June 21, 2018 1486 Stakeholder Advisory Committee Meeting Introductory Training Topics Notes

Summary

These notes cover the discussion led by the Texas Institute for Excellence in Mental Health. This work group meeting took a different format from previous meetings, wherein the stakeholders spent the majority of the time in small group discussion. The purpose of this discussion on introductory peer training topics was to build consensus regarding the topics which would serve as the most informative, cross-professional content for an introductory or orientation training that targets both individuals seeking certification as Certified Peer Specialists and Peer Recovery Coaches.

The information that was collected from the group during this conversation, including any notes of caution or guidance, will be delivered to a subgroup of workgroup members who will draw from the existing specialized trainings to create an introductory curriculum. This group will report back to the larger 1486 workgroup throughout the process for feedback and approvals.

After collecting and reviewing workgroup member feedback from the previous 1486 group meeting in May 2018, eight potential training topics were presented by evaluators at the UT Texas Institute for Excellence in Mental Health to the workgroup as suggested to consider for inclusion. Overall, the workgroup was supportive of inclusion of the entire collection of topics presented:

1. history of the movements,
2. co-occurring conditions,
3. language,
4. cultural humility,
5. trauma,
6. self-care,
7. the state behavioral health system, and
8. peer roles in systems.

Important overall points about combined introductory training in relation to current trainings:

- The introductory or orientation training should prime participants for the in-depth follow up in specialized trainings.
- All topics in core shared training are starting the conversation and more high level – dive deep is in specialized trainings; that said, the introductory training should help the individual understand if they are ready for the specialized training and the role of a peer specialist or recovery coach.
- Keep general don't go too deep and get into the weeds in specific practices in the introductory training but should be an intensive orientation to peer support. "This is what you're in for."

- Advantage for participants: Can I do this? Take 8 - 12 hours and then decide do I really want to be a peer specialist? Allows them to decide before committing more time to the specialized training.
- This training will be just one of the gates to pass through on the way to become a certified peer… application, core training, knowledge assessment, specialized training, knowledge assessment, supervised work experience, certification.
- Hiring practices will also be important for gatekeeping and retention. People will hire person in recovery, call them a peer, and then find out they don't really want to do this role. Recruitment and hiring practices are very important.
- Core should be what's the same because the differences and specialized pieces will come in the in depth individual trainings and recognizing differences will be discussed later.
- Workgroup members present expressed that the current specialty curricula are needed as they are, regardless of what the introductory or combined training looks like. To keep the current curricula as they stand, a vote should be taken with the entire workgroup.

Format

Feedback was collected from the group via a two-step process to review each potential introductory/orientation topic: 1) small group discussion (3-4 in each group), followed by 2) small group report out to the whole committee. Participants on conference call provided feedback during the report outs. Approximately 18 minutes were used for each round of topic discussion.

Because the two Codes of Ethics for CPS and PRCs are similar but may be expressed differently in their work, discussion groups were asked to keep this in mind as they determined which topics would be suited for an introductory / orientation peer training, including any high level notes or caveats for each topic.

Active discussion participants included: Noah Abdenour (Chair), Shannon Carr (Vice-Chair), Reggie Smith, Joseph Sanchez, Dennis Bach, Ellen Goodman, Jason Howell, Karla Rose, Jason Johnson, Joe Powell, Sachin Campbell, Amelia Murphy (phone), and Patty Doty (phone).
HHSC participants: Robert Dole, Rebekah Faulkner, Sheri Jackson, Laura Munch.

Content topics

1. History of the movements

Overall: Acknowledge and celebrate differences in histories and language, but emphasize shared purpose and movement so as not to create a rift. Keep this section brief and high-level with detail in specialized trainings but focus on peers supporting many paths to recovery and that each person determines their path.

- Language: What is recovery, what is pathways? SUD has specific verbiage. MH: this is what I lived through and this is what I did through my recovery and wellness
- Pathway – used differently between SUD and MH
- Opportunity to define those words and define them together so we can all agree on them.

- Clarify and come together on definitions, make it one definition
- History of the language are a little different, but self-empowering for both
- Build together yet celebrate individual movements
- Dive deeper into specific language in specialized training
- Core training should acknowledge and celebrate differences, but emphasize we're in this boat together – emphasize the service provided
- Core training should be "peer 101 basics" – leave talk of specifics to specialized in depth trainings
- Separate stories and separate language - but together here to help
- Don't go too deep and create a rift – keep it short
- CPS: Shoulders to Stand On section in basic CPS training is inspiring – more than a job, it is a movement
- Need the history piece to build on as a movement, it lights the fire.
- Understanding the power of the peer movements – hope and shared lived experiences
- Keep it high level and emphasize what is shared and unifying
- Medical model language and approach works for some people but not all (this is often a difference between peers in mental health and substance use recovery)
- Acknowledge differences in language
- Need to heard other perspectives
- Advocacy and trauma experiences are shared by us
- Where is the movement today?
- What does recovery mean? Pathway – discussing world view and way you think it applies to you is not the same for others
- Everyone's recovery is not the same
- SUD: Part of our history was AA - one way only. Now we are opening up to other pathways
- For training participants: for some, their recovery concept is now being challenged – that can be scary for people coming into peer role. People need time in recovery to be able to have their path challenged – at least 12 months
- How do you determine what is means to be in recovery? What does it mean to SUD and MH? Can you use substances and be in recovery? Can you be dealing with symptoms and be in recovery?
- Agree - keep section brief and high level. Establish history on BOTH Sides
- Also concur– brief and high level

2. Co-occurring disorders

Overall, this section brings up issues of how people identify with either SUD or MH and how different approaches to services are based in their recovery framework (e.g., surrender v. empowerment), which is often dependent on which door you walk in. People may walk in different doors, but trauma is frequently at the root (bring in ACES study). Co-occurring includes physical health too, resulting in some of the biggest opportunities for cost-savings as peers can increase access to care and reduce hospital/emergency costs (bring in this data).

- So intertwined, as discussed in current co-occurring endorsement training, it is influenced by the door they walked into – where they get services or how they started recovery

- All the cultural influences that helps people define their own recovery are unique to each person
- Providing context is key
- Underlying trauma is shared
- Experiences are often shared but your path to recovery informs your understanding and your point of view
- Ex: Surrender (SUD) vs. being empowered (MH) – that this is the same thing was a revelation to me – how I define it is based on my framework for recovery
- Importance of trauma and ACES
- So many people have substance use and MH
- Focus on role of enabler/caretaker
- Definition of co-occurring, removal of "disorder" as this labels
- Challenges not disorders
- Bill White open to letting people decide language for themselves – discussion is more important than exact word – what are the beliefs and values underneath?
- Co-occurring piece – this is a more vulnerable population and there is higher risk for re-hospitalization and more costs. This is an opportunity for peers to have an impact on access to care and cost.

3. Language

Overall: Huge opportunity for shared learning - what impact does language have and how can we use it (experiential language)? Recovery language not only removes barriers for people, destigmatizing (or non-recovery language can negatively impact people), it also has the power to shift the system paradigm toward recovery. However, contextual or system factors other than being person-first and recovery-oriented can affect the language we use – e.g., you must have a 'disorder' or diagnosis to get paid for services. Must acknowledge such points. Also an opportunity for more training on how to use human experience language.

- Some words and language that we may want to borrow from each other (e.g. resilience)
- Specific words from SU that don't translate well and vice versa
- What can we share; what we can't – different meanings to different cultures of MH and SU
- Also cultural and language issues re: minority populations and Criminal Justice culture
- Strengths based and recovery language changes clinical world
- Moving out of illness based language – the recovery movement pushes the new language
- Power of changing system with language – peer as change agent in systems
- Derogatory language towards people receiving services is often used in clinical settings, peer code of ethics helps change that
- Peer specialists also change perceptions of people who received services – their presence meant people saw the organization as more recovery oriented.
- Address the stigmatizing history of language
- Acknowledge role the system plays - using stigmatizing language – needs to be changed
- Need diagnosis and "disorder" to get paid for services
- System change - can't fix things because you need problems to get funding

- Doesn't like word "should" in "language should be non-clinical" – there may be circumstances where working in clinical group and this is appropriate
- Disagree - keep the word "should" in to keep peers from being co-opted by clinical staff or being treated as a consumer
- Should be in the introductory training – more training on how to use human experience language – describe experience and what it looks like instead of labeling thing. What does it mean that he is anxious or angry (labels)? What is happening? What is he feeling?

4. Cultural Humility

Overall: There are many layers of culture, so this section should focus on the bird's eye view, priming the conversation that will continue into the specialized trainings. Tie back to advocacy and social justice (issues of power and privilege) aspects of the recovery movement. Focus on how it affects the peer role.

- Big part of training – really cool exercises
- Could be in either core or specialty
- Need good guidance for this
- Intentional peer support and how it framed around world view is a good model
- So many layers of culture
- What is the bird's eye view?
- Maybe start the conversation - to be continued in specialty training?
- How does it affect the role? How does it pertain to history and language?
- We are not the experts on this.
- Ties into advocacy and social justice movement – why peer support even exists
- Trauma – helps having it validated for people
- Cultural humility is key element of trauma informed care
- Some people that get into recovery forget where they came from – above people who are still using – be humble not judgmental
- Cultural congruence of power and privilege – what is the significance of cultural humility?

5. Trauma

Overall: Trauma responsive care means that it's not enough to be informed, but you must do something with that information. Keep in mind this may be a peer's first introduction to this concept – including how it should affect their interactions with people and how to recognize a trauma-informed workplace for themselves as employees. Peers may be the harbingers of trauma-responsive notions at their organizations. If a person hasn't worked through their own trauma, this can create difficulty in their work as a peer.

- Not trauma informed care but trauma RESPONSIVE care
- Create a responsive environment – information doesn't matter, actions do
- Being responsive is beyond being informed: Strong agreement by group!
- How we treat each other internally. It's a way of life
- Shared by both MH and SUD – should be in core training
- This may be new to a lot people – learning is a life-long process. This is introducing concepts that are integral to their own recovery and their ability to help others.

- Introduce employees to what you should expect from a trauma informed workplace
- Ongoing trauma informed training should be available on the job for all employees. Changes in policies and procedures at the organizations are required. Took a lot of time – maybe a year or more. Board to maintenance levels. Direct care staff MUST be trauma informed – tech/recovery advocates.

6. Self-care

Overall: This section of the training should be less didactic and more experiential, for example, time for self-care activities should be built into the training: teach by doing. Information should include recognizing compassion fatigue, what are healthy boundaries (don't become the rock in someone's life), and role-modeling self-care. This should tie closely to what is being taught in the peer supervisor training as we must walk the line between HR policies that support preventing secondary traumatization & burnout and maintaining focus on job performance (not mental health issues) during supervision. Statewide standards may assist with integrating effective policy and practice that support employees with frequent exposure to secondary trauma or on-the-job trauma.

- In the core, be less didactic and more experiential
- Should be interspersed throughout training – do self-care activities with training group rather than talk about them
- Address again in specialized
- How can you identify if you are experiencing compassion fatigue?
- Healthy boundaries
- Role modeling self-care for other staff
- Ties closely to supervisor training
- Compassionate HR policies
- But Professional - Don't set up second class employee
- Peer leadership development
- Set statewide standards
- Don't lose yourself in helping - don't take away others self-empowerment
- Help people create rocks in their life, don't become their rocks
- Subcommittee should address Supervisor training
- Connection between trauma and self-care – loss and grief experienced on the job

7. State BH system

Overall: Focus on helping peers understand the peer role in the larger system as well as funding streams and how that affects differences within the workforce as well as differences between the peer workforce and others.

- Beyond just state system – how do services get funded beyond state
- Advocacy – connect people to what is out there
- How do potential peers fit into larger system?

8. Peer roles in systems

Overall: Opportunity to teach peers about various work settings, roles, and job descriptions. Focus on importance of maintaining integrity to the peer role and not being co-opted by a system which is not yet fully recovery-oriented. Peers have different day-to-day programs and job roles, but they also have a broader role as change agents and advocates in the system. A recovery oriented system must have peers, but just having peers doesn't make a system recovery oriented. Opportunity to educate peers about roles they may not have known about, but feel they would be highly effective doing. Opportunity to educate peers about what they're in for (systemic pushback) and what to expect.

- Sample job description in the SUD training– what is similar and different between MH and SUD jobs
- Let people know about:
  - Different work settings
  - Different roles we play in the system
  - Where do my passion or interest lie?
- Encourage the integrity of peer role – systems will not be recovery oriented and will try to fit you into what they do. Danger of co-opting by the system.
- Understanding to voice what your work role is how it is different and how it complements what's going on in the system
- feedback from LMHAs – peer specialists are not toeing the line, especially around medication management
- Need to orient system to recovery. Just having peer specialists does not make it a recovery oriented system – peer wither there
- There is respect within the system for each other in our organization. It can work well.
- Challenges you will face in integration
- How do we talk to clinical staff without seeming arrogant – how to effectively advocate within agencies – some of that in basic CPS training - maybe more in specialized training
- All this should be included in the road show
- Multi-step. Introductory session "This is what you are in for." First gate is application to introductory training. Introductory do you want to do this. Then go to specialized.
- People will hire a person in recovery call them a peer and then train and people don't want to do this – speaks to poor hiring process.

Next steps

- Smaller group with curriculum development experience will work on the introductory training content.
- Content will be reviewed and approved by the entire workgroup.
- HHSC has staff who can assist with developing the facilitator curriculum, participant manual, and any slides needed for the training.
- Rebekah will send out Survey Monkey – Need Quorum to recommend keeping the current specialized curricula as they are.
- TIEMH will provide page numbers in the respective curricula that correspond to the shared topics.

Content topic page numbers from PRC and CPS manuals

Content Topic	CPS Trainer Manual	CPS Trainee Manual	PRC Trainer Manual	PRC Trainee Manual
History of the Movement	pp. 35-43	pp. 15-19	Day One: p. 17	Day One: p. 15
Co-occurring Disorders	Topic not included in curriculum/manual	Topic not included in curriculum/manual	Day Four: p. 17-21	Day Four: p. 19-24
Language	pp. 57-68	pp. 27-30	Day Four: p. 22-24	Day Four: p. 24-28
Cultural Humility	pp. 233-249	pp. 93-98	Day Four: p. 3-16	Day Four: p. 2-17
Trauma	pp. 99-113	pp. 43-48	Day Three: p. 17-20	Day Three: p. 20-23
Self-care	p. 31, 185-186	p. 75-77	Day Five: p. 3-4	Day Five: p. 2-3
State BH System	pp. 301-312	pp. 121-126	Topic not included in curriculum/manual	Topic not included in curriculum/manual
Peer Roles in Systems	p. 39 (History of peer work and its implications for peer work/roles today) p. 254-299 (Modules 17, 18 and 19: Ethics and Boundaries, Change Agent, and Power, Conflict, & Integrity)	p. 103-120 (modules 17, 18, 19: Ethics and Boundaries, Change Agent, and Power, Conflict, & Integrity)	Day One: p. 16-22 (Roles, where peers work, job description, differences from other staff) Day Three: p. 10 (resource broker) Day Five: p. 20-21 (Ethics and Legal issues include topics related to peer roles)	Day One: p. 16-23 (Roles, where peers work, possible job description, differentiation from other staff) Day Three: p.12, 14 (PRC as resource broker) Day Five: p. 39 (Ethical conduct related to peer roles)

Method used for discussing content topics