what they need on the weekend, so weekend services should be available. The weekends are often when people like us get into trouble.

It would be helpful to have workshops and/or trainings once a month for the peer specialists at the RCs to get to know one another and know what's going on.

The family helps us with our recovery; however, there is a need for some type of group/education for family members. Family members can help us help the peers overcome

their barriers. Unfortunately, family often neglects the person who is going through a difficult time because they don't know what is going on and don't understand.

Outreach is very important. People need to know that there is place where they can get help. We need a place where loved one is not hurt/arrested if in trouble, but a place where he/she can get help.

Once the RC exists, it's important to continue getting the perspective of people who are attending the program.

Wouldn't it be nice if children had a place they could go where they can "tell their secrets?" It would be great to have a way to get to the undiagnosed people out there.

I like the name "recovery center" and think they must address the main 5 – home, job, friends, date, transportation. If they don't address those things, they are falling short. I liked the idea of benefits advisement as independence depends on the amount of "jingle" in your pockets. Also, we need to make a voice for ourselves in the community. The RCs should have both a permanent and mobile location. A mobile and physical space needs to be blended because people need to have a place they know they can go, and a place where they can get connected if they are not going to services. OMH should think about leveraging space from agencies that receive state funding.

Teaching people about politics and civics is important for advocacy. Often people don't vote and are not taught civics. It's important to understand that the people who are voted-in make policies and decisions about us.

Computer training is important. Computer literacy is vital-everyone needs to be able to use a computer.

Supportive employment is important. Once someone starts to work, we need to be able to provide assistance and answer questions.

The formation of alumni groups could be useful. It would be a way of giving services back to the community.

I was talking to a dear friend of mine with whom I have known for so long, who didn't even know that this population [peer specialists] exists. If we are only speaking only to mental health providers, you are either only speaking to the choir or talking to folks who might be affected by billing mechanisms so we need to do more outreach. Also, change the word "recovery" to "wellness"; "recovery" is a stigmatizing word. I don't need to recover, I want to be well.

Important to have someone help with navigating immigration and naturalization issues. Many people have lost their green cards and/or don't have proper documentation.

When we start moving out to different communities, whoever is staffing the recovery or wellness center, needs to be sensitive to culture. Culture often impacts how people talk about and perceive health and mental illness. There should be staff training to understand different communities and how people understand and want to engage in services. Staff needs to be able to present things in different ways to make it understandable and acceptable to different people.

When I graduated in 2004, I had a class in cultural competency, and it was excellent. We talked about things like how different people from different cultures perceive things different.

Would be nice to have 1-2 beds where I can just have a place to be safe overnight as opposed to having gone right into a hospital.

My family really needed support when I started my own recovery. We need to spread the word. Some families may not understand or accept the mental illness or substance abuse, and have no insight about what they can do to help. It's important for family members to learn how to communicate with their loved ones.

Lindy Fox – so, there may be a need to include those other self-help groups for family members that were mentioned earlier (e.g., Al-Anon).

I think the whole idea of the RCs is good, but it's good to have a center in each borough in addition to the mobile service.

Important to have support for the LGBT community. This is a much underserved population- there are 11,000 in NYC with unmet needs.

Part of the center should be dedicated to reducing stigma. We should educate the community by having speaker's bureaus. In my experience, it astounded me how much powerful, educated people did not understand mental illness. Education needs to be a major part of the center, not just a third or fourth priority. Even car dealerships have liaisons with DMVs to make things happen quickly. Why can't mental health providers have these same kinds of connections?

Systems bridging is important. When a person is just getting out of the hospital or jail it's hard to navigate the systems well. People need access to social services, health, and hospital services. An official contact person who is available at all times is needed.

With scarce resources in NYC we might be able to co-locate with some of the established family resource programs. We could provide advocacy services and may be able to co-lead parent groups at locations that are already established.

Would like to see an economic development council with a pool of money for community and social enterprises. We have a contract at one of the residences, and they found they needed a bookkeeper; could that bookkeeper be for several small organizations; that can help us do our billing? Could the billing be done through the economic council for that group; in other words, how do we expand opportunities; let people try it out, and if it works, we need to copy it.

I'd like to speak to "non peer programs" as I was co-chair of a council that consulted on the response to RFPs. In the proposals, many programs said they had a respite, transportation, recreation and peer advocacy program up for grabs. I was appalled because they had so much peer involvement in the applications and I would like to see what they are doing and how it compares to what they promised.

We often use food as a tool for engagement. A lot of people are diabetic, pre-diabetic, and we people feed people a lot of carbs and sugars. We need to teach people how to eat nutritiously; we need an exercise group or exercise programs like walking, running, yoga, etc.

When I first got diagnosed, I got put on this old drug called stelazine which caused TD and seizures. I think the recovery/wellness center should have an education resource center where

people can learn about their diagnosis and medications. A psycho-educational resource would provide people with information from someone who is knowledgeable about services, illness, and symptoms.

We need to focus on access to health care, and not just mental health care – some of us don't have health insurance. We must provide links to resources for free health screening because no matter how good your mental health is, if your physical health isn't well, then where are we going?

Need to educate children whose parents are coming out of the hospital. Children are sometimes taken away from parents and don't understand why. We need to be able to support and educate parents and children on what is going on.

Lindy Fox – we should also add parenting classes.

Getting back to the point of distressing, I think it would be anti-stigma to have a creative arts resource. It would be good to have people who have talents be able to have access to resources (e.g. a piano for someone who used to play). We need art and music resources as a way for people to develop talents and creativity.

We had mentioned having a career club. It would be helpful when someone gets a job to get assistance in helping pick the right insurance. People don't always know what the different options are, and sometimes pick ones that don't provide enough mental health coverage

We should help people access spiritual retreats; it's great for stress relief and it can be cheap. Spiritual retreats are a great way to have self-awareness and a place for people to get in touch with their spirituality.

How do we get the information out there? I've been doing this [peer work] for a while, and there are still whole pockets of people who don't even know that we exist. We need to get the info out there so that people can be more able to come to us.

It would be good to advertise at a social security, welfare, or Medicaid offices. We may want flyers in places like this where people are going often and are out in the community.

I think the mechanisms are out there for getting the word out. There should be literature about what psychiatric disabilities are and information on where people can find more information about recovery centers and other non-profit organizations. Getting the word out about what is available out there is needed.

We can educate people on what spirituality is. People can learn about how to have a relationship with spirituality and use it on their journey.

I want to make sure the parenting classes are not minimized. There are no services for parents who want parenting classes without involving ACS.

Let's also include yoga, Reiki, herbal pharmacies; the more self-based treatment, the more effective we will be. The RCs can't just be symptom management based because we don't want providers going into these places and peddling their "wares". Also, we don't need to reinvent the wheel and if we focus on symptoms too much, we will end up focusing only on disabilities and diagnoses.

Need to make sure we balance traditional with alternative options. We should focus on educating people about all of the options available to them such as psycho-ed, aroma therapy, pet therapy, etc.

How do we keep the focus on moving people through the program rather than just creating another place where people stay long-term? How can we keep the focus outside of the building? We don't want the van sitting outside the building again and when people start hanging around, people don't want to encourage them to leave.

That peer council can help keep the center focused – a peer steering committee – an outside council that can keep you on the right track. The council would be objective and can keep you focused on where you are going. The committee would need to have no outside agenda.

We need to think about informal communications (e.g., in the grocery store) so that we have a connection in the community. We as peers need to be good communicators because informal conversation is a good way to get information out.

We serve “people”. They aren't consumers or clients. They are people. Partnerships within the community are vital to our success as RCs.

www.samhsa.gov has a lot of useful resources that can be shipped to you.

People who have lived the history need to be part of the evaluation of the program. Many people deteriorate or relapse because of lack of supports,

We need socialization services to provide information and opportunities for people to socialize and have fun together.

We need to get away from anything called “treatment”, but rather think about empowering people. People should think about what they want to do and then think about how they can get there.

When we consider integration into society, do we necessarily need the resource centers to be peer operated? This summer we have had a summer-youth employment center. At the end of the program we asked youth if they know that they were surrounded by people with mental illnesses, and they said no. These people are able to walk away with an experience which will help to reduce stigma that is pervasive. There are other people out there who may be able to help these centers and some may be volunteers.

We are the community; we come from the community and say who we are and educate others. If we let them know who we are now, people will not be scared to think about someone with mental illness as someone they see portrayed in the media. They will know who we are and will want to interact with us, they will embrace us.

John Allen – I want to take the last couple of minutes to tell you where this is going to go. The core of self-help is really what we have got to do. So, in that array, the broad menu of self-help is something that we need to pay attention to. To move a lot of the self-help ideas into the recovery centers sounds right. I have heard a lot of good reminders of things that I already think about but haven't said yet, like a centralized location, importance of cultural competency; the next step is to do more of these forums around the state; for those who come to the September

WRAC meeting, we will continue this dialogue at that time. The concept of degrading to the mental health model; diagnoses won't be necessary to enter a recovery center. I met with someone who I met 30 years ago, but this was a person who was in one of my programs 30 years ago. He is still there today and hasn't moved on from there. It is a reminder of how critical it is for people to move on from the program. I don't want people to spend the rest of their lives in the program if they do, we aren't helping people to reintegrate, recover or help people on their journey. Please continue thinking about what we talked about today. There will be an RFP for the TAC.

Transformation Transfer Initiative Peer Forums 2009
Islandia Marriott, Hauppauge, NY
August 28, 2009

Executive Summary

Background: The Office of Mental Health is exploring the possibility of developing peer-led Recovery Centers that would offer focused supports to individuals who are in the process of working towards defining and achieving their personal recoveries. One aspect of this process has been work done by experts at Dartmouth's Psychiatric Research Center to interview peers across the country who are currently involved in such Centers. This will provide OMH with some perspective on what seems to work (and not work) in other locations. A report summarizing this process will be issued in the near future. Another aspect of this process consists of holding a number of regional forums with consumers throughout NYS, asking for their input into the planning process. This is one such forum. Participants attending this forum identified the following themes:

Reactions to Concept of Recovery Centers

Participants in the forum were generally enthusiastic about the concept of Recovery Centers. They particularly liked the fact that the centers focus on individuals' strengths and interests rather than labels and diagnoses. The Recovery Centers demand creativity and innovative thinking. Participants commended the concept of Recovery Centers as a means to move forward to a more integrated life. They were enthusiastic about helping people find their passions and agreed on the need to expose consumers to many things to find out what excites them. Participants acknowledged that consumers can lose their identities in long-term programs and expressed the desire for supports that help build self-esteem and emphasize that the world is more than mental illness and mental health treatment.

Need to Address Stigma in Community

Forum participants consistently expressed concern about stigma and how recipients of mental health services are received in mainstream society. They agreed on the utility of a speaker's bureau to educate the community. Participants strongly encouraged allocating funds for marketing and advertisement, both to publicize the Recovery Centers and address stigma.

Spectrum of Needs for People with Serious Mental Illness

Participants expressed the desire for Recovery Centers to support individuals comprehensively, beyond their mental health concerns. This includes support in a number of areas, including:

- Physical health
- Addictions
- Social skills training, including listening skills
- Art classes
- Spiritual enrichment activities
- Opportunities for employment
- Guidance about benefits
- Mentoring within the community

Some participants suggested an online resource for training and employment opportunities. The speaker's bureau could be a resource for finding individuals with various skills and talents to travel around the state and share their knowledge.

Recommendations about Operations of Recovery Centers

- Participants encouraged development of an advisory council that includes people in early stages of recovery as a reminder of the range of needs.
- Focus on moving peers into the community—we are the community. It's not them versus us. Non-peer programs should transform to peer-run models, with suggestions and support from the advisory council.

Participant Feedback:

We should not allow non-peers to come into our peer-run programs because we are not a backburner for things. We are human and we are able to run our own program. I say no because that is just defeating the purpose of the peer run program.

I think that you were comprehensive in the wide array of services you talked about and the focus on wellness and recovery is important. The idea of having professionals take the background such as something on networking and understanding the roles of peers as professionals are helpful. What are those roles? How do we shop for professionals that we need?

I was excited. I saw the transportation mission. I think it would be helpful to include travel training. We could teach people how to get reduced fare cards, how to get driving lessons, how to own your own car and how to maintain it.

We also need to set up social sexuality groups. We need to talk about how to date, understanding the nature of human sexuality, and education of homosexuality.

I think it's still important to have psycho-education as part of outpatient treatment. It really helps to have a therapist or a professional to be able to provide therapy.

I'm excited about helping healthy people find their passions, and I'd like to hear more about what the passions are. I am excited to have people look at themselves and think about what they are passionate about. People need to speak up and speak out about their passions.

It is fun to look for the "twinkle in their eyes" and see that "glimmer of hope."

Community involvement is important. We need to create speaker's bureaus where different groups speak out. In the community I serve and in small towns, a lot of people don't really know what is happening in the mental health community. If something horrendous happens, then that is all that they see. Let's get groups of speakers going around speaking to other people to give us some new exposure. We need to put advertisement dollars into educating the community..

We need more sensitivity training for staff in the community residences administering programs for the mentally ill. We need to create less fear of reprisal for people who speak out. I think having a peer specialist in places like emergency rooms to do outreach would be beneficial.

I like the idea of using passions to integrate people in the community. It's important for people to realize there is a whole world out there.

This idea is something that is always running through my mind. What if somebody wants to be a chef? It would be great to get them a job as a chef in a restaurant and get some on the job training.

For adult homes, there isn't a program to get people more hope. We need peer bridging for the adult homes because I have noticed that if you provide good services in one environment, people don't have a need to go anywhere. There is nothing developed to give them hope and have them move on.

One thing about the RCs I like is that it demands creativity on everybody's part. It makes you not use excuses about things that cannot be done. Everyone will need to be thinking outside the box while battling stigma and discrimination. We need more vigilance about discrimination. There are a lot of fears on both sides, but this is a great opportunity to go to war on discrimination and stigma.

Peers have their own expertise but could use some training in crisis management and de-escalation strategies.

Also, I think that it pushes us. Maybe 10 years up the road, there might not be a mental health system anymore. You will have to let go of your mental illness diagnosis, which is your comfort zone, and become who you really are. We need to drop the labels which are false. No one wants to hear that diagnosis doesn't mean anything and that there are no such things. It is psychiatry that makes up labels. I have been saying that there is no such thing as diagnoses, and I was shut up right away. Why? Because it takes away from their power, practice and training – the psychiatric label. Watch that DVD-psychiatry is driving the mental health system and making up diagnoses.

We need to be looking to move the system to peer-run and psychiatry supported.

The spark of life is a good idea. In peer programs, peers are supposed to do everything. In my program, I cook, do training, I'm the shoulder to cry on. Not everybody here can do everything and because of that, there is a lot burnout. A lot of people want to use what they have to bring a lot back to the consumers. A lot of peer programs however are understaffed. The training and recruiting process is really tricky.

Not asking about people's diagnoses helps. I worked with a person for a year and I never asked about or talked about her diagnosis. People are people and we should find out what their talents are first. We need strength-based programs where we can recognize people's talents and what they can do. Then we can focus on the direction they want to go in.

I think an important piece is advocacy. I'm lucky because I can advocate without yelling. I was in a position where I had to advocate for myself or I would have ended up in the hospital and I was able to do it in an appropriate way without getting out of control. I don't know how many people are able to do that.

We should present to the people we work with that the recovery center is a means to move forward, so that it doesn't become a place to find a home.

Part of the transitioning to the RCs is asking people what they want and instead of telling people what they need. We need to provide choice for what people want.

I would like to move away from a label. Everyone should have their own identity of who they are. I am an artist and love the arts so I was excited when you talked about art councils and artistic and spiritual activities. The arts are something that enriches these programs from the ground level. We need to make sure to ask people what they want; while remembering that inclusion of the arts is important.

There is so much fear about integrating into the community. We need to work on addressing the fear that keeps people from coming to us in the first place.

People lose their identities in long-term programs. We need to help build self-esteem and make people realize that there is more to life out there. There is more than mental health. Consumers eat and sleep mental health. Everyone is asking all the time, "how are you doing?" I get sick of it- people are watching you constantly- in the ER people are always watching you and you feel it and then you're diagnosed as paranoid. How do you get people to realize that there is more out there?

It's not just who you are, but also what you are doing.

We need equitable pay in group homes and social and recreational opportunities. There needs to be less stigmatization by staff, more morale boosting activities and more networking between staff peers and clients.

In my recovery, I was not feeling useful, and I called my sponsor and said I am tired of always "taking." I was asked "can you look like you are listening?" I said "ok" to which my sponsor responded "then you are useful." I was able to sit there and just try to listen. My sponsor suggested that I should be glad that I was able to do that and to honor my own contributions.

I got tired of always being the "consumer". I learned to pay attention to the contributions that I am making. It's important to practice other forms of behavior, rather than always being a "consumer". Learning about protocol when I would go in the community is important. For instance, I was scared to go to the library. I was scared that people would look at me and I didn't know if I could speak out loud or think that I was odd. Important points include (a) mentoring such as sponsor mentoring or peer mentoring. (b) affirmations from others that you are contributing, and (c) what are the training and supports we will need to provide to get to the next level? One other questions is, how do I go about talking to people? Is there a set of curriculum we should think about developing?

When we are training people to be peers, are we separating them out and pointing out that they had had a mental health issue.

You aren't just born with the right set of skills to be able to support each other. We learn at different levels and in different ways, and so, what might the training look like? Not everyone is a great peer leader.

To be a good listener it is really important to listen to what people are saying and what is it that they want to work on right now. You need to listen to what their goals are in the moment so that in future you won't have to help them forever.

We need to teach skills for building listening skills.

How do we get salaries and benefits for people? There may be apprehensions and fears about going back to work. Weighing the balance of risks and benefits of going back to work is important to talk about.

Most of the people we work with have had their self-esteem diminished. We not only teach advocacy skills but we develop peer buddies. You observe your peer buddy through the class and observe only the positive thing that he/she is doing. In trainings sometimes the human training is left out, but a lot of our peers are "socially inept", and they lack confidence to explore things in different social situations. We need to work on building self-esteem, socialization skills, and normalizing social roles.

For supports and training; the program I am in is fairly new. A lot of what I'm doing is giving training and supports. It would be good if we had a website, and if you needed a particular skill and needed somebody to talk to there are resources. A website resource and training center would be helpful. For instance, I'm willing to travel to these certain communities and offer training in such and such. If someone had a need for benefits counseling, substance abuse counseling, a website would be a good resource for linking peers with people who can train. We should think about transition teams; the model I came from is the ACT team. Why can't peers implement something, like, "if you need us, we'll come."

I like the idea of bringing an addictions person into the picture. There are lots of reports about co-occurring disorders since we're all trying to self medicate. Being able to recognize and address both mental health and substance abuse, a holistic approach, is important. You need to view someone as a whole person, not just as an "addict" or "are you symptomatic?" How is that helping? My identity was lost through the years of using and abusing myself. My brain was not being utilized. I went to IPRT, and she asked a few questions and then just drew up an action plan. My arousal was through the roof because I didn't feel like I was anywhere in the action plan. She waited until I regained my listening skills and then I was able to be active in the planning. You lose your identity when you are dependent on something. There is a course that teaches you how to be an active listener. Active listening and building a sense of identity is important in reestablishing identity.

People have expertise in a lot of different things. A speaker's bureau would be helpful. If someone is able to speak on a topic, have people travel around the state and talk about their topic. We will need to come up with a fund to pay for travel. The topic could be "what is your passion", or teaching. The mobile training curriculum could be an on the web resource where people would be able to identify what is available and have a way to contact speakers.

We need more interactions with peers and supervisors, not just supervision. We need to make sure that the peers and supervisors are not isolated from each other because of ideology.

I found that the biggest problem between peers and providers, is that providers say they will call a person a specific day and time, and they don't. They don't have the decency to let people know beforehand- people need to meet expectations. There needs to be common respect, a standard code of conduct and some monitoring of that conduct.

I think that peers need to never forget where they come from and what you once were. Getting into the system and "becoming" the system. we become controlling, we become provocative. We forget who we are and where we come from. Some of us have had peer advocacy classes. Active listening skills must always be free of inside traffic- it must be clear. We must remain clear in our minds as we are listening to our peers. How do we help the peers who are staffing these centers stay grounded in who they are, and not being co-opted by the position? How do

we help people filter out distractions? You know you are a good listener when you can repeat back everything they said to you. We need to remember that we were once in the same position as where are peers currently are.

Having providers who treated both my mental health and substance abuse problems was very important. You need to treat “all of me” and not just the “pieces of me”. How do we support the development of new programs where we currently have none?

We have to help people find out what they like. Some people say “I don’t know what I like because I have forgotten.” We need to expose people to different options and help them find what interests them and what they like to do.

People just want to live life. You could go through courses or groups on different activities, but unless you are out there in the real world, you can’t do that much. People should be encouraged to get out there and see different things. We should have the motto “each one, reach one” so we are always mentoring and bringing people along.

I’ve had a lot of opportunities to share my story, and I seem to always be functioning in a survival mode. I feel as if I don’t do this right “disaster is going to happen”. Need survival skills. Feeling more comfortable takes practice not just an idea. We need to practice skills with compatible people. There is a lot of potential for the group experience. When we are talking and practicing, you stop talking and focusing on the diagnosis and instead focus on humanity. You may feel “I’m special in this way and when we practice this interaction, I am more like you than I thought.” These commonalities make me more willing to take a suggestion from you.

Something like an advisory panel that might include people in the first stages of recovery; would be important to keep us grounded. In all of the stages of life there are things that come first and we are not all in the same place at the same time, We need to have different things for different people at different times; but should always be focused on moving peers our into the integrated community. We are the community; it’s not us vs. them.

In order to support the development of programs in areas that don’t have peer services, we need to write to local representatives and try to get funding. There should be more fostering in the individual and not just the client. A cognizant effort to not have any triggers of any kind for staff and peer efforts is important. Some people take things very personally.

There should be specific competencies for peer specialists. There should be some sort of certification for people to be competent in being with others and talking with them.

The structure and employees are already in non peer programs. By adding the peers, I am supportive of letting non peer programs transition to peer programs as long as they let peers come in to help run the program.

Doing outreach into the community is a good way to develop peer programs. In order to support new programs, we need to first make it known that our services are available and people need to be able to get in touch with us. We need websites and information.

The higher you go up in non-peer programs, the less the people know about the people they serve. We need to caution people that it can’t revert to a traditional program, it has to be all peer run from the receptionist to the top.

I think that networking between groups is important. If peers are in one part of the state, they should be able to connect with others from different areas.

I think it's positive for non peer programs to transform to peer programs. That would be a part of system transformation. They could take the good stuff and some of the services that we already have in place. It would be great for them to begin listening to us.

They should put us in charge of DSS. We would be the best one to know how to help clients with DSS benefits. You need that education piece, so peers who have a solid education should get into DSS and get their hands on it. They can learn how to help others who are being "messed up with their checks" to look it over and get it fixed.

For people around the state who don't have peer support in their area, it would be good to have a conference over there, and a busload of people over there, and have all of these experienced people come and share their experiences.

When they come into the recovery center there should be a form that asks, "what do you want to know more about", and there should be an email that would go to the agency who can help them. After 6 months we should encourage people to go back to college.

This meeting meets us where we are at. It is attainable and tangible. We are in an area that might be populated with other peer organizations, and we have brought a lot to these concepts to our program. Two of our people are in college, and in jobs. Sometimes you don't know what the question is; but as we progress, we will know how to present things so that they know the right question to ask. We need some continual exposure to the concepts processes about how to present to peers.

In rural areas, can we look at what exists and see if OMH sees a need? From there we can talk about transformation and assistance from OMH.

Could we look to make case management more transitional? We should encourage case management programs to transition to this kind of service.

We need some kind of massive outreach, or small workshops to encourage development of peer programs in areas that don't have these programs.

We need to be sensitive to the needs of the client and need to use sensitivity in our speech and actions with others.

Money – the root of all evil and the root of all programs. Where is it coming from? John said that there is 1.4 million this year, and 3 million next year to implement, transition, all of the above.

This is very different from what we have seen already. I see day treatment programs and clubhouses, and on any given day, it all looks the same, there is the van, there are the meals, there are the couches; this is NOT that. It's not an activity program or a skills program. We have been "grouped" to death. This is a resource center to integrate into the community and to be a citizen. This is something that has never been created before. Visually, it is not the van, couches and meals, but getting what they need and moving on. This is not a place where people are all outside smoking and gathering there every day.

I also see it as bringing in the community into our community. I hope these peers get a decent salary.

John Allen – In October, we will issue a RFP to create the technical assistance center to support these, and by the end of the year, we will issue 2 RFPs for 2 centers to begin developing these center; the priority will be parts of the state where there are no peer services; next year another 12-15 programs that we will RFP around the state; developing a steering committee to help guide and keep this grounded; the concept is not an incremental step; we are looking for a developmental leap to begin designing the next several decades of peer programs; I don't want to find what I found with my first drop-in center, where people congregate and never get out. It sounds like you are in agreement with the concept we have proposed.

Transformation Transfer initiative Per Forums 2009
The Cornerstone Residence, Newburgh, NY
October 8, 2009
Meeting Notes

Attendance: Approximately 27 people attend this forum in downtown Newburgh.

Lindy Fox, Dartmouth College:

There are 39 peer programs that we contacted. 30 programs responded to us. Many of you have copies of the questionnaire that was used when talking to these programs (See Questionnaire). There were different elements that those questions covered. There really weren't any surprises from the questionnaires. The missions of the programs were driven by where programs were located – rural or urban – but the recovery-oriented mission that drives your programs was part of all of their missions. That mission was evident in all of the programs. Additionally, their vision, or sometimes called “rules of the road”, empowering people on their road to recovery was also quite similar to your programs. I talked to programs in: Arizona, California, Canada, their underlying values are very much the same everywhere we go. I actually read all 30 questionnaires, and although they began to mush together, the underlying values were still there. The history of the development of centers was very typical. For instance, recovery Innovations was started by a husband and wife team. It was driven by somebody being unhappy with what they are getting.

There were two categories of peer programs – older peer programs developed with the typical “drop-in” center model, and then the newer programs with a wider array of services which include wellness centers, outreach to hospitals and jails, employment. The more traditional centers had a harder time developing an array of services. Many programs are offering the array of services (e.g., WRAP, employment services). Unique services; included: employment, parent services, justice diversion, business opportunities for peers, 10 week recovery strategies, Consumer Choose (Florida), Project Return – wellness center that were all peer run.

The value of “consumer managed” services is there. There are a lot of programs with a mix of peer and professional staff out there. We did not quantify this, but there are still mixes of some that have professional staff mixed in with peer staff.

Dartmouth found that leadership is a central issue. People are attracted to charismatic leaders. I talked with some people who started programs, and some were very passionate and charismatic. Passing the baton is a very big concern – who will take over their place? Who will carry on that mission and vision? That issue needs to be tackled by peers who decide to develop recovery centers. Word of mouth was often how people found out about a program. Most programs felt the needed to find better ways to advertise.

Recovery and “giving back” was a central theme. I heard many organizations saying they don't want to duplicate services that already exist. Many peer programs have a huge emphasis on wellness. Recovery Innovations was one of the peer programs. Recovery Innovations has a “wellness city” with a complete focus on health and wellness. The Village has a wellness center where wellness is a huge focus. Most did have some wellness component being incorporated into the programs. Some programs had positive relationships with mental health services in the community. Outreach was often a big part of peer programs. Some did outreach to hospitals and jails. Programs varied in how positive they viewed traditional mental health services. One program had staff working within the mental health center to work directly with staff in the

mental health center to develop WRAP plans, which I thought was a really good effort. I think that peers can have a great impact if mental health professionals are willing to listen.

We looked at community relationships. Programs that are most successful are those that look outside of their discipline. They look at churches and community centers, but you have many people who use alternative services. It's important that outreach goes out to the alternative organizations. We are finding lots of people who need treatment that aren't part of any traditional program.

Domains of supports: There are a lot of elements to peer support programs, and a lot that these programs offer. Peer support groups we interviewed were lead by peers, provided information on what's available in the community and what resources are available, did outreach to hospitals, jails, shelters, and all had a variety of educational opportunities. Some had links with community colleges and people could earn college credit there. Some could take classes for college credit within the center. They partnered with community colleges and had artistic and spiritual programs. Many had some kind of emphasis on employment, housing supports, and advocacy support. One program only did computer education classes. Many offer some kind of social aspect within the drop-in component or linking with some kind of social aspect in the community, some had apartments for people, and offer some kind of advocacy programs. Many have WRAP within the program, social activities, health and wellness component. Much of my work is in the co-occurring domain, and I was excited that many peer programs who offer groups for co-occurring disorders (e.g., "double trouble"). Programs highlighted were:

- Women's empowerment – recognition of women's trauma issues
- Pathways to recovery in NYC – Education and employment focus
- Village of Long Beach – Wellness Center
- PEOPLE, Inc – Rose House hospital diversion, nights out – using natural supports, crisis workers, housing first, supported housing. "Hope greets us at the door, and recovery is the expectation"
- Recovery Innovations, Arizona – developing peer programs and absorbing other traditional services programs. Links to education strong.

John Allen: What should be the next generation of programs look like? What do we have now?

John reviewed the history of peer run drop-in centers and provided list of services currently not available all in one place in NYS.

Programs should offer a menu of options

- Include benefits counseling.
- Career clubs - to help people with how to cope with social relationships on the job.
- Community kitchen and meals, computers/ internet access are key components
- Crisis support/warm lines
- USDA certified food pantries are often available because people struggle with living in poverty – Step by Step in Watertown is an example of a program that offers a food pantry.
- Forensic services – jail services - HALI
- Home of your own – IDA accounts – use to start business, buy a car or home, often available through credit unions.

- Partner with Habitat for Humanity – invest time in building and getting access to a Home – Jerome’s Home, Georgia
- CSP of NJ

Comment: the government gives money to drop in Centers to buy washers? Some have found donations for their Centers.

- Need to work, continue to change and to grow
- Literacy training/ Education support
- Link to college and financial aid for those with SSI
- Outreach and engagement – NYS Clinic restructuring will use peers for outreach and engagement.

Comment from the group: Were any involved in broadcast such as a radio station?

Response: New Mexico has a radio show featuring Gilberto Ramirez – a peer; I think the show is called “white light”.

Many programs help individuals link to colleges and help them access financial aid for those with SSI.

Outreach and engagement – NYS Clinic restructuring will use peers for outreach to those who have difficulty accessing clinic services. Some organizations currently provide outreach – for members but not necessarily other parts of the system.

Training education and support for parenting – MHANYS was offering \$500 K to assist in the development.

- Peer mutual support – core function, bridging with other services
- Payees, budgeting, asset accumulation Unity Way offers programs
- Speaker’s Bureau – the way we market and educate
- Social recreation events – A core function that goes beyond socializing. It should serve as means to get to the table but help with other things.

Most of us are “grouped to death” Groups should be something that connects people with other things.

Volunteering referral are core components.

What’s new for the future?

We want centers to be part of a network of MH services, as a provider and advocate. Should centers coordinate services? We do not want to do the same thing over and over again. The direction is to move people out of the system.

What is the Recovery Center vision?

A Center builds on the array of services we discussed and incorporates principles of Olmstead.

What is the Focus of Recovery Centers?

Helping people find, ignite and burn the “spark of life” – connect people to their passion which is often their reason to exist. Centers are about re-discovery, helping others, renewing zest, and

opportunities to practice what gives us passion and hope. Help people to develop passion, create opportunities to experience their passions.

How do we do this? I like to call it the “Cheers concept” – everybody knows your name. Help build connections in safe environment. Let people experience being involved not lectured to. Direct experience of the thing will get people to ask, how do I participate? In the center, you may meet people from community groups and then go out there and connect.

Comment from the group: Finding new passions or re-discovering... it’s never too late to do what you want to do.

The idea is to link people with other zealots. Other zealots are focused on what they are passionate about. They often do not notice that you might be a little weird. You may find they are too.

Comment: you get case management they will encourage you.

This is about linking to passion, not encouragement. But finding passions then linking them. We need to use imagination – the person who wants to be a pilot, think about linking them to airport, activities, work or flight simulator technology. Feed and fuel passion.

Regarding community participation it is not a mental health referral. – give examples of community participation, opportunities available with existing groups. We would like to see individuals connecting to individuals and more community participation. Finding opportunities to use natural strengths, and turning negatives into positives.

Comment: Need to be trauma informed. A good peer program should be doing this – we agree with the focus.

Use virtual groups as a way to connect people.

Comment: What do you mean by integration? Response: Integrated – means part of the community – most programs are closed. We do not want separate but equal. We want people to find places outside the MH system to feed their passion.

John discussed the development of a technical assistance centers to help peers with skills around running the “business” of a recovery center. TA for management will have strong peer oversight.

Should we allow non-peer programs transition to this model?

Do we look at transitioning for traditional providers? If they embrace this model and want to transform services into this recovery model, they would need to make changes to be “peer run”. Board composition, employment of peers, outward focus. Etc. If they have the infrastructure and will to convert to this model, they could partner to make this happen.

Comments: centered around a fear of tokenism.

What do you like about this concept? What have we forgotten?

Group Comments:

- A seed to spread around the world. Happiness inside, happiness outside, forever
- Transportation to community activities is an issue.
- I like recovery mentor/life coaches to link to experience that and connect to community.
- Safe houses that divert hospitalization need to be totally voluntary.
- Person centered recovery planning with goals – assistance with this, going and doing
- Peer mentoring or peer life coaches
- Childcare to assist parents, family member involvement, family support, and legal services to keep children.
- More affordable housing

How do we move people from the MH system to the world?

Group comments:

- What makes this less scary to make this happen? How do we create the change, make possible in the future? How do we connect childcare in the community?
- Exposure to doing things they have not done. Not isolating. Go outside, meet-up with community groups.
- Learn how to trust and know people.
- Resource center that can connect to opportunities. Finding the contact meeting the contact, then going out to meet that contact.
- Helping to locate work for those who want to return to work.
- Working with homeless population, have a shower available
- We could have a Peer liaison to connect with community groups.
- Take a risk, have a conversation on the train, build confidence. Enabling people, we do a disservice and hurt other people.
- Mainstreaming – go to an open house at college, go to city hall meeting, free in the community would help us mainstreaming.
- Incentives. Develop ways to reach out to employers. Peer bridges to get into employers. A dialog with recovery center and community. Apprenticeship with skilled crafters, builders,
- What about like: community integration, peer run, passion, build on social skills. Mentors
- Existing things response: not working because lack of choice. Does it connect with the person's vision? Is it delivered by a staff who thinks the person is "less than"? I want to learn from peer, equal, culturally competent and trauma informed.
- Help people to dream and focus on those dreams. Look at a different tomorrow. About choosing their dreams.
- The idea of Resource center, communications. to flow through.
- Outward focus – part of the model. A resource to get on with life, and how can the peer center help? Response: The mental health system creates dependency. Recovery Center is a transformation from dependency to independence. Need to look at finances, career, and family.
- Need a future, not more of the same.
- People helping people, not like *using* Peers regardless for what you need help with.
- Communication skills also important to connecting to people.

- Taking back your life with supports. Taking back independence and being free, responsible for yourself and having skills and tools to continue with your life.
- A place to get information, skills to go on with life.
- Family issues very important. Need lawyers. Support the passion of being a mother.

John Allen: Did we forget something to help reach aspiration and reach that level of integration? How help build self confidence?

Comment: Take life back, through a series of successes and peer support.

Value of role modeling with people struggling with self confidence.
Focusing on passion, the reason is guided discovery through exposure, look for the glimmer.
Connection to legal supports for a variety of needs.

Life coach/recovery mentor – strength based coach with process of empowerment.
System makes you forget your dreams and passions. Need training to look at glass half full.
Shift to strength base.

How do we shift from deficit approach to life dreams? What do we need to do?

Comments:

- Life coaches. Training and supports.
- We have lost concept of self reliance – giving over my choice. Re-claiming essential
- Strengths - re-identifying (suffocating under the care/dependency models)

How do we re-claim?

Comments:

- Too much help – we stop thinking for ourselves. Finding your own way back. Re-igniting
- Functioning .
- When it becomes more reinforcing to be well.

What gets you excited about life?.

Comments: Let people have the space and time to re-discover. Take a passive role not a helper. Concept of coach. It is internal work.

How get existing groups to understand? How get more people to hear it?

Comments:

- Peer network reach out to different places.
- Self-soothe, hold on while going down. Learn skills or not get it. Learn it from other peers. Here and now, how to deal, minute by minute. Attend to a hurt, and know your own triggers.
- Standard training to bring along about core pieces. Helping people learn how to heal. Healing leads to dreaming. Healing and trauma based.

How do we restore dignity? Help build self esteem? And how to believe in ourselves?

Comments:

- A thing once defined, put training and get it out. What is the training? Dignity, role model and shared experience, self management. strategies, trauma informed care.
- Knowing that people are in your corner, keeps you grounded. Belief in you, by others.
- Self help – that people can get through, cope, and succeed. Role models.
- Being an effective role model. Helping people know how much they have changed.
- Ideas need to be encouraged, followed through. Help dream and vision to an implementation strategy.
- Training key to success. Not see self as illness but a survivor – empowering. Training importance of language, strength based language, not negative. Learn reframing.
- Importance not thinking linearly. Not black and white. Mutuality – erase lines between staff and peer. Recovery is a journey with good days and bad days, recognize and ability to share that.
- Educating about medications and choices, information so people are informed.
- Training staff in treatment and medication side effects and recovery to people.
- Taking baby-steps to recovery, gain confidence, making progress to self soothing and independence. You see that the journey is worthwhile. Going at that person's pace.
- Understanding force and coercion and how that affects us.
- Leave a legacy, template for others, documentation sustainability, reciprocate, and not compete with larger family.
- Making sure people know their rights, informed re: medications
- Left out talking about we are people as sexual beings, finding love, sex, and life partners

How do we help people to use choice and make choice?

- Know gifts, many striving through adversity – strengthens us.
- We are human beings with souls, in progression, and not illness in remission, turn it into confidence.
- Trust: sharing with peers to strengthen trust.

How help support places that do not have any peer support? How get one developed?

Comments:

- Need a place to get together, get information out.
- Expose to other places, RAC (Recipient Advisory Committee)
- Set up training on self-support groups.
- Transportation

John Allen: We will not fix public transportation, not in our lifetime.

- Worldwide recovery center and resource center.
- Virtual centers for places do not have it.

Is it okay to help non-peer programs to transform?

Comment: What are the safe guards? John Allen: That they are peer run, and lead .

- If the State has \$1.4 million - Let the centers be peer run.
- We are not in competition with non-peer run.
- Time is needed to change cultures. Some are not offering true peer support.
- I do not want to see us pushed more back in the system with the conversion of non-peer programs.
- We work off trust. If non-peer providers start to speak our language, we may lose trust.
- Pay more attention to people's physical care

Magic Wand: If you could create the ideal recovery center what would it look like? Make any part happen. What do we do to put in place not talked about?

- Connections with other beings – animals, pets.
- Signs saying: GET A LIFE, Reclaim your life, access to healing alternatives.
- Help getting advanced degree or training.
- Need to be able to have relationships with clinics to help them go.
- [Recovery Center Programs] need to have training. Staff need to experience secondary recovery. Looking at their own lives. Extensive life problems need to be dealt with. Staff has to have a life. Centers need have to have a welcoming environment 7 days a week.
- For those who do not choose – no one is left behind.
- Paid or unpaid/peer/or non-peer. Privacy officer need to know about rights and confidentiality.
- Workers should be vetted, screening, background and have references.
- Positive environment, soothing, healing, reinforce belief in self.
- Progression centers rather than recovery centers
- Exposure to alternatives
- Never kick anyone out. Maybe out for the day but not forever. People can get better. It's the place for multiple chances.
- Needs to have mutual respect. How have you addressed the inappropriate behavior that may have happened in center?
- Staff should have a living wage, taking care, supporting , against burn out. Zero tolerance for violence.

John Allen: Remembering that we are going to get support and then move out. Not a destination but go through to make connections to someplace else. Place to go through. I cannot tolerate the idea that people do not have dreams.

- Having a positive attitude to encourage others, encourage one another
- Know your community – develop relationships w/. and share
- Reach out and break down discrimination. Bring in people. Expose to people -break down stereotypes
- Benefits management important.
- Recognize that physical health is important. Use health coaches and link to health centers.
- Computers and internet need to be a part of the recovery/resource center.

Summary: John Allen

We will be continuing holding forums. OMH will issue an RFP for the technical assistance center. With this we are looking at distance learning technology. This will be a technical center to train peers on the business aspects of running a center such as, managing contracts. Peers will drive the program aspects, delivering it, organizing it. Peers only one delivering the program training.

TA centers will be designed to increase skills in managing the business side of center. There is money to fund 2 recovery centers. OMH has made a commitment to Rochester. They are closing clubhouse, and they will begin a program where there is none.

The exception is Restoration Society in Buffalo. This program currently has a majority of staff that are peers and the Exec. Director is. converting from a Club to different model. Not looking to convert non-peer agencies at this time however, in this instance we are converting a peer program to something else.

NYC does not have self help and support. Howie Harp and Baltic Street are two centers for the entire city. Priority will be given to NYC then look at other parts of the State.

To expand, change, is not in phase 1. TA not new funding. Request for proposals will be sent out and the winning proposals will be awarded funding. Programs that have relationships with other resources / programs could score higher. OMH does not dictate relationships.

Define peer run. 51% peers on Board. Can have a judiciary arrangement to pass through funding. Can they fund through non – peer agency? If the peer program has a agreement with another to fulfill that role. What are the mechanisms to deal with this? OMH not addressed officially but will sponsor TA to help understand fiscal relationships.

Transformation Transfer initiative Per Forums 2009
Saratoga Springs, NY
October 9, 2009
Meeting Notes

Attendance: Approximately 40 people attend this forum

Lindy Fox, Dartmouth College:

From the survey conducted at Dartmouth, findings, history, domains of services, and broader range of services were presented and discussed. The innovative peer programs highlighted home ownership, advocacy, and the concept of a wellness city. Co-occurring self help groups and WRAP planning were all mainstays of the programs contacted. In regards to integration with traditional mental health programs, Dartmouth asked "did they consider program having a good relationship with traditional mental health programs?" Those programs that were completely peer run and did not see the benefit of working with the broader system. Peers saw themselves as separate and apart. Others felt that in order to bring in money to support the Exchange (center) they needed to have a relationship with the system. This was the direction some centers took in order to obtain Medicaid reimbursement.

Outcomes were often related to the funding source or the accreditation organization. A few were family-parenting sensitive and offered support or training.

Lindy reviewed the history and background of how peer organizations developed.

Question from the group: Pathways to Housing has a peer component. Why did OMH choose to highlight this program? Dartmouth, not OMH, chose to highlight this program because of the unique focus on housing.

John Allen, Division of Recipient Affairs

What will the next generation of peer self-help /peer support groups look like? We would like to widen the range of services that peer programs currently offer and get everyone up to the state of the art.

John reviewed the following definitions: mutuality, peer, creation of peer support groups. Initially the peer movement focused on civil rights, however people are now getting together because the system did not meet their needs. This lead to the development of drop-in centers. There are 50 different things offered by self help peer support groups and not all of them exist in any program in NY State.

What are the things centers need to do to get funding, and what will be the optional services?

Many peer programs operate a substance abuse support group, or make space available to outside groups. Some offer WRAP facilitators, trained by Mary Ellen Copeland. offered.

A key component of a recovery center is that it must have some ability to help with benefits counseling. Benefits counseling would include: help getting them, and also how to go back to work while protecting your benefits. Peers need to be knowledgeable about the Medicaid buy-in program.

Career clubs often play an important function with individuals returning to work. Many peers can know the job or work, but not know how to be successful in work environment. Career clubs can assist peers in being successful on the job.

Getting together around food is something most of us do. If you want to get a group together have a pizza party, offer food. The difference in the recovery center of the future is that the gatherings are not solely for the purpose of socialization; rather facilitate a learning experience or facilitate a connection to the larger community.

Mutual support, warm lines and helping each other in times of crisis, most peer programs have numerous ways to support each other.

Question from the group: Crisis support – Is this a boundary issue? Asking someone to spend the night when they are in crisis. Not necessarily, however if a person is exploiting another person, then that needs to be dealt with.

We would like to see food pantry in centers working, under the USDA model. Also, opportunities such as the Cornell-like healthy cooking and on a budget. These are options centers should be thinking about

Jail diversion supports. Some centers offer support within prisons to help re-settle peers back in their communities. We would like to see pre-forensic diversion, where we support the person before an arrest. On Long Island, HALI works directly with the police when someone is picked up for acting “weird”. The police do not take the person to the jail, they bring them to HALI. The person is welcomed, given a cup of coffee and asked how they can be helpful.

Housing, from a home ownership perspective, is something that recovery centers could be involved in. Through financial management and asset accumulation, peers could gain information on how to develop an IDA account that is matched \$4 to \$1 contributed.

Sixteen Credit Unions across the State offer these type of accounts that can fund a home, car, and other things. Does anyone know about Jerome’s Home? Jerome’s Home is a home that a peer controls. Jerome’s Home comes out of Georgia.

What do peers have a lot of? We have a lot of time on our hands. A group of peers decided to offer their assistance to Habitat in return that one of the homes would be built for a person with a mental illness. In Georgia, the person’s name was Jerome. We would like to see more of the Jerome’s Home concept.

Literacy – Some programs offer assistance with basic literacy. Centers should be aware of the Dept. of Labor grants to support education, including college, if an employer promises to hire them.

Outreach and engagement – We are encouraging centers to do more of reaching out to other peers. Under NYS clinic reform, OMH is building in peer outreach in order to help people to get into clinic and also to leave services, with access to peer support. Training needs to be supplied by each agency that plans to contract or hire a peer. In proposed regulations will address some of the core competences for peers who want to provide outreach.

Parenting training and support – Most peer support programs do not offer parenting support. Recovery centers of the future will support people who are parents. MHA is planning to offer training on how to do this on an agency level.

Peer support in recovery centers of the future, can we think of a different approach? Not as a group but individual supporting another individual. We are usually sharing a similar experience in peer group. Instead, can we use groups to work on common goals? Working together as a group? We do not need 27 different groups, especially if it is offered elsewhere. We are grouped to death! Peers should choose what they need, whether peers get together in groups or not. The effort comes from the organic growth of a group need. An example would be a driver's education group for those who want to get learners permit.

Peer Bridger's – Recovery centers can offer Bridger services for folks in the hospital. Peer can help peers to get connected or stay connected to the community.

Consumers want choices. "The more jingle you've got in your pocket, the more choices you have." Centers can play a role in money management skills and asset accumulation. I mentioned this before. Some peer support groups take on representative payee ship, however if we look beyond rep. payee – IDA accounts can build assets but cannot be counted as an asset against other benefits.

Peer programs have traditionally had recreation groups. The new center will link peers in order to use recreation events in the community. If we want to help people move on with their lives, a recreational event is a means to get to a different place. Engage them and move on.

The new in a Recovery Center will build on the existing best practice of mutual self-help. We want people to access the most integrated setting possible (Olmstead). Isolated environments are out. We need to assist our brothers and sisters in remembering and rediscovering passions in life. Helping members see their passion and reason for living and connect their passion in ways that connect to others with the same passion. Link peers to places of "zealotry". Use social recreational events as dynamic learning experiences, not lectures. How do we do this? We combine igniting the passion, the dynamic learning experience with what I call the concept of the "CHEERS" phenomena. Part of the concept of recovery centers is to introduce people, build a relationships, so when a person chooses to engage it is not a frightening experience and they connect more easily with people.

What is community participation? It is not a program. Recovery Centers should exist to support all people in the community. The kinds of things we would like recovery centers link to can be from a range from: faith based organizations and the types of supportive activities they offers, to networking with other people in the community to meet your needs. Centers will help people understand their networking opportunities. If you are going to link people with passions, look into the internet.

Next steps include OMH issuing an RFP to support a technical assistance center for peers to learn about the business of running a center. Also there will be an RFP for funding to start new groups where none exist.

We have seen that groups often fail because peers do not know how to run a government contract. The first RFP will be to help with business mechanics so that centers can be fiscally sound.

Peers will drive the self help portion. We hope to buy a distance learning model through a university.

Input from the Group:

What do you like about this concept?

- Bringing people into the community, getting involved in the community. Not wanting to keep you inside yourself.
- Will this be helpful to those in Adult Homes? Answer. You can create linkages to Adult homes. This approach is effective with people who have lost dreams vision. RC's can reach out to the community. Not having a life can be defined by an institution. (Adult Homes).
- I like that you don't get stuck in a program.
- Education, peer involvement, can do it w/out being in a "place". Get to a place where we feel that we can do it.
- Value to get out of concept of around the coffee pot and reach out to others.
- Reaching people through networking with community programs.
- Model gives ...people skills and value to community.
- Like the idea of helping people get in touch with their passions.
- Housing, how can we change the process of access and living in areas we want?
- Alternatives, linking to Reiki practitioner, yoga practitioners and massage therapists.
- Overlaying needs – looking at what the community has to offer.
- Education about the community.
- In regards to suicide and homicides, can we reach out to people before this happens?
- Should we include outreach to the community and engagement of the community?

What else to be included? How do we protect our program? In times of budget cuts, how do we get fidelity to the model of helping people? How do we be true to who we want to be? Are we doing this for the benefit of the individual?

- Needs to be a stronger push to get people out of poverty. Want to learn more about asset accumulation.
- Enhance supports to bring people out of poverty.
- RC should address needs holistically (toothbrush, laundry, food, and wellness).
- I like the idea of optional parenting assistance.
- Need to hear from peers who have a lived experience and who have a self-help philosophy or attitude of not considering themselves as mentally ill. I'm against labeling people.
- A host of things, including rights come with disclosing a disability .How you choose to identify is okay. Those labels confer legal rights under the Americans with Disabilities Act and give protections. We do not endorse labels.
- Important for any organization (peer) to promote self advocacy.

To change we need to change the way we think and need technical assistance to adopt policies. How do we assist others who have not peer self-help programs?

- We could assist with brainstorming with non-traditional solutions to get us there.

- In Hamilton County they created virtual links. Need to get together and brainstorm and sponsor local forums.
- True community integration and sparking dream, embracing everyone. Stress RCs have diversity to represent the community. Core is culturally diversity and competency.
- Going into the community is difficult in areas like the west where the weather is snowy. Based on the geographic area we need to pay attention to and virtual solutions.
- Housing programs often take people out of their community and they never get back to their community of origin. Older people also get displaced. Life continuum, elder issues and alternatives for institutional housing. Housing first model.
- Centers need to be trauma informed and trained. Environment itself needs to be sensitive to people's safety issues and deal with real concrete things, for example sexual harassment or when people are unaware or inappropriate.
- Veteran's have many issues needs for support. Pay attention to their issues. Many identify as wounded warriors. Need to be knowledgeable about veterans' issues.

How do help existing peer groups understand this new concept?

OMH could provide resources intentional peer support, a 2 wk. intensive advocacy training. This concept is embedded in the model. Awareness is the beginning. Many people have not heard of this. How get this message out? Radio, U-Tube, Face book. Peer programs need transparency to other programs.

- Link to search engines. Need mentoring from others need to truly self help and help each others. TA going to peer support, MHEP – only happens infrequently. We need to maintain connections with each other. Link local groups to each other through peer networking groups. By providing assistance to each other.
- Peer networking groups call each other for support. We need opportunities to engage with other parts of the system (clinics) to partner, and contract for services.

What training or supports do we need to transition to new model?

- WRAP training, not easily accessible. Need more of it here.
- Ongoing TA, groups to adopt this model. Groups don't necessarily address skills training and issues like, how do you build a team? How do you do engagement? Facilitate community connections? How does the RC organize, obtain the related skills to build a movement?
- Linking with other agencies, (other than mental health) to obtain those skills. Ongoing education, grant writing, fundraising, new crafts and skills are needed.
- Develop a training model how it is set up (a morning presentation).
- Connecting with community colleges, contract with others and pass on to college professors.
- Supports for groups transition such as learning communities, mentorship, sharing experiences through video conferences and distance learning. Training is good, but how do you put skills to use? Response: It involves a process to bring people together. What talents, skills, where do you see yourself 10 yrs from where you are now? Need a process to bring centers along rather than training. Need to happen in combination with training.

How to get people to be thinking differently about themselves and view a center as a place to get connected?

- We need to be *unwilling* to give up on people; all people have dreams and would like to be able to live the dream. It may take years to discover their dreams.
- People become part of your success story. Recovery Centers are defined by the people who attend. The Center becomes part of who they are. It is scary to connect outside.

Response: This is about a clearing house to help link people to the community. The OMH is funding this initiative as part of a mental health system. Find a passion, link the person to it. Move beyond the mental health system and have a life.

The definition of a recovery center – It would have no time limits. If it fosters dependence – this is not what we want to see. Centers could help build skills, and empowerment. A Center w/out walls, a place one goes through. Mental health programs are not a community place. We do not want to see separate but equal. Mental health programs may be in the community but not part of the community. Help people to move on with their lives not replace their life.

How do we support organizations that are located in a part of the state that have none? In counties and communities, how do we pay attention to this?

- Public service announcements, contact with Recipient Affairs.
- The passion to expand the “hope” use people who have successes.
- Reach out to others. Promote from peers *and* the service delivery system.
- Cautiously. Effective quality peer services are desired and not token peer programs.
- Offer invitations to adjacent areas. People could use K. of C. to develop speaker’s bureaus.

Should non-peer programs be allowed to convert to recovery centers? If the members elect board, and the majority of board are peers and major of staff peers, should programs be able to convert their funding? Further, should we offer technical assistance? Is that okay that programs convert to a real peer/member run organization?

Response from the group:

- Suggest a 75% peer presence on the board and staff.
- Programs need to be encouraging disclosure. Yes it is a good idea. Many of the non-peer programs do not know how to operationalize the values of the program. Also, I do not trust that OMH to hold programs accountable. When programs are getting cut, RC may be an attractive model.

Peer run, in the new model, means that the agency is membership controlled. Membership organizations are policed by Dept of State.

- Build in a mechanism with the new model, that says that you cannot bastardize it. State says you’re a membership organization and is responsible to police.
- Can an employer discriminate in hiring persons with mental illness? Response: Legally, no practically, yes. Legally you can protect yourself through the ADA.

People enter the mental health system through inpatient, outpatient clinics or through the day system. There is a general perception that consumer groups in the “other program” (e.g. Drop-in centers) are peer run. In NYS that may not be the case, however across the country drop-in centers are synonymous with peer run.

Peer run means: in new model. Membership controlled (in new models). We need to build safeguards into new model to ensure that they are peer run.

Next Steps:

Following the Peer Forums we will work on the federal grant report that will inform us in the development of the RFP for Recovery Centers. This work (peer forums) will ensure that we have the right things included. The funding this year will support a technical assistance center that will ensure that the programs succeed. A group in Rochester serving over 100 people recently got de-funded. They are getting technical assistance in order to move to a RC model. There is another pot of money that will be available by the end of year for parts of the State that do not have a peer program. Currently, there are only 2 peer programs in NYC.

One program in the western part of the State is converting an existing program. “Restoration Society” is moving to a different concept/membership organization.

Around November, we hope to issue the RFP for the TA center. We need to give the award to a college that has the capacity to give credit and to provide distance learning capability. Next year, \$3 million is budgeted to expand into areas that do not have peer services. Please let us know your comments. Call and give us feedback.

Transformation Transfer Initiative Peer Forums 2009
Syracuse, NY
October 14, 2009
Meeting Notes

Attendance: Approximately 10 people attend this forum

Lindy Fox, Dartmouth College:

Lindy' presentation discussed innovative peer programs that we surveyed including their: mission, history, domains of services and supports.

She discussed the movement from traditional support services, to providing information resources available in their communities. Support, outreach, employment, and benefits counseling were also part of the menu.

Many programs sought non-duplication of services in peer programs with other programs. They sought out community services, and did not develop in the center what already existed in the community.

Collaborative Support program of NJ. – Wellness focus. Other peer programs focused on budgeting and money management

Question: Can you define a Peer? Someone with a lived experience with mental illness. Peer to peer, helping each other. Reaching across.

Focus on cultural competency for peers involved in work force (culture of workforce)/

Some programs hire traditional services (psychiatry, nursing) HALI, uses peer advocate, liaisons with hospital and work hand in hand. Others not want to integrate with traditional mental health programs.

Dartmouth asked about outcomes and there was wide variation in programs collecting this data. Often peer programs only counted attendees, and some did satisfaction surveys, or the number of individuals who got jobs.

The governance of these organizations included: a board of directors, majority who are peer, some have non-peer members as well. Hours varied widely. Many had weekend hours. Some were completely peer run and some have a mix of staff.

Regarding Certification – A few programs certified peers in order to provide Medicaid billable services.

Question: Did you look at Unique Perspectives? Response: This is a peer program within an organization, and not the model we chose to look at, however does a number of good things.

Question: Can peer programs bill Medicaid? Response: Currently 18 states have the capacity to bill Medicaid. When we looked at financing most were grant funded programs, however the housing programs received funding from HUD.

Specialty Services: Lindy spoke about the Laurie Mitchell Employment Center, Family Options parent peers program, Sound Times – consumer owned business. Consumer Choose, self directed care in Florida, Project Return, within a wellness center.

Women's Empowerment Center – Offered a variety of different support groups. At the Empowerment Center, that is all they do. We chose to highlight this center because they had a focus on trauma.

Recovery Innovations has a focus on education, offering college credit for education courses.

If you could design the ideal recovery center, what would it look like?

Comment: Transportation is hard to get, not always have the funds.

John Allen: Are you familiar with TLS self-help program? Yes

How do we get more peer programs and ensure that they offer an array that augments the system?

OMH has budgeted \$1.5 million this year and \$3 million next year for peer programs. What will we fund? We are looking at the next generation of peer support. Self help looks the same however we have added new things over time.

What is peer support?

A peer is someone who has used the mental health system. Peer incorporates anyone who has used the system. There are 4 elements of peer support groups. Mutual help, which is the support of each other equally. Member run, which means the organization, is owned by members. Members control organization - In the new world, peers have the ultimate say, not a 3rd party. Members elect board and set policy.

John Allen reviewed the history of peer run drop-in centers and provided list of services currently not available all in one place in NYS.

The early groups were civil rights focused. Many people never got discharged from programs and demanded that their voices be heard and rights enforced. Drop-in centers are the earliest organization. The concept got started in public places, like churches, restaurants and open when traditional services not open.

Self-help and peer support is not just one thing. Different groups have different parts.

Question: In NYS is there program for crisis, grief and loss? Response: There are lots of services but few that are peer run.

Question: Should families have a vote in peer group. Response: No, only peers. In family groups (NAMI) they have a vote in their groups.

List of services: Some of them will be required other will be optional

- Include benefits counseling.
- Career clubs - to help people with how to cope with social relationships on the job.
- Community kitchen and meals, computers/ internet access are key components

- Crisis support/warm lines
- USDA certified food pantries are often available because people struggle with living in poverty – ‘Step by Step’ in Watertown is an example of a program that offers a food pantry.
- Forensic services – jail services – HALI (Hands Across Long Island)
- Home of your own – IDA accounts – use to start business, buy a car or home, often available through credit unions.
- Partner with Habitat for Humanity – invest time in building and getting access to a Home – ‘Jerome’s Home’, Georgia
- ‘CSP’ of NJ

Transformation Transfer initiative Per Forums 2009
Batavia, NY
October 15, 2009
Meeting Notes

Attendance: Approximately 35 people attend this forum

Lindy Fox, Dartmouth College:

Lindy discussed the narrowing down the number of programs to be interviewed to be conducted by Dartmouth. They selected programs for different reasons. Talked to programs that took about 3 hours per interview. Tried to find what is new and innovative. Good things happening, however not wildly different than things we have heard of. The interviews to be scanned and made available to those who want to review them.

For the most part, the mission and values are driven by welcoming, support, and advocacy. This was common to most programs.

History of peer programs: Started post-deinstitutionalization, by people dissatisfied with the traditional mental health system. They have evolved into the traditional drop-in centers and the newer peer programs. Traditional programs had a harder time in developing a wider array of services

Domains: Services that peer programs offer: support/resources/outreach/educational opportunities, artistic & spiritual activities. Advocacy, health and wellness and link to self-help for co-occurring disorders. Money management and budgeting, WRAP planning respite housing, outreach and engagement, peer collaboration with traditional mental health. Also, outreach and education.

Outcome measures: Programs were variable in how they looked at outcomes, at minimum they counted the number of people using services. Some measured employment; others measured the outcomes tied to the particular funder's deliverables.

Organization and governance: All of the programs we spoke to had a majority of peer on the Board of directors and a mix of peer and not peer staff. NYS does not have certified peer specialist as a Medicaid billable services at this time, however other states have this capacity. Most programs Dartmouth spoke with were grant funded.

We asked, how do people find out about you? Website, newsletter, mainly word of mouth and many groups saw "getting the word out" as a challenge.

Innovative Practices Highlighted: Voices, opportunities, employment clubs – sponsored peer run businesses. Wellness and recovery programs – CSP of NJ. Consumer choice – self-directed care Florida's Medicaid program.

Five exemplary programs noted by Dartmouth PRC:

- Women's Empowerment Center in DC – is a drop-in center for women who are impacted by trauma and substance use.
- Pathway's NYC – drop in center with a focus on education. GED courses, employment searches.

- Village of Long Beach – community integration piece very critical.
- PEOPLE – hospital and jail diversion at Rose House.
- Recovery innovations AZ.

If you could design an ideal recovery center, what would it look like?

Group responses: Integrated care with physical health, a focus on whole person, parenting, family support, Wellness city

- Did anyone talk about peer accreditation? Response: Not many.
- Emergency housing? Response: Yes, safe housing an issue for many programs.
- Employment? Response: Almost all have an employment piece.
- Tutors? Response: Many who do education have teachers coming in and some have peers also acting as mentors
- I would focus on healthier food to help body and brains.
- 'The Main Place' has peer advocacy, to help people walk through the system. Response: Yes, many have peer advocates.
- Did you talk about active outreach? Some did do that as part of mission? This individual did not feel they needed to recruit. No one had the experience of not serving enough people. Response: Many do aggressive outreach, META services, goes into hosp. 'HALI' does outreach and education. Many see this as part of membership recruitment.
- If you had to choose a top 3 programs? Response: Programs that offered housing, employment – difficult to choose.
- Comment: Need to have Peers with lived experience, offer continuing education, conferences, correlated with peer specialist.

John Allen: What do we mean about self help and support? Are there universal in types of services and what dimensions that have changed?

History of the origins of peer support. In the beginning of the peer movement, pees sought a separate path or alternative to the mental health system. The new paradigm should support people holistically. Drop-in center are universally perceived as peer run, however not in NYS, where it is a program category not always peer run. Drop-in centers where universally available when people needed often like a key club where members could go and open the center, and available evenings, weekend and holidays.

Menu of peer supports: These services have always existed, in part, in many peer support programs. These services will continue to exist in new recovery concept. Some will be mandatory some optional. This is the floor we are starting with. These are not new things.

- Addictions support & support groups – many and varied types. We see this as a mandatory, however the center does not have to do, but could have the site available to provide groups.
- Advance directives – WRAP plan: help develop plans, crisis services., etc. that plan your wishes are followed in times of crisis.
- Advocacy training – to be better self advocates, systems advocates around: policy regulations, funding. This is likely to continue, highly supported.
- Benefits advisement – mandatory component of RC, seen as a core service.
- Career clubs and employment – I don't know how to talk to myself about being successful, and my family does not know how to talk with me. Career clubs that support

employment are a valuable component. Changing our own identity moving from the mentally ill person to the productive successful person.

- Clothes closet and community meals. In the new paradigm we will bring people together not for socialization but to work on other things. This is an important change.
- Do programs that get homework when people practice skills. Support peers in doing a pot luck dinners. Share, economies of scale, build relationships, building camaraderie *and* life beyond the program.
- Internet access – more programs offering. Especially young people. Internet critically important to find resources and jobs. OMH offering used computers 501C3 funded by OMH.
- Warm line - A place to talk to a peer. Create peer support that is a core component of peer organizations. Strongly recommend peer organization build. Start with telephone tree
- Help support healthy eating. USDA, Cornell Cooperative extension prepares and shop for nutritious food. – People should be able to access.
- Jail diversion: A core component. Peers can be doing innovative things in this area like HALI. On Long Island, if you get picked up, the person is brought to HALI where they are asked: what do you need, rather than the police having the person booked and processed as a criminal. Localities can impact on this issue.

Question: Many times I was brought in and forced to take medicine. Response: You can change by systems advocacy training.

- Housing programs do great things. We would like to see home ownership programs. In order to get out poverty, we need assets. Home ownership is something we like to support. If we have time on our hands, peers can work with Habitat for Humanity. Jerome's Home is the first Habitat home build for an individual with a mental health diagnosis. Encourage people to get involved. We can change the discussion from housing programs to home ownership.
- Mail services: especially helpful for people struggling with homelessness
- Outreach: Under the new clinic restructuring, this will be a mandated service for clinics. I will be available for peers coming into clinic or getting services. Clinics can hire peers, or contract with peer organizations. Peers can help with engagement about community life. The reimbursement will be to the clinic. This is a beginning option, to contract with clinic, then centers will not need to worry about billing. Question: Is this happening soon? Response: Yes, with the new clinic regulations, once implemented – clinics can enter into contractual arrangements.
- Parenting support: Building skills for family unification. Address global issues for mothers and fathers. Child protective is not involved in these groups.
- Peer Support: Not to offer more groups, but strategic about what to offer and what to access in the community.
- Peer Bridger's: Peers working to help people leave the hospital with a peer who has done that and can walk you thru the system.
- Money Management: Critical. Centers should be knowledgeable about IDA's (typically offered in Credit Unions), that can be used to buy a car, house and other things. IDAs do not affect benefits. This will be a required service. Look a budgeting, asset accumulation and money management.
- Speakers bureau: Ways that centers do stigma busting and attract new member or utilize skills
- Social recreational events: Not want the event as the outcome.

- Psycho-education and wellness self management education.

This is the menu of what has existed. What we are saying we want to see more of that. That is a given for new recovery centers.

What is new?

- Recovery centers will build on best practices
- Build on the Olmstead decision. LC vs. Olmstead– sued to be in the most integrated setting and out of the hospital. Hospitals are artificial community for those in the mental health system. This is a civil rights issue. Recovery centers of the future will focus on getting out into the community. Comment: The Olmsted report has been out 10 years – we are still waiting.

Recovery Centers build on an individual’s passion, act as a clearing house, and assist in finding and igniting the “spark of life”. The spark of life is a motivating force: a spouse, child, or a hobby. It is the thing that gives life its meaning. Many of us have killed off passion to protect us from grief and pain of the loss of our dreams.

How do we focus on passion?

If I help connect you to your passion and with other zealots, then your idiosyncrasies seem less important than what you are passionate about. Connect with the persons passions then they connect to community. Focus on igniting spark of life. Hope and recovery are then possible and life becomes worth living. RC will focus on bringing people together. Developing an experiential learning.

The “Cheers Phenomena” Where everybody knows my name!

The world is a scary place, a frightening place. If in the RC I can meet people that connect with my passion, I am going to a place that is not an intimidating place. Then I can get out of the segregated community and get engaged in larger community and experience what it feels like. The Center needs to be exposing people to things that might give them passion.

Question: If doing this, [going into the community] does you in, what do you do?

Response: the traditional systems still exist.

Everyone has a passion. RC continuously explores ways to get to the spark of life and connect people to the community.

Question: Did you talk to administration? Do they know this? Professionals need to know about this.

Question: What about those in the PCs for 20 years. Response: Reach out. Some peers are already doing this.

Concept of community participation:

This is not about keeping people segregated. We do not want to connect people to mental health services but their passions. Help make connection to the faith community, for dating, clothing, food. Connecting people to their faith or connect people around sports, nature, pets, learning, fitness etc. Take advantage of what already exists. Volunteering can create opportunities for membership in that organization. Connect with Toast Maters for public speaking skills and networking around getting a job.

Networking can change how this works. Turn a symptom into a positive – Neighborhood watch groups. Connect people for supports on the internet. Goal to link to naturally occurring places that connect to supports and their passion.

Next Steps:

We plan to gather input on recovery centers through your feedback, the Recipient Advisory Council and family advisory committee. We will need to develop a transition plan that outlines how to get from here to the RC of the future. This is the next generation.

OMH will contract for technical assistance, to support the **business** around running self help. Most peers get into trouble with contracts, finances. In order to increase quality of management skills technical assistance will focus on distance learning opportunities and the running of the business of a not-for-profit organization.

Question: This is great. What is the best mechanism for needed resources? What is the best way? Technical assistance needs an assessment of what is currently available to address the need such as: board training, support center, financial development and fund raising. We need a clearing house to connect people to.

What a good way to communicate as we go along? We will be setting up learning communities as we go along to help each other to avoid the same mistakes.

Remember that the recovery centers of the future are a place not that I go to, but go through. People feel indifferent because they are always told what to do, focus on passions.

Afternoon session:

What do you like about this concept?

Responses from the Group:

I'm excited. I like independence.

Housing project, I'm excited about the concept.

What about a small fledgling group? Afraid they might get run over by this concept?

Response: technical assistance will be available to develop the skills to grow. TA is first step to help peers develop skills for the expansion where we want to go.

Love the re-integrating in the community. Not want to see duplication of what staff has done to us. Not stuck but transition out. Going back to the community and let the community come back to us.

Food pantry is essential. People are choosing to buy medications or food.

I like parenting support for moms who lose their children.

I hate the word psycho-education.

I like this concept. You are hearing us. My concern is that to do this, you need peer run organizations and peers. Will this trickle down to people doing independent groups?

Will you be able to take advantage of the access to funding?

Response: It is up to you. TA piece will create universal access to the tech. piece.

Social clubs have not been mentioned? Will the RC replace social clubs?

Response: This is not a simple question. There are a number of things OMH has opted not to continue to fund due to budget cuts, and some are or are not Medicaid billable and the science that says that they are not helpful. Sheltered workshops are being cut. Not see sheltered

workshops as linking people to real jobs. Social clubs isolate people from community, separate but equal is not the philosophy. They have been cut in the past. A segregated place to socialize, ok but needs to be a stepping stone to the larger community. CDTs have also been cut. We have said that they [CDTs – continuing day treatment programs] are good places to go hang out, see a Dr. and get meds., but we would like to see them convert to PROS to help people manage symptoms and move on with their lives.

Need to do more education with the community for this to happen. Police courts are afraid of mental illness.

Finding our passions – great! Set a tool to find passions, have people support to link. Eliminate unproductive groups. Survey to start, what do members want?

Get them linked, centers check in speak to if it is productive or not.

Parent groups essential.

Need to brainstorm solutions.

Will it be a place or network?

Response: Not a large place to collect people that get stuck, but come to get connected find passions and to the community. Large enough to meet the need.

'Strong Ties' – After 25 yrs. this CDT is switching to all clinics, for financial reasons. As a peer helping people to transition. There are peer run groups to choose from. New Directions will be the new peer run program. My feeling...when people ask me what am I doing "peer specialist at Strong Ties" volunteering.

Suggest that instead of day treatment for the smoke and rock, I found valuable is going to a place to exercise. The Y also has metro adventure – bike rides, camping, that is the community integration we are talking about. Scholarships are available at the Y.

How do the RCs address the native people, who are most distrustful? Why don't we look at developing on native lands and people? This should be a priority.

Past history has shown peers get funded because they have "connections" or have programs. Are those programs getting funded first?

Response: We will look at what exists or the need to create something new.

In NYS programs compete with an RFP process. Decisions to fund will depend on how appropriate the response is to call letter. If you have experience doing certain things this will weigh with the committee's decision.

RFP is a procurement process and will look at the organizational capacity to do the thing. Technical assistance will help new groups get educated. It does not attend to isolation or connecting with others. Something that is not connected, all along, is likely to be scored lower than those that are connected to other peers. It will fund people who meet criteria, have a track record and are connected to the community.

Can you talk about respite as part of peer programs? Response: It is an option. Often, though, it is a clinical service. There is nothing about a RC that is clinically based. Crisis alternatives can provide support.

There needs to be face book, or a Craig's list for networking exchange. A linking point to what is going on in Center that can be used at home.

What did we forget?

Healthy food and preparation. - That is a given.

Vocational component? Using internet to find jobs? Get peers with background in computers to come in. Need more computers.

Need to be careful regarding community integration. Allow RC to have resources to refer to other. Place to go thru and not to, however a place to go back for supports or in crisis.

How do we know that people are still connected or drop out? We don't know? We have no interest in policing. -People are committed body and soul to doing it.

How is this different from settlement houses, which help to get out. Response: Settlement houses have a broader participation.

When my passion is in the hole of despair, if I did not have transportation to connect with. We do not want to re-create the little van to go bowling.

If someone comes who is co-occurring do I refer to in house group or out? - Maybe both.

We have a large immigrant population and are able to connect with refugee centers which could help them avoid becoming a mentally ill client. All centers would have trauma informed cultural competence.

What about COMPEER? Response: It is just you and the compeer and the community. It is not an integrated program. It is an assigned companion. The idea is that you have friends that are not connected to a program or place. COMPEER is a segregated service.

Prevention. Talk about advanced directives and WRAP? What about on demand services? Training? Response, crisis services and outreach to meet people in need – core concept.

How people work in centers? Some are paid and some volunteer. Staff are not friends. They are paid to be friendly but not to be a friend.

Computers – We could set up a yahoo group to plug in? If people having difficulty, they could provide support, communicating.

When people feel part of a group want to do things – why not use the van? Separate but equal not what we want. Competitive per run business = economic development.

How do we help other peer groups to understand this concept?

Get more information out. Some groups want to perpetuate the same. Use the media and how they portray us. The stigma is out there. Organize clubs. Make use of peer networking groups, virtual network, and share trials as we operationalize. Host a virtual forum.

Surveys, town meetings open it up, talk to people, keep it simple. Wickkopedia approach. Workshops or seminars that invite peers to learn about new implementation.

Job clubs – could be some help

This is not a hard sell when we get peers in the room. Integrating people into the community, however the community, many feel NIMBY or NOPE. When we focus on mental health we ostracize. If focus on passion I'm not a mental health consumer and I happen to have an interest.

Breaking stigma. Stigma is reduced by integrating. MH has own culture. Some people do not accept you and look down on you. You develop relationships with people you have a commonality with. Over time you can change the neighborhood – long term. It is the way we created integration in the civil rights struggle.

Do you foresee the culture continuing? If we do we will always be segregated and be, if chose to be stuck.

We are talking about asset based community development project, social entrepreneurship and interconnecting social networks.

How get out of comfort zone? Present ourselves a human being that is a zealot? Everyone will not be your friend? We will reach out to peers.

What supports/training will existing groups need?

Attitude. Some people want to re-create the same type of day program. How to manage the risk of reaching out to outside group? Community access – educating If you have been segregated – TA needed on what is available and how connect if no resources are available.

Police and courts, anger management needs to be taught. How help peer programs to move to this model?

Needs to be continual follow-up. Need follow through, for method you are using.

Center could outreach to colleges. What do we need to be trained? Support will be given to people who do those things. Go and tell our story.

Program to program now. Mentoring with each other. RC could help people get connected to service / free or paid.

Brainstorming needed, use a survey, or FISH diagram. Vote on priority. When start to implement feedback from members.

RC would not come in if Peer agency exists. How do we get them the skills to become new model enhancing, next generation of service?

Metamorphosis mentoring.

How to avoid being staff dependent. Organize the learning dynamic experiences.

Some of us live in programs in the community. This is not the community.

Consumer operated services – brought peer programs together educational group to support each other in being successful. Education on what is happening in converting it. The whole structure of peer networking group is doing that.

It is important how we see ourselves.

Are there going to be regional centers or one in each community.

Response: Peer groups will transition and convert. In places that lack – they may start on a large scale and then split off other centers. It's about taking what we have helped them become the next generation of peer programs.

Webinars monthly for people who have questions, to better understand brainstorm and keep it fresh.

Can people ask about therapy resources? Response: Recovery centers could have information on clinic services and develop a memorandum of agreement to provide supports. Not come to a center for clinic support. PROS or others would provide that.

How do help parts of the state that do not have peer anything spur the development?

Identify peers who have a passion to communicate. Create media presentation.

Larger programs could work to develop satellite programs. Field trips to drop-in centers, get inspired. Recovery on the road! – visit other areas.

Successful organizations mentoring others to develop. People need to learn the business. Organized mentoring programs from larger to developing organizations.

The County Director of Community Services (LGU) should have input and get them on board. Get communication going. Work with other ad MH resources.

Wonderful if peers could run the system?! Not realistic at this point in time, however it would be good if agencies would hire peers as clerks, or peer counselors.

Peers within traditional organizations, sometimes follow along.

If programs converted, they would have to fire the board and the peers would re-elect a new board.

Yes we should let them. If you could prove they are sincere and make it a worthwhile endeavor. They need to understand that “peers can do the work”.

Steve Kough – continue to provide TA to be self sufficient.

Would like to see welcome parts of the community that want to be a part of peer run organization, be person centered, and really practice it.

Ten years – they could evolve to places where anyone could come. The initial use is to help people get out of the mental health system. The initial focus to help people get out.

Convert only after we solidify what we are doing. Why not share it with others. Circulation-avoid stagnation. Create a flow. To get linked need recommendation letters. To even volunteer in the community.

If programs not convert, could the RC access? Yes, through a MOA.

No. It's our time now. Not only 1% of the budget. A lot of people that are passionate peers that can do this for peers with peers. This is a peer initiative with peers.

Providers are clueless about person centeredness. This will not work if agencies/clinicians unaware.

Motivation factor. Some people are not motivated. Need a way to get people motivated to do this. Complacency, need to have responsibility.

People have grown apathetic; don't have a passion focused on. When motivated, it is not an issue. Focus on passion as a first step. If I find your passion, the motivation is there.

This is just one of other opportunities to provide input. Let us know. Kathy Lynch peer person, let Central Office and Recipient Affairs know.

OMH will be issuing the RFP, hopefully by the end of year look at developing the RFP on new centers and for technical assistance.

First we will get the technical assistance piece out then other questions will get answered. Your thoughts and ideas are captured and will be incorporated into a report for the grant. The report will inform us about what will be in the centers. We will use the RAC (Recipient Advisory Council) and other process – to build consensus on this.

We agree on some of the questions, vary on others. The goal is to figure out where we have consensus, where not, and where need more dialog. Then figure out how to move over the next year. We are looking to collect feedback first of the year RFP for areas of State that do not have a peer program.

[Appendix #6: Peer Forum PowerPoint, Lindy Fox](#)

[Appendix #7: Peer Forum PowerPoint, John Allen](#)