We know about peer services and peer support. So I'm just waiting for [INAUDIBLE] to give me the high sign here, and then we'll officially get started. And I'll repeat myself a little bit. As I said, we are recording or will be when we momentarily.

So I think we're ready. For those of you here at Creedmoor, welcome. And for those of you online, welcome. Today's workshop is about best practices for effectively integrating peer staff in a workplace. We're going to be talking about a number of things, and this is considered an interactive workshop.

If you're online at one of our remote sites, you've got Joe Carpenter. One of my staff is monitoring the chat dialog. If at your location you have a question or would like to provide feedback into the discussion, we'll stop at various points in the presentation. When you've got someone typing into the chat dialog, Joe will be monitoring that and interrupting me as you have questions.

We also have Johnny [INAUDIBLE] on my staff is setting up and recording. We're recording this to become part of the academy of peer services. So we will be adding a supervision class to the academy portfolio of classes for peer supervisors. And this will be one of the classes there. So this is what's being recorded and video sharing.

For those of you who at remote sites, we have about 400 people participating, both throughout New York State and a couple sites around the country. So for those of you that are participating virtually [INAUDIBLE] today's webinar, my name is John Allen, and I'm Special Assistant to the Commissioner at the New York State Office of Mental Health.

Let me do a couple of housekeeping details before we get started officially with the program. If you're at one of our moderated sites, and you're looking for social work CEUs, there's a separate sign-in sheet that you need to make sure that you've signed in.

If you're an Office of Mental Health social worker, and you're looking for CEUs, please make sure that you put your N number, which is your employee number, on the form. If you don't know your N number, that's OK. Breathe a deep sigh of relief and just email one of my staff, see one of them during one of the breaks, either Joe Carpenter or Johnny [INAUDIBLE]. You can find them in the State Outlook address book. Email them your N number, and we'll add it in for you.

The Bureau of Workforce Education and Development needs your N number in order to give you credit toward social work status. And we are paying for those credits if you are an RMH employee or if you're not, then sign up.

For those of you from other disciplines, whether it's if you're a specialist, CRCs, the CMEs, or CNEs, we are looking to add those kinds of credits as we go forward into the future. Everyone will be getting a certificate of participating if you are at one of our moderated sites. If you're online, we don't have that function available yet. We

are working to add it in the near future. So those are future things to come.

We can't do one of these presentations without a lot of people participating. So let me begin by thanking our site facilitators where each of our sites that are awarding the social work CEUs presently, and we've got a number of people who volunteered or as Johnny says, they have been now told by their supervisors to help and assist us in that regard. But I want to thank them personally for assisting us in that process, because it is their work that makes the awarding of CEUs possible. We have to have someone actually moderate those types.

I also want to thank all of my staff on both of our regional advocacy specialists and peer specialists in the central office who all contribute to putting these workshops on and help with advertising, promoting, setting up the sites and doing all the leg work to make these things happen. It's because of them that we've got over 400 people participating today, and so I'm very thankful for that.

Let me kind of walk you through today's process. We will be taking a break this morning. We will take a lunch break and because we've got people at remote sites, we'll allow enough time for people to go wherever they to get and gather lunch and come back to those sites. We will take a break this afternoon. The class is expected to last for five hours. And that is a requirement in order for our social workers to be able to get [INAUDIBLE] credit for those CEUs.

So let's [INAUDIBLE] doubling back on sound. OK. So we fixed that. Thank you. So we had a little echo for those of you online. I apologize for that. Staff are working out the mechanics of putting that together.

So let me walk into today's agenda and what we plan to do for today. And then we'll begin the workshop. So ladies and gentlemen, we're going to begin by asking about who is a peer? And for those of you that are peers, this may seem like an easy simple question. But it's not actually that simple. And if you are a supervisor, it may not be that simple at all.

So we're going to have some discussion about who is a peer and what does that mean? And what's the value of doing that in a variety of workplaces? We know that as we're going [AUDIO OUT] in New York State, a number of you are looking at managed care opportunities and participating in a variety of managed care settings. Nationwide, that also is critically important. Many manged care settings are looking to hire more peers and have more peers as part of the workforce.

So understanding what is it that we mean when we say peer? We want to look at what do peers bring to the workforce? Because if you going to hire peers, then you need to know why you're hiring peers and what is it essential that they bring? Having a peer drive the van adds very little value to somebody else driving the van. Why? Because the most important thing is driving the van and getting everybody there safe. You don't want to

have an interaction supporting people if your primary focus is driving a van.

So we're going to be talking about what do peers bring and what is the value of having them as part of the workforce? We're going to be defining what is the case. So for those of you that are managers and supervisors or advocates that are advocating for the inclusion of more peers in the workforce, we're going to give you a number of scientific technical references that actually highlight the research value of having peers as part of your workforce.

We're going to be defining BOR-E. Now, I know all of you are thinking this is going to be bor-ing instead of BOR-E. BOR-E is bona fide occupational requirements for employment. And that's going to be critical for you to understand, because there are things that you can ask.

People say but we can't ask about someone's experience being a peer. But we can under certain circumstances, and we'll be helping you identify what those are and how to go about doing it. Because one of the common myths is I can't ask you about your experience. That's absolutely not true. We'll give you the reference that the Equal Employment Opportunity Commission has used and the legal guidance that they've provided.

A couple of the slides that we use for reference are very long and wordy, and don't expect me to read them for today's workshop. Anyone that's been signed up for attendance, we will be emailing everyone copy of the PowerPoint so that you'll actually have it. You'll actually have those slides for reference. So those really are for reference. They're not for our conversation today. Don't get upset if I flip over them really fast and don't give you time to read them. They're really more valuable for reading and using for advocacy outside of today's workshop. And I'll be describing it.

The next section is preparing the ground so that if you've agreed to hire peers, what do you need to do to ensure that you're going to have successful peers in the workforce? So it's not just that we hire peers and great. Good luck. [INAUDIBLE]. Great work. You actually have to plan for how we're going to use them, and what is the most effective way to utilize them in the workforce? And how does their peerness add value to the clinical services and processes that we're doing? So we'll be talking about that as well.

We're going to talk about recruitment. And one of the things that we often hear a lot from people is I can't find qualified peers. So part of today's agenda is going to focus on how to find, even select, screen, recruit, deal with disability issues, which are unique.

Those of you that think that just hiring peers is like hiring anybody else, there are some unique issues in hiring peers. One is dealing with disabilities. Another is dealing with boundary issues. We don't often think about boundaries when we think about peers. There is some uniqueness there.

And so how can I hire someone who's a peer, and I now hire them and expect them to follow social work and other boundary standards that say you'll have absolutely no contact with anyone that we serve? And yet we hired them because they're a peer, which means that's the people that they're friends with. That's who they have contact with. So if you're saying that if hire you, you have to give up the rest of your life, that's not really what this is about. So we'll give you some guidance about how that plays itself out.

And then dealing with history. A number of peers actually have a history that includes contact with law enforcement. And at least in New York State we've accounted for that, and nationwide we'll give you some hints about how you might deal with that in a way that values that experience.

Now, you might think that are certain kinds of legal disqualifiers, so if you've ever been convicted of certain crimes, that might disqualify you from working. As one of the people that participates and managed the office [INAUDIBLE], I would say just the opposite. Those experiences might uniquely qualify you to work with certain populations. And we'll talk about that when we get to that section.

We also want to talk about supporting the employee. So after you've hired your staff, what do you do to keep them functioning and working optimally? And how do you make that happen? What's the training that we need to provide? What are the unique experiences in supervising that you might be faced with? If you're a supervisor, what might you expect, and how might you deal with certain kinds of settings and issues?

And then what's the ongoing professional development? We don't just want to hire someone, and for the next 30 years you're going to be doing what you did for the last 30 years. We want you to grow, develop, and change with the times and address things in a professional and confident way. So that's our agenda for today.

So before I start by asking all of you who is a peer, let me see, are there questions from the audience here online about today's agenda or concepts before we get started? Questions about the agenda or what you expect. So everybody is here for a peer workshop on supervising peers, right? You're not here for security officer training or infectious disease control and other things. Well, you might be, but that's a different part of today's workshop. So the exam will cover those [INAUDIBLE] in great detail. So make sure that you pay attention to those [INAUDIBLE].

All right. So let's jump in and talk about who's a peer? So who would you all here say is a peer? And for those of you online, I'll repeat the things that we get from the audience. So who's a peer? [INAUDIBLE]

A peer is someone who has identifiable and similar life experience with someone else who would be in the mental health field.

So Bernard is saying a peer is someone who has identifiable life experiences as others who are in the mental

health field. [INAUDIBLE] others? So who's a peer? Who do you think?

[INAUDIBLE] peer specialist [INAUDIBLE] and that's how I had a chance to be a peer specialist. [INAUDIBLE] having lived the experience [INAUDIBLE] which I did. And when I took the test and exam, I [INAUDIBLE] change. Well, what is the difference between [INAUDIBLE] provisional and [INAUDIBLE]? What's your entitlement? What [AUDIO OUT]

So part of the question is that-- or part of the conversation is what [INAUDIBLE] explained that he is a provisional certified peer specialist in New York State, who sort of got excited and engaged in the process, because another peer talked to him about the process. And to get to the question now, what's the difference between provisional and regular certification? We'll talk about that in just a few-- a little be later today.

So what is a peer? I would say that there are some other definitions. So you all are peers. You all sit on your hands, I'll start randomly calling on people in the room. That's the downside of physically being in the room with me. So we'll let you jump in. [INAUDIBLE]

[INAUDIBLE] to experience [INAUDIBLE] is also now working. So [INAUDIBLE] and coverage between training and now working.

Here's just to say a peer is someone who has [INAUDIBLE] experience, who's kind of been through the system and is now working and able to do some of the role model.

A peer for me is a person that shares your [INAUDIBLE] regardless, whether it's methadone or substance abuse, trauma, just about in a variety of areas, but some are [INAUDIBLE]. Whatever their [INAUDIBLE] whatever area that they're struggling.

So the conversation here is a peer is someone who shares your experience, whether it's in trauma or substance use or developmental disability or other areas. You share that experience with others who share a similar experience and choose that. So, yeah, it could identify it.

It doesn't matter if they [INAUDIBLE]. And it could be for cigarette smoking. It could be eating. It could be [INAUDIBLE].

Was she saying for cigarette smoking?

[INAUDIBLE]

It could also be a colleague.

Right. A peer could also be a colleague. We are all peers of each other, depending on the workforce that we're in. You may, in fact, if you're a social worker, your peers may be social workers. You may have multiple peer identities. You may be a mental health consumer peer. You may be a social worker peer. You may be a physician peer. You may be a peer as part of the team on unit B. You're going to be part of different what are often called affinity groups. So yes.

What makes a peer different than your colleague is that peers are hired under the conditions that they have to [INAUDIBLE]. Your social worker could have their [INAUDIBLE] back with experience, but they don't have to disclose. But if I identify [INAUDIBLE] struggles, but they don't have to disclose that. They're not able to disclose that. That's part of the boundary.

So part of the conversation in the room is that peers are hired, at least here in New York, and part of hiring of a peer specialist or in many of our setting is the requirement to disclose, as opposed to other people that don't necessarily have that requirement. So let me just sort of ask the question, is someone who has been hospitalized 20 times who presents themselves as a licensed clinical social worker, who never discusses their background information with clients at all, a mental health peer?

[INAUDIBLE]

Well, they're a peer in a way. But they don't have to disclose that. I mean, because you're a social worker, right? That's what we said.

So the conversation here says, well, they're a peer in a way, but they don't have to disclose it. So would you consider that a peer?

I do not consider that person a peer, because they're not going to disclose that part of themselves.

So [INAUDIBLE] saying you don't consider them a peer, because they're not willing to disclose [INAUDIBLE].

And they're not [INAUDIBLE]

OK. So what do other people think? Yes, sir.

[INAUDIBLE] saying for peers, peers have self-disclosure as a tool, right? [INAUDIBLE] the peer, different peers might use self-disclosure in different ways.

So the conversation is peers have self-disclosure as a tool. So peers might use that in a variety of different ways. How can you be a peer to someone if they don't know that you're a peer? [INAUDIBLE] But the person who doesn't disclose, are they a peer?

Yes. I think it's with experience, right? Because you can identify with someone in the same sense.

Or let me help you analyze kind of where you're going. So you said a couple important things. If people can self-identify with you, how can someone identify with you if you haven't disclosed who the you is? So with the you that they know, is the psychiatrist with the prescription pad, how do they know that you are one of them?

So let me take this out of mental health and give you different kind of scenario. So one of the probably strangest things that I've done in my lifetime, I've been skydiving. I don't exactly know why. Like probably one of the scariest experiences I've ever had in my life, also one of the most exciting, after I got safely on the ground and didn't kill myself, it's a really good thing. Why don't you try it again? With that said, how do I know who my peer skydivers are--

Your instructor.

--if you never disclose that you've been skydiving?

People that [INAUDIBLE] know.

Well, I know the people that are disclosing, because they told me. The people that are teaching me, I know they're part of my peer group. But I'm willing to bet, between our audience that's online and here, that there are at least a couple of other people in the 400 or so that are attending today that have jumped out of a perfectly good airplane for no perfectly good reason, which is how most people that have done this describe it. But how would I even know that they're part of my community, which is what we talk about, if there's no disclosure?

So if you're a social worker, and you never tell me you're a social worker, you're not part of my peer group until we have that conversation, and I know that you're part of that peer group. So part of being a peer is not just having an experience, so it's not just jumping out of a perfectly good airplane for no perfectly good reason at all. But it's sharing that experience so that others know that you're part of that group. It's sort of like being part of the club. How do I know that you're part of the club unless you've got the membership card or unless you're identified as part of the club?

So part of being a peer, if you're going to call yourself a peer in the sense of being a mental health peer, is the ability for other people to identify you as such and use that to meet their clinical needs. If you're not willing to disclose, then you may, in fact, have that experience. But I would argue that you're not a peer except that you shared the experience.

So how do I know that you shared that experience? I don't. So you're not my peer. You might be a peer for me,

but you're not my peer, because you're not part of my group. I have no way to identify you as part of the group that shares that common experience. So part of when we talk about who is a peer is people that share a common experience that are known to each other. Because if I don't know that you're part of the group, are you part of the group?

No.

If I never show up for a meeting, if I don't have the-- we often know our professional credentials by the initials or letters after our names. So if I don't have 47 initials after my name, to immediately what other groups I belong to, how do know if I'm part of the group or not?

So part of hiring the peer is not that you're hiring someone who just lived the experience, but are they willing to disclose it? Because if they're not willing to disclose it, they may be part of the group with this experience, but if I really want someone to be a peer and be part of that process to engage clients and to help them move forward and to help bridge your experiences, then they have to know that I'm part of their group.

And if they don't know that, how can they relate to me in that way? You might, as the professional, identify that you have similar experiences to me, but you're not part of my peer group unless I know that you've been hospitalized, that you've been restrained, that you've been secluded and all of the other similar experiences to me. So part of the peer is not just what our experience is, but the willingness to disclose it and use it. And that's part of the value of hiring a peer that we're going to talk about in a little bit.

Hiring someone who's a social worker and with experience is valuable, extremely valuable. We're not saying that that's not a valuable commodity for them to understand and use that skill as part of their professional credentials, but they're not part of that peer experience from the people that they serve. Because the people they serve are going not going to identify them as an equivalent part of that group.

Isn't stigma or discrimination part of the lived experience with being a peer and how can you do that in the office [INAUDIBLE]?

So the question is, aren't stigma and discrimination part of the experience of being a peer? Well, under the law, I would like to say that discrimination and stigma is not something that should even enter the equation. However, in reality, stigma and discrimination are alive and well, particularly when we talk about people who have lived with mental health problems [INAUDIBLE].

It's the one newspaper headline where it's perfectly acceptable to say [INAUDIBLE]. We've eliminated putting race in newspaper headlines a number of years ago. It's no longer politically acceptable. It's a good thing. But it's still politically acceptable to lead with someone's mental health diagnosis or experience as part of that label. So the

stigma's alive and well.

I wouldn't say that people who have not experienced [INAUDIBLE] people experience stigma in a lot of ways. So that's not necessarily part of the conversation, that if you're going to counsel me about what it's like to be me, then I need to understand that you've got that similar experience.

When you tell me you understand, and you're not disclosing, well, you don't understand. And if you tell me you totally understand what it's like to be me, well, nobody can understand what it's like to be me, because each of us are unique human beings. But when you say that you've shared some common experiences, then I can relate to the experiences that we've shared.

That's part of the definition of what it is to be a peer. And this conversation is going to be important when we talk about why we're hiring people. So before we get to that, we need to have an understanding of at least how I'm going to use who is a peer in today's workshop. So it's a little warm in here, so I'm going to get rid of my jacket just because, otherwise I will be floating away or melting away.

So why not peer staff? So now that we've identified, well, who is a peer, why should we hire peer staff? People who are going to identify and break all the boundary rules that all of our professional disciplines have, why would we hire people who are going to do that? What do you all think? Don't everybody jump in at once.

I'm giving it a try.

Go for it.

Because when you leave the hospital, trying to negotiate [INAUDIBLE], trying to negotiate an illness, trying to negotiate the medications, trying to negotiate the medication side effects, and after having this tremendous biographical disruption, [INAUDIBLE] like how do you [INAUDIBLE] the diagnosis will [INAUDIBLE] who would want to take the mental patient? And if so, [INAUDIBLE] Doctors don't know the answer to that and [INAUDIBLE] don't know the answer to that. But a peer will know the answer to that.

Interesting conversation. So it's having lived with this diagnosis when you're discharged, how do you do common things like dating, whether you disclose that you have a diagnosis or not? Can a physician actually help [INAUDIBLE]

So why not point your eye up here. [INAUDIBLE]

Well, I wouldn't say [INAUDIBLE] peer support [INAUDIBLE] also here I think that the individual [INAUDIBLE]

You said a couple of really important things. You said to help someone go through this experience and be able to

talk to someone who's been where they are. And then you said, equally powerful, to offer some hope on the other side. Really powerful messages. So yes, [INAUDIBLE].

I think there's [INAUDIBLE] they need to speak up for [INAUDIBLE]

So the [INAUDIBLE] here is doctors, social workers, and other professionals need to understand the point of view of the client and that peers and peer specialists can often be the-- I'm going to paraphrase your words-- the translators of what it's like to be the peer for the professional staff. So Joe, we have a comment online.

Peers change things. They're change agents. And peer staff help increase engagement for participants.

So peers change things. They're change agents. They can help increase the role of participants in that process. Very valuable. Bernard.

Yes. Also by hiring peer staff, [INAUDIBLE] are ready and boost the self-esteem of the people that are known as peer specialists or peer counselors. And again, when other people see the self-esteem, they're attracted to it.

So Bernard's saying that part of the value of hiring peer staff is it boosts the self-esteem, the people that are hired, and then that other peers who are part of our treatment continuum are attracted to it. And I would call that kind of role model, that you're actually modeling something for [INAUDIBLE]. Yes, sir.

Well, I would say peers [INAUDIBLE] go places where [INAUDIBLE]. For example, [INAUDIBLE] but a peer could actually bring the client through the process.

So really powerful. So he's saying that peers can go places that sometimes other professionals can't. So a professional might get a referral to a 12-step group. The peer that's been through substance use could actually take someone and then participate with them in that group. Very powerful [INAUDIBLE]

And some definition of a peer [INAUDIBLE] and the fact that the [INAUDIBLE] really stigmatized and [INAUDIBLE] in our society [INAUDIBLE] and is now functioning. [INAUDIBLE]

So [INAUDIBLE] is talking about a lot of role modeling that can occur. Let me pose a question to you on a different context. A lot of people wear their pink ribbons today. You all know the significance of the pink ribbon. Breast cancer awareness, right? Do you know of any woman who is undergoing a breast cancer diagnosis who doesn't want or benefit from talking to a breast cancer survivor, somebody that's been there?

It's commonly accepted in our society that people experience value in finding people that have been through a similar tragedy and understand that. Family members, parents who've lost a child find support-- like find the

support groups of other families who have lost a child. People who are survivors of rape and abuse find support by being in groups with other people who are abuse survivors.

This is not unique to mental health. But we all can think of it with a little bit of professionalism is our field makes the business something highly unique and different than what we're used to experiencing. And in fact, it's what the somatic medical community uses regularly and all the time.

We have people talk to survivors of the disease and of the experiences. Why? Because they offer hope. They offer possibility. They offer value. So if you don't disclose that you are a survivor of that experience, how can you offer those benefits? Let's go back to who's a peer.

You may have the lived experience, but if you're not sharing that, one of the unique values of hiring peer staff is to have people who have been there, who are offering that hope and role modeling what the future can look like. And in mental health, that's critically important, not just for the other mental health consumers. So who else might hiring peer staff be critically important for? A couple of you mentioned some examples. [INAUDIBLE].

Family.

Family. Absolutely. Family is critically important. Why? Because the families of people who are coming to a mental health program, the other clients of the mental health program. What do they see as possibility for their loved one? What they see in the other clients, which is pretty dismal for most people, to see someone who can say, you know, this is going to be OK. I've been where you have suffered [INAUDIBLE]. I have been on that recovery journey, and I know lots of others that have, and that's possible for you. This is a really powerful kind of example. So being a living role model for family is critically important. Who else might this be helpful for?

[INAUDIBLE] having peer staff, I think a lot of times a peer will be a complete liaison between therapist, practitioners, doctors. And the reason why I'm saying this is a lot of times the word expression is omitted. If I fell that my client, who I'm working with, is in some sort of imminent trouble, I don't use discretion. That's something I have to address. If I feel they're going to hurt themselves or have an episode of sorts, that's something that you have to bring to the staff.

And it's important-- so part of the conversation is sort of risk assessment and evaluations. All professions have requirements about risk reporting and [INAUDIBLE]. I don't think that's unique to peers. Our interpretation of it may be a little bit different, but I would tell you from wearing other professional hats, it's not unique to peers to have that experience.

Part of this process of hiring peers is equally important for staff. Now, this doesn't always translate easily. So let me sort of explain what I mean. We're here at Creedmoor in an inpatient psychiatric hospital setting. And some of

our remote sites online are inpatient sites. But many of you are also out in the community. An inpatient setting, who does staff see? They see people when they're at their worst.

I can tell you from being part of the management team of a large hospital system, I go to any of our hospitals and ask staff to name five frequent flyers-- the word that they use to describe people who have been through the system multiple times. And virtually every staff can name at least 20 without batting an eye.

If I asked them to name two people who have recovered, they might get to one. Why? It's not that people don't get better and recover and leave the hospital and go on and lead fulfilling lives. Many of you all, both here and online, are a perfect example of that.

But the staff don't get to see the fruits of their labor. They don't see people when they leave the hospital. They don't see what good comes from people when they're out in the community. Having peer staff is an excellent reminder to the great work that other professional disciplines equally do and a reminder that we do add value.

Everybody that's-- there's a newspaper headline that many people use when they talk about sort of anecdotal or convenient sampling, which is a slide that shows President Truman holding up the Chicago Tribune, where it says Dewey beats Truman. The reason that the Chicago newspaper got it wrong was they relied on something of convenient sampling.

We look at who do we have access to to evaluate what the outcome is? If you're an inpatient nurse, social worker, psychologist, psychiatrist, RN, LPN, or other discipline, what is your sample? Your sample are people that are in the hospital. What you know about what happens to people are from a sample that you have available to you. And yet that's a flawed sample. Why? Because that's people who are at their worst. You're never seeing people when they're at their best. And you don't see what happens after people leave.

So in spite of the convenient sampling where any hospital staff in psychiatric hospitals can name 20 frequent flyers, when you sit down with them and start analyzing all the people they've seen over the years who've never been back, who have gone on with their lives, who have gotten advanced degrees, who have finished school, who now own houses, who started jobs and businesses, who have gotten married, who have children, have grandchildren, our success rate is actually incredibly high. And yet most staff never see that.

And so think about hiring peer staff with the role to remind our other professional disciplines of what the real experience is to give a valuable commodity. Otherwise we start losing sight and becoming hopeless ourselves and believing that, as we used to believe 10, 15, 20 years ago, that mental illness is a hopeless condition and a life-long affliction. So, yes.

Another reason to add to your staff.

Well, another reason and that people say online is that peer staff are cheaper. And in some ways they may be cheaper or they may not be, and that's partly what we want to talk about, particularly from the managed care perspective, having peers able to intervene at levels that we don't need a PhD psychologist or an MD that also happens to be MPH and other experiences, actually does create better quality of care for lower cost. I wouldn't equate that with cheaper, I'd equate that with better quality. It [INAUDIBLE].

So why might we have peer staff? Well, we might be having for the part that's hiring, which is not something that you all talked about, which is meeting our business requirements to hire a diverse community of workforce. We might hire for role modeling, and that's something that you all did talk about. We might hire to provide them unique perspectives and contributions in the team.

And here's something that's not intuitive, but there are a number of studies. Unger in 2002 came out with this, and there are others that say that hiring people with disabilities, they have a higher retention rate than other people without disabilities, meaning they stay in the job longer. So if you've got a lot of turnover of staff, think about hiring people with disabilities and actually lessen your turnover in staff. Well documented in the literature.

So what do peers bring to service delivery? Well, you all said this when we were sort of talking about what can peers brings, and why do we hire peers? Well, peers, there's dedication and commitment. And typically when I'm interviewing, that's really what I'm looking for is the dedication and power. I can teach many of the technical aspects. I can't teach passion.

It's passion that I'm frequently looking for-- the ability to create an immediate connection with people. If someone who is homeless on the street knows that I was homeless and living on the streets, when I'm talking to them, do you think that they're willing to listen differently than if I show up in a four-piece suit wearing, you know, a gold ring and a jeweled watch and all of those fancy things?

If I show up and talk about by time of the street and having been there, do you think that builds just an immediate affinity with someone? That's part of the value of the peer, that you may actually be able, with someone that's acting out or even potentially violent, peers may be actually able to help lessen that because of this ability to build an immediate sort of affinity with someone in a way that that professional staff can't.

The ability to use stories and lived experiences gives our hope. Now, this is a double sword that we often have to help peers identify with, which is that your job is not to tell your story. Every encounter with another peer is not to tell your story. Telling your story is only useful if it is useful for a clinical point that you're trying to make.

The point of you being a peer is not to tell everybody your story and kind of where your experiences and kind of

this narrative on your chest that people can read. You're not the big P or Superman or woman in that process. But the ability to use our personal narrative, our experience, in a way that can engage others to help provide hope for others or to help convince others that they're not necessarily stuck, but their need to explore other ways of dealing with things can be very powerful, and that becomes more of a tool.

And then the ability to build bridges that engage providers of the treatment team. I've often encountered, having worked in the system now for most of my life, which is approaching 40 years, in that I've encountered young social workers who talk about, well, why aren't you going out on a date on Saturday night? Why aren't you going to the movies? Why don't you go to the rollerskating rink? Why don't you go out to dinner?

We don't necessarily have an appreciation of what it's like to live on SSI. Depending on SSI, you don't have the money to necessarily go out for dinner. Maybe to McDonald's if you save things up a little bit this month. But after you pay your rent and pay for your travel and pay the co-pay for medications, and pay your co-pay for your physician visits and pay for food and all the other things that you need, there's not a lot of extra disposable income. And having people tell you that, oh, you can just do this-- there are lots of opportunities in the community, that's true, but most of them cost money.

Peers who have lived on SSI know where all the free things are. How do I know this? Years ago when I was doing homeless street outreach, I ran a homeless shelter. And the one thing I can tell you about the guys that used to come in, they would know which grocery store had the cheapest of everything-- what was on sale where. Why would they know that? They're homeless. Why do you think homeless people would know which grocery stores had the cheapest?

They're buying it.

They're very limited.

They're very limited. Well, they're not buying things, I'll tell you that. That wasn't why they knew. This is one of these things about why it's important to be a peer. If you've never been homeless, you won't know what's the one safe place at night that you can go into and not get thrown out of-- grocery store. And as long as you've got the shopping cart and are putting things in it, you can stay in the grocery store for several hours. It's warm. It's dry, and it's safe.

And I'm not going to check out. I'm going to just fill up my shopping cart until I've spent enough time at the store, and I start getting worried that they're looking at me weird. And then I abandon my shopping cart and go to the next all-night grocery store. People that have lived on the streets all know that. People coming from school don't.

Peers know where the food pantries are. They know where the soup kitchens are. They know the secret handshakes of how to get into them when the line appears too long. They know the places that you can go to get emergency handouts and supplies from frequently.

Unless you've lived that experience, life living on the streets, you wouldn't know why homeless people happen to know which grocery stores have the cheapest things on sale this week, not because they're shopping. It's because that's where it's safe, warm, and dry when it's cold and raining and snowing out in winter. I can spend all night in an all-night food store and never get thrown out as long as I have my shopping cart, and if you're shopping.

That's part of the value of peers, is having that lived experience to be able to understand where are those places in the community that people ca go and participate in that don't necessarily cost money, that don't necessarily take away from people or say certain kinds of folks aren't welcome.

We've all been places that you show up and you're not exactly dressed exactly like-- well, let me see if we can get a table for you. People experience that every day. And when you are homeless or when you have a mental health diagnosis, and you may not have all the resources that others have, you experience those things a lot more in ways that aren't readily apparent to others that haven't been there.

So if you're ready to guide people in accepting community resources, and that's what I was really just talking about, the ability the help connect people to, not the mental health resources, but all of the other supports that exist naturally in every community. We're going to talk more about those this afternoon when we start talking about things that your program or your agency might design as part of the services that peers are going to [INAUDIBLE].

The ability to model healthy relationships. If you've grown up in a dysfunctional world, which today I think many of us could argue that the rest of the world is dysfunctional in lots of ways. But if you lived in family situations that were torn because of a diagnosis and the experiences there or torn because of poverty and complications or torn because of race and discrimination and all of the effects of those things and then added to it of having a mental health diagnosis or being homeless or having substance use disorder, then the ability to see others who are living and experiencing positive role models and talking about having relationships in their lives and talking about having hobbies and friends and talking about-- dare I say it-- buying a house or buying a car or taking a vacation, those are really powerful role modeling things that professional staff can convey and talk about their vacations.

But vacations are something for the wealthy. They're not something for the poor. And having someone who's been in your shoes talk about how they were able to put that together, it's a powerful statement of hope and possibility for people that may not see any for themselves.

We already talked about that ability to demonstrate to family members. I think you said it very well when you said to be able to role model for families. And that's incredibly important. He said particularly families come in to public mental health system often have been told this is a chronic lifetime condition. You do know this is serious mental illness. You do know that it's chronic and persistent. You do know that-- think of the message that they're hearing of hopelessness.

And having someone be able to say, yes, it's going to be painful. Yes, it's going to be a struggle, but your loved one, I can see the possibilities in there. And you're holding out that candle for others who aren't able to have the flame for themselves is a very powerful motivator and reason to potentially hire peer staff.

What peers can do that's different is bring this different perspective to the treatment team. Now, let me describe this in a way, because I know we do have a number of clinicians and supervisors in a variety of settings here as well, aside from peers, that would not necessarily seem intuitive. When we have a very difficult case in an inpatient setting, what do we do? We call a consultation. We bring in a physician or psychiatrist expert who's an expert in this diagnosis.

The Office of Mental Health, you know who they call after they've called in all of those people, and they still don't what to do? Me. They call in the peers. Why? Because often we look at things, not from a clinical perspective, but how might we engage this human being, who we've often lost sight of as a human being? How might we engage them in a different way? Not with mental health treatment, not with mental health conditions, but by other simples things.

Sometimes the things that we propose have created frequently life-changing experiences for people. Sometimes having a simple thing like-- example of one that we did recently-- a pet. Someone who can give you unconditional love made the difference in the quality of life for this person to engage in clinical services. Why? Because they had never experienced unconditional love [INAUDIBLE] treatment team, and they were always testing whether the team really did love them unconditionally by provoking the team, harassing the team, and challenging the team with really problematic behavior in a way to test to see, are you going to give up on me too like everyone else in my life has? And being able to connect them to something that provided genuine unlimited amounts of unconditional love and affection made the difference in building a clinical engagement that changed the whole course and enabled people to be discharged.

There are lots of different kinds of examples and not just bringing in things but thinking about other ways that we might connect with them as a human being, as opposed to connect with them from a clinical perspective.

What happens with people who are abusive and assaulted? The people who are overtly psychotic and

unresponsive to medication? And a variety of other kinds of clinical examples, where you might begin to think about when you've tried everything else. You brought the kitchen sink. Try bringing in a peer. You might be able to have a different kind of conversation that's unrelated to mental health and treatment but very directly related to engaging the person and a person and finding the connection to make treatment possible.

Supporting language of recovery. We often, particularly in clinical settings, start using a shorthand of schizophrenic, the bipolar, all that borderline personality disorder instead of remembering these are people with this diagnosis, first and foremost they're people. Having peers in the workforce is a good, both reminder for us to reinforce with the language. But the language says something subtle to our psyche that we then internalize. [INAUDIBLE] first or nondisclosed specific language, often we end up internalizing a different belief structure about what's possible for people and limiting those possibilities.

So building the competitive edge. Well, one of the things that's critically important now in managed care is how you be competitive with other health care providers to provide clinical outcomes of support more efficient, better outcomes and less costly. Well, one of things that's not necessarily intuitive is how do we find skilled staff to meet our workforce needs?

In the United States, there is an extreme shortage of psychiatrists, believe it or not. [INAUDIBLE] child psychiatrists are virtually nonexistent, not totally, but many places really struggle on where to find and how to hire a child psychiatrist. Even you're saying today it's very difficult to find in many parts of the country because there are not enough nurses to meet the requirement for nursing. And even social work in some areas is greatly depleted.

When we say we don't have enough staff, one of the ways that we can address that is by hiring, not paraprofessional staff, but professional peer staff, who are able to deliver competent and qualified services that augment the other kinds of professional disciplines. And we'll talk more about what those are specifically as we go through today.

So let me give you some of the literature, and these slides are wordy, and they're intentionally wordy, but they're not meant for you to read all of them. But they really are for reference if you have to make the business case to your organization about why you should have peers.

There's a group of researchers, starting with Grant 2009 and Humphreys, Loomis, White and others in 2000, 2002, that looked at this process of having mental health peers provide productive outcomes in the areas of substance abuse, parenting, loss or even cancer and chronic illnesses. This is across the board for every discipline.

And I already gave you the example of we wouldn't think about running a breast cancer treatment center without having a breast cancer survivors group and encouraging every participant in our clinic to continue to participate in it. Yet we regularly offer chronic mental health treatment without offering a support group of people who are getting treated in that system or who have been in it.

Across the United States, we have extensive family support-- NAMI and Parents Supporting Parents and Parents Together-- that provide excellent family support, yet our clinical services often don't think about including them as, again, part of our treatment paradigm.

The peer support was a product that was done by the Federal government, and in that report Davidson, Sabin, Daniels, Briscoe, Burdett, and others all researched that certified peer specialist ability to assist consumers in gaining balance in their lives and positive value, not just in outpatient settings-- but I'm going to highlight the last one-- in the emergency rooms and in crisis centers. Larry Fricks and others in 2005 were able to document that empirical research.

In crisis centers, the place that we think we need the highest level of clinical [INAUDIBLE]. Here, this provided extensive impact in a positive way on the ability to effectively deliver services. Again, more in peer support-- Shery Mead, Curtis, and Hilton look at this value of lived experience. It gave people this unique ability to build relationships. And the literature citations are here. You can look at them.

It was the ability to instantly form relationships and make possible faster engagement. And for those of you that are in other licensed disciplines, the building of clinical alliance and treatment alliance so that our treatment goals were aligned effectively between the client, the family, and the clinicians.

So a number of our folks here from New York-- Chip Felton, Peter Stanstny, David Shern, Andy Blanch, [INAUDIBLE] Donahue, Ed Knight, [INAUDIBLE] Brown-- were part of a documentation that showed in a hospital-based setting. And this is critically important for managed care. And those of you working in manged care setting, having peer staff shorted length of stay. Having peer staff shortened length of stay.

Critical managed care indicator, we looked at length of stay in a variety of settings. Peer staff directly impacted them and reduced the overall need for other mental health services over time. Chinman, Klein, Cnaan, Whitecraft, and others have clearly documented that in the literature.

When you think about consumer-operated services-- and here is again part of the role for not just peers on our staff but also linking to peer services in the community-- what did we find? That peer-provided education models, including drop-in centers and New York State recovery centers, mutual support and other kinds of centers said that subjects who received these reported higher levels of personal empowerment and control than subjects that

only received traditional services.

Well, if I'm a managed care company, do I want to pay for all of the supervision and support that someone needs or do I want to empower them to take responsibility for implementing the controls and the support that they need for themselves? It's higher quality of life and cheaper that people take that responsibility themselves. And the literature says this is a proven way to do that.

And lastly, they looked at comparing several different models of peers that delivered services, whether they were stipend or not, and peer and non-peer case managers. And participants reported overall that they received better feedback, better quality of life, and better empathy and support from peer case managers than non-peer case managers. That the effect at 6 months of being in case management with someone and at 12 months the effects were significantly better for peer-delivered case management services than non-peer-delivered case management services.

So here's a study that I love to [INAUDIBLE] or highlight, which is Dr. Ben Druss. So Ben is at the Carter Center. And often when we talk about managed care, and if you want to make the one sort of caveat pitch if you're a service provider and a managed care partner to be able to say you can effectively reduce overall medical staff-- there are two points to this-- is that Ben identified two things.

So I'm going to talk about the study that's not cited here and then related it back to this study. Ben has identified that traditionally people will mental health issues are underserved in community health treatment settings, overserved in emergency rooms, and underdiagnosed for a variety of other health conditions, most notably heart disease. And that there is a standard of care people should get for heart disease.

Aspirin therapy is setting the Gold Standard. Doesn't cost much. Virtually everybody that has coronary heart disease would benefit from aspirin therapy. Pretty simple thing. What Ben found is that people with mental health diagnosis and substance use did not receive the standard of care that everyone should be receiving. They didn't receive it, which suggests that there may be a bias in health care delivery systems against people who have mental health issues.

What Ben found is that of wellness coaches and using participants to deliver the recovery supports in a global setting, not just for mental health, but toward the global health conditions people experience, had positive effect both on engagement and health outcomes and reduced overall medical spending.

Now, I'm going to divert from the slide for a little bit and give you one other hint of something that will dramatically reduce overall expenditure costs. And this is an area where peers can directly help [INAUDIBLE]. Does anybody happen to know what the number one means of reducing the health care expenditures is that managed care

could use? We're in a managed care environment here in New York. What's the means that managed care uses to reduce medical staff? Anybody hear things like-- yeah.

[INAUDIBLE] prevention?

Prevention certainly-- certainly does. There is someone literature talks about prevention.

[INAUDIBLE]

[INAUDIBLE] Well, that may, but usually that just changes when the costs are paid for, whether they're inpatient or outpatient. Yes, sir.

Health, wellness, fitness.

Health, wellness, fitness. Sure.

Cut down on emergency room visits.

Cut down on emergency room visits. Well, that's what you're going to try to do if you're a managed care company. But there's actually a study-- it's called the mathematical study that we replicated here in New York from-- I had to help an economist at Cornell replicate the study portion. Turns out the number-one strategy that anyone can use to reduce overall health care expenditures for people with chronic mental illness? Help them get a job.

Employment reduces overall health expenditures by as much as 47%. That is more than all other managed care strategies combined. It's more than utilization management. It's more than psychotherapy. That's more than targeted interventions around emergency room reduction. 40+%. And for people of color, the effect size is even bigger, to reduce medical spending even more. A really powerful tool that peers involve and engage in that.

So let's shift gears here a little bit before we take a break. And can we hire a client? So we're in a clinic. We're in a hospital. We're in a treatment setting. Can we hire somebody that uses our services? [INAUDIBLE]

As long as they live in a different area [INAUDIBLE]

So you're saying, well, as long as they work in a different area. What do other people think?

In some places, [INAUDIBLE]

So in some places, you're saying [INAUDIBLE] The answer is no. Can we hire a peer?

If they receive services [INAUDIBLE] in the same facility, then no.

They received in the same facility, no.

Not state run.

Not state run. What do you all think? Yes, sir.

[INAUDIBLE]

So the question is, [INAUDIBLE] hire some patients? [INAUDIBLE] We hired a whole bunch of them. But if you were a clinic operator, could you hire someone that used your clinic services?

[INAUDIBLE]

How many people think yes, you could hire someone that receives services at your clinic? So how many people think, no, that you shouldn't hire someone who received services?

You need [INAUDIBLE]

A good point, yes.

[INAUDIBLE]

All right. So the audience here is split about 50/50. Let me take it out of mental health and give you a different example in a different area. In rural communities, most of New York State-- for those of you from other states online may not realize this, but most of New York State, outside of New York City, is very rural. And depending where you go-- in Delaware County, in Herkimer County, in Hamilton County-- Hamilton County has no hospitals in the entire county. They have no clinics in the entire county. There are no doctors that live in Hamilton County except for in the summer. Hamilton County is right in the middle of the Adirondacks. Very large physical county but not lots of people live there. It's right in the northern middle of the state.

If I ran a rural hospital in an area where there's only one hospital, do you think my family can go to that hospital?

As a patient?

Sure.

Yes.

So why could they go in that hospital if I run the hospital?

[INAUDIBLE]

Do you think I could go to a hospital if I was having a heart attack? Do you think I should go there?

[INAUDIBLE]

Well, the audience here is laughing [INAUDIBLE] Why the hell can't our patients work where they get services? In rural communities across the United States, doctors get services where they deliver services. Nurses get services where they deliver services. Social workers get services where they deliver services. In fact, in most rural hospitals, they're what they call self-insurers. When you work at the hospital, you have to get services from the hospital. Why? Because it's cheaper for them to [INAUDIBLE] their own services.

Well, every other part of the health care delivery system says it's OK for clinicians to get services from the place that they deliver services. Why in the hell can our people not get services from the place that they deliver services at? Well, the reason they can't is we've got a whole bunch of biases about that.

So the red herring that you're going to immediately tell me is oh, dear god, what about confidentiality? They're going to be [INAUDIBLE]. But do you think a doctor that runs the hospital in Upstate New York is particularly going to be a good patient when he comes in for cardiac arrest? Doctors are notoriously not particularly good patients. Do they know other things about the other patients there? Are they going to see other patients there? Well, yeah, no kidding. But there's no other place for them to get services.

Why do we create an artificial boundary that is unique to mental health and only unique to mental health? If any other area of discipline in medicine, with the exception of substance use, which has sustained sort of a weird belief system, you get services where you deliver services, particularly if you live in a rural community.

If you live in a rural community, there's only one hospital-- only one hospital for several hundred miles. You go to that hospital or you die. So if I'm a clinician there-- I'm a nurse, I'm a doctor, I'm a physician, I'm a psychologist, I'm a pharmacist-- where am I going to go for services? I'm going to the hospital that I got my services from.

Peers are bound to the same confidentiality that anyone is. If we had certified peer specialists, they are trained and bound to the same HIPAA laws that anyone else is-- the same way a physician is. You mean to tell me physicians don't talk about their caseloads with other people? Yeah, they do. And they're all [INAUDIBLE] common conversation. What we have to be careful of is ensuring that people understand their boundaries well. And whether they're a peer staff or not a peer staff, that's not a real issue. It's that your people understand the boundaries and the limits of confidentiality.

Now, there's no prohibition in HIPAA or HITECH that says you can't get services where you deliver services. In fact, a physician who is the emergency room doctor who has a heart attack is most likely to get services from the

same emergency room that he delivers [INAUDIBLE] if he lives in a rural community. Why? Because it's the only place to go. And yet we've set an artificial boundary as if he ought to go elsewhere.

Now, I want to talk about the best practice for how to do this in a way that has been validated by lots of experience and minimizes the potential for conflicts. It's not conflict-free. You have the physician who does the emergency room show up in the emergency room [INAUDIBLE]. There are lots of conflicts. That's the reason why chief of physicians and physicians aren't particularly good patients, and he's going to try and tell the staff what they need to do.

I want to talk about HIPAA and HITECH in just a minute. The piece that I always want to talk about is role confusion. Is this a client or are they staff? Regularly being the chief of the peer workforce at the Office of Mental Health, I'm asked by our other supervising staff, whether it be a hospital director, a clinic director, or others, you know, I've got a peer staff who is not doing well. Should I ask are they taking their medication today?

Would you ask the pharmacist if they were taking their high blood pressure medicine today? Would you ask the nurse were they taking their gout medicine today? Or would you ask the RN did she take her antibiotic today? No. That is not a legitimate question.

We often confuse that we hire peer staff, that they're patients. They're not patients. They're employees. Now, they may be both patients and employees, but they're not both at the same time. That's the difference. You can't be an employee and a patient at the same minute. In the same day, you could be both.

But you need to understand what is your role and the rest of the staff need to understand what is your role at each point in the day. When I'm a staff person, your supervisor should not be asking about your mental health status. That's not something that we ask any employee unless they're acting out and not doing their job. And then we talk about them not doing their job, not their mental health status.

If we talk about their mental health status, now we've violated the law. Because the law is very clear that if you're an employee, there are certain things a supervisor does not have the right to have a discussion about. They can talk to you about your performance.

Now, this is a double-edged sword. For those of you that are peers also means you don't hide behind when you're screwing up at work, oh, you have to be reasonable accommodation because I'm mentally ill. That's [INAUDIBLE] kind of comment. And it diminishes all of us in ways that are not positive. We're all responsible to each other.

And as supervisors, there's a limit to our supervisory inquiry. I can ask you about your performance. I can ask you-- if I notice something, I can say my suggestion would be that you get some help and support to deal with X. I'm not going to say you need psychotherapy and 10 mg of antidepressant four times a day. Now I've crossed

over from being your supervisor to being your treater. If I am both, I may need someone to arbitrate and separate and be very clear what the boundaries are. When am I a patient and under what settings? And when am I a provider?

In the same way that if I show up in an emergency room that I run as the head physician, I'm now a patient. I'm not going to be looking at other patient's charts. There are limits. I need to understand what my role is. Right now, I'm a patient. Tomorrow afternoon, I'm an employee.

But to say that we can't hire people because they work in our setting or because they receive services in our setting is not consistent with the rest of health care and actually might be violating EEOC and Fair Employment Act because you're discriminating against a class of individuals by virtue of them just being in a class. Yes, ma'am.

I'm curious, based on what you're saying, when did this rule for that red herring, when did that go into effect?

Well, there is no rule. It's court hearings. The courts have ultimately said that it is illegal to discriminate against an individual on the basis of their illness. So if you're discriminating against me on the basis of that I get services with you. That, in and of itself, as I said, in all other health care settings, in all other health care settings-- let me repeat it again-- in all other health care settings that's not the case.

So we created something [INAUDIBLE] that is not supported by law. In fact, the law would suggest this may be, in fact, discriminatory. Now, there are some safeguards that you have to do. So should we just hire patients and have them be a patient and attend group while they're on payroll? No.

We need to clear on what's your role. While you're working, you're working. When you're a client, you're a client. What's the difference? Can we separate functions so that people aren't delivering services in the same area that they're receiving services in? Yes. And that might be a reasonable combination. But actually just blanketly denying people employment opportunities because they receive services may, in fact, be discriminatory, and many places have had successful suit for such things. And there is a growing body of litigation around it.

I want to talk about the last red herring, and then I'll come back and see if you have more questions. And then we'll take a quick break, because I know people are getting a little fatigued. So we'll take a quick recess.

But the last red herring here is that peer staff can't look at the charts. They can't sign progress notes. They can't write notes. What? Do we have other staff that don't write notes? Well, no. Most staff write notes in the progress charts. They write notes of what they've done. They write notes on their observations. They write notes the same way.

Peer staff, there's no prohibition on peer staff. And if you're in an [INAUDIBLE] facility, I personally have given

guidance to every HIM director that there is no prohibition. You need to open this up. You need to be available. Peer staff, if they have a legitimate need to participate as part of treatment team, which we would hope they're part of a treatment team, they should be treated like any other part of the treatment team.

This is not as we treat them differently. If we treat them differently then, in fact, we are providing disparate treatment, which is the basis for a lawsuit. When you treat people in a disparate or unequal way, that's the basis for a lawsuit. What I want you to be careful if you're thinking about employing peers or if you're already employing peers, that you don't fall into the trap of these red herrings.

Now, I hear regularly clinical staff say, well, they're not licensed clinicians. Well, OK. Do you have security treatment assistants sign in and make progress makes? You have mental treatment aids make progress notes. You have other treatment aids make progress notes. Where's their PhD? Where's their license? Where's their other credentials? This is no different, yet we have created in our minds an artificial barrier and block that say these people, peers, are not [INAUDIBLE], which automatically sets up for litigation on disparate treatment as an employee.

So I caution you around that, because there is a lot of successful litigation that has occurred around that, and how do we press these issues? Well, we're going to come back and talk more about the confidentiality piece so that you understand that it's not just a peer can be there, and they can say anything to anybody at any time? No. They're bound by the same HIPAA HITECH rules everybody else is, but there are some unique things that we have to be careful of in terms of boundaries with peers, as I said at the very beginning.

So why don't we stop here and take a 10-minute break. Those of you online, we will start promptly in 10 minutes. So if you want to take a 10-minute break, for those of you here, there's a key to the restrooms in the back. The restrooms are across the way. You will need a key to unlock them. Please don't take the key in with you, because if you leave it in there, then we can't get back out. Thanks.

[SIDE CONVERSATION]

So where are you if you've thought about where you're going to get support for yourself in that process? Because the people that you used to look at as peers aren't going to see themselves as your peers anymore in the same way that they used to, because you're taking a different role. So being aware of that and being aware of role confusion, even though you're a peer-- I was talking to somebody here on the break, and they were saying, well, in one place they're a mentor, but they don't disclose that they're a peer.

It's perfectly great to be a mentor. That's a perfectly valuable role, but you're not a peer mentor, you're a mentor if

you're not disclosing. Because you take on different leadership roles, it may be appropriate or inappropriate for you to participate in the same way that you used to participate. And if you can think about not only your experience [INAUDIBLE] for me, I was being selfish. It would have been great for me to go and get support from the people that used the drop-in center without making a decision [INAUDIBLE]. That was not the right decision for them. And I never considered that at the time.

So when you're thinking about hiring people, think about where you're going to go for ongoing support as peers, because it is something that's unique. Social workers need this. Psychiatrists need this. Psychologists need this. We all have our guilds where we don't talk to other professionals, which we value and respect to get support.

As peer specialists, peers also need this, to have a process and get feedback on various things that they're dealing with in the very short settings that they exist in. That's why in New York State we created peer accreditation process and the process to build support systems for peers and virtual online support communities.

But if you're hiring a peer in your clinical setting, have a conversation about where they're going to get help and support. And encourage them to be part of other personal and professional growth opportunities, because it is one thing to be out there telling your story, and it's another to be able to get support telling your story, because telling your story is not without consequences. And I'll share some of that a little bit later.

So supervision is one of those critical [INAUDIBLE]. Now, I told you I was going to talk about BOR-E and try not to be bor-ing. And BOR-E is a legal term called bona fide occupational requirements. And we often call that also experience. So what is someone's experience?

So can we say that we want someone with lived experience of being in the mental health system? The answer is it depends. It depends on what are the job requirements. If one of the job requirements is to role model recovery, then having someone who's lived and recovered may in fact be a bona fide occupational requirement.

But if someone is a van driver, then someone who has lived recovery is not a bona fide occupational requirement. So when you're thinking about what are the requirements for the job, what's the minimum set of skills is having life experience of being in the system and being a person who's experienced the system, something that is necessary to complete the job.

If part of the job is role modeling, then the answer may, in fact, be yes. The Equal Employment Opportunity Commission says if it is part of a bona fide occupational work requirement, then you can ask questions about it legally. And I'll give you the citation here, which is the lengthy part of this.

But I'll tell you where this actually comes from. Independent building centers, which are part of the Rehab Services Administration, there are places that are operated by people with disabilities for people with disabilities and has a

bona fide occupational requirement that the majority of staff are people with lived experience living with a disability. To role model opportunities for hope and recovery and possibilities for others.

What are the requirements of the job? Are there expectations? It's written in their job description. That's what I mean by an occupational requirement. EEOC was asked specifically about this and could you ask if somebody had a disability? And part of being a person with a disability is part of the job. The answer was yes. This is the legal citation with all the words pursuant to it. And it comes out of the EEOC Compliance Manual. Version 2 from 1988. That provision is still in effect today. This is not a new thing. It's been available all along.

So if your personnel department says that you can't ask about that, the answer is, unless it is a bona fide occupational requirement, which means you've written it as part of a job description, and it is explicit in that regard, you can give them this reference. We're going to send all of you the PowerPoint so you actually have the legal [INAUDIBLE] and citation [INAUDIBLE].

So what's an occupational requirement? Well, it's the job duty, skills, and basic work requirements that are part of the job. It should be written out as one of the qualifications to be able to even apply for this job was the experience. And oftentimes in community organizing or in advocacy, we'll say five years experience working within a typical mental health agency performing a similar kind of function blah, blah, blah, blah. If you don't all the blah blah blahs correct, then you're not able to apply.

Here, we want to specify that we're really looking for someone to role model recovery if this is a person who has experienced recovery. And what do we mean by that? Do we mean that somebody that was on SSI and can help others navigate off of SSI? If that's part of your written job description, then that's something you can ask about.

[AUDIO OUT] be really clear when you're writing the job description, what is it that we want? Do we want somebody who is sort of a generalist, who lives and recovered, in whatever way you define that word, from having a mental health condition? If so, that would [INAUDIBLE] legitimate job requirement. So it's going to be a generalist who can describe what it's like to experience a mental health condition and then work towards recovery and all that goes in it and how they engage family and clinicians as part of the process. Well, write that as part of the job description.

So let's talk about roles for peers, because this is one of those things, if we're going to define what is the job, then we need to define what it is we want them to do. So these are actually roles of peers that come from a variety of settings. And what we try to do is think about-- when I did this, this actually comes from a paper that I published-- that was 100 years ago it seems-- on what are all the roles of peers in a variety of [INAUDIBLE] traditions? We tried to identify all the places that might hire a peer.

Let me go through these and talk about some, because if your agency doesn't have some of these, you might want to think about adding some of these to some of the work requirements. So drop-in centers, recovery centers, AA meetings. And we'll talk about each of these in a little more detail.

Advanced directives, WRAP training, advocacy training, benefit advisement, career clubs, clothes closets, community meals and kitchens, computers, internet access, crisis support, warm lines, food pantries, forensic, jail diversion may be critically important. Housing, literacy training, education. Parenting is something that [AUDIO OUT] money management, social recreations, support groups, psycho-education, volunteer referral, recovery coaching. And then a bunch of additional roles.

So some of these are not intuitive, and we'll come back to these. Environmental review. What do I mean by environmental review? So all of you had to come through the hospital to get here. How many of you can tell me how many bulletin boards you passed on the way to this room?

[INAUDIBLE] Why? Because you're used to being in a center and seeing lots and lots of bulletin boards. Yet think about if I'm a consumer or family member, what do all these signs and roles and regulations say about how warm and welcoming and supportive this environment is? And what does that say for family members about how warm and welcoming and supportive and caring you are about my loved one as opposed to role-based [INAUDIBLE]?

So I'm not saying that signs and posters aren't useful. But it is important sometimes to have a fresh independent set of eyes who's not [INAUDIBLE] with the environment take a look at them again and say what does the environment say about us? Because the environment says something about us. Now, I won't happen to tell you [INAUDIBLE] actually a pretty good one in my experience. There are only seven bulletin boards that I passed from the entrance to here. And why do I know there were seven? Because I pay attention to--

[INTERPOSING VOICES]

Why? Because that's important as part of my

[INTERPOSING VOICES]

So when we think about our environment or the environment of care in clinical settings, we often call that the milieu. What does the milieu say about recovery and hope? What does it say about possibility for people? Is this a role-based milieu or a milieu that's offering hope, guidance, recovery, and support? Is it a schedule-based milieu or is it one that's promoting opportunities and change for people?

Well, any of that is said by how the environment is laid out and yet we see the environment every day. And one of

the roles [INAUDIBLE] of peers can be inviting others in to look at and evaluate the environment of care for us. That's something that, if you're a hospital, JCAHO regularly does as part of our visits.

Translator, PSYCKES, family support, recovery guide, community integrator, restraint, seclusion, peer bridger, HCBS services. We'll be talking about each of these in a little bit more detail. So for HCBS services, this is something, if you're in New York, [INAUDIBLE] community-based [INAUDIBLE]

[INTERPOSING VOICES]

Has that thing stopped? OK. I thought the announcements aren't just in my head today for a change. That's interesting that you all are experiencing it. So when we think of HCBS services, we may want to hire peers specifically to help deliver some of our community-based waiver services. In New York, these are specific services that are identified with Medicaid waiver, and peers can directly deliver either independently or under supervision with others. Here's an example of the kinds of services that are available.

Now, there are several conditions that we just want to make sure that people are aware of-- pre-crisis and crisis support services. Great opportunity. Remember the citations that I gave you earlier of the value of having peers in emergency rooms and crisis, shortening length of stay and increasing the effectiveness of hospital care? Here's a great opportunity for us to think about including peer support for persons [INAUDIBLE] community support before or after a crisis or relapse. Great opportunity to build that in if you follow [INAUDIBLE] of your program design. Something to think about.

I want to highlight the last thing on here, developing crisis diversion plans. One of the valuable tools that we have that many people cite-- our very own [INAUDIBLE] WRAP, Wellness Recovery Action Plan. That's a tool that can be fully implemented and integrated in the clinical treatment setting to provide supports for an individual and used to help de-escalate and avert, if you're an inpatient setting, seclusion and restraint.

Drop-in centers. Well, if you're offering them traditional mental health programs, having a place where peers can go to drop in that's less stressful begin to engage difficult-to-engage people may be something, in fact, that you want to focus on. And you may want to think about how we might use a drop-in center as part of our overall engagement and outreach strategy.

Adding low demand and low requirement does not mean no demand or no requirements. It's a great place to begin engaging people when using others with lived peer experience. And certainly hours may vary, and you may use other donated spaces. We often think when we're providing these that we've got to provide all the space and it's got to all be decked out.

Well, many of the places that drop-in centers [INAUDIBLE] church basements and other kinds of community-based settings. Community-based settings add value for this type of service, because it becomes part of an integrated model that you can then more easily engage other partners in the community [INAUDIBLE].

Running AA, NA, DTR meetings. If you're not familiar with double trouble and recovery, that it's a peer-operated service, that what started here in New York has been expanded nation and worldwide. Similar to AA but not with the focus on strict concern about any substance in you.

Now people with mental health conditions often are prescribed psychotropic medications, and some of the more striking AA models don't support medication of any kind. So thinking about how you might want a hybrid kind of organization. Well, then your structure may, in fact, add value to it and may actually provide support for others in the community that are struggling to find a 12-step support group that supports people using appropriate medication to address and minimize symptoms.

Advance directives and WRAP plans. One of the requirements for every medical American decision in [INAUDIBLE] system today is does a client have an advanced directive? And are we offering support for them to help develop an advanced directive when they're in a safe or stable place? WRAP plans can be equally part of an advance directive strategy.

If you're not familiar with the WRAP plan, these are a great opportunity to take a concept of thinking about who helps me when I'm doing well? Who do I want around me when I'm not doing well? Who can provide support to me when I'm in a crisis? Who's the worst person to have next to me when I'm in a crisis? Who don't you want to talk to when things are going bad? Who do you want to talk to?

Sorting all of that out can be part of both an advance directive as well as a de-escalation strategy or restraint, seclusion reduction strategy if you're in an inpatient setting. This can be very beneficial to decreasing your incidence of restraints [INAUDIBLE] the inpatient. [INAUDIBLE] how to help people develop a change of locus of care.

So let me describe what I mean. If I'm in the hospital or treatment setting, and many even outpatient clinics do this as well, what's the locus of care? Meaning who's responsible for my care and well being? If it's inpatient setting, it isn't me. It's them, the people around me. So what happens if I get angry? It's their fault that they haven't de-escalated me. Well, what happens if I need to express my frustration? Well, it's their fault when I'm frustrated. Why? Because the locus of control is not in me, it's in them.

One of the things that WRAP plan can do is change the locus of control from external to internal so that I become responsible for me with supports. And the treatment team is clearly part of the support system that I may take

advantage of. But if all of the locus of control is external to me, then don't be surprised when patients act out.

Don't be surprised when they blame you for their acting out. Why? Because you're the person in control. You've not given any control back to them. It's your call if then you've gone wrong. Why? Because you're the one in control.

When I'm in control, and it's clear to me that the expectation is, that I'm able to [INAUDIBLE] myself, then I have a responsibility when I start over-reacting and start acting in inappropriate ways. When I'm not responsible for my actions, and you're going to take responsibility for all of my actions, then don't be surprised if I become combative, assaultive, and confrontive when I begin a variety of clinical studies. Why? Because you're the control [INAUDIBLE]. Focusing the locus of control internally is critical as part of the change process. We can exert change from an external locus of control, but we will not sustain change from an external locus of control. People have to internalize it in order to create change. [INAUDIBLE]

I just want to put a plug in that now people can upload the [INAUDIBLE] WRAP plans to PSYCKES [INAUDIBLE].

So in New York State, we've created something called PSYCKES, which is a medication and treatment sort of monitoring protocol. And for the first time, peers using MyPSYCKES can actually upload their advance directives or WRAP plans to that to be shared with people that they chose to share that with. Something other states, those of you online might consider, those of you in other treatment centers might consider as well.

Advocacy training. Now, why is advocacy training supported by running a clinical program? Well, part of surviving in life is being able to advocate for yourself. I want to live [INAUDIBLE] place. The landlord tells me no. Or I need something repaired, and the landlord says they're not going to do it. Being able to advocate for myself is critical to my survival unless you're always going to be there to advocate for me. And guess what that means? That you're the person always advocating for me. There needs to be more of you because [INAUDIBLE] advocate [INAUDIBLE].

So all of you that are feeling overworked and underpaid, think about how you shift that locus of control from you back to the individual client. Here's where peers and peer specialists and peers can help in that process. So it's not you doing for someone, it's you supporting them to do it for themselves. If there are problems with the landlord, you don't call the landlord and negotiate. You support them in making the phone call and working through the process. [INAUDIBLE]

I just wanted to add in the peer, we do our jobs well, we makes ourselves obsolete, and I think that should be the goal.

So the person saying that if they do their job well as a peer, they make themselves obsolete. That's really the goal

of all clinicians in our system, is often to make ourselves obsolete so that the person is in complete recovery and ultimately back in complete control.

But yet this is one of those areas that we don't think of providing training and support for. So if I always stay in a system of care that's providing for me, and I live in a hospital-- so Office Mental Health [INAUDIBLE], I've lived in the hospital for 20 years, now you're going to discharge me and tell me I've got to fix dinner? Well, you always delivered my dinner to me on a tray before. [INAUDIBLE] What do you mean I've got to make my dinner? Them's fightin' words. And you've already [INAUDIBLE] a fight. Well, duh. Doesn't have to be.

So how do we start having peers and peer staff work with people to provide them individual advocacy skills so that they know how to advocate for themselves and not get people to do things for them? So I'm still not going to cook you dinner, unless you happen to come to my house for a party. Then maybe I'll fix you something [INAUDIBLE]. I am known for throwing a decent party sometimes.

But it's how we help people navigate what's going on in the rest of their lives, not by doing it for them, but helping them learn to do it themselves. And that's actually how we get more hours to do more work. There's a little trick that at some point you get older and wiser and you start learning, that it is real easy and faster to do things for people than to do things with people.

I only have one thing to do for you. It's faster for me to just do it. Then I don't have to explain it. Ba da ba da da da, it's done. OK. Thanks. Except now the next time I need that done, John, you know, I'm in trouble, and I need your help, because I need this done. Ba da ba da da da, It's done. The next time, John, you know that thing that you helped with twice before? Well, I kind of need some help with that again, and ba da ba da da da, now it's done. [INAUDIBLE] all the ba da ba da da da's, pretty soon you've got a significant investment in time.

So instead of doing it all yourself, you end up with more time [INAUDIBLE] coaching and assisting the person to do it themselves. You teach the person to fish. You don't give them the food. And so part of advocacy and advocacy training is exactly that. It's teaching a person to fish, metaphorically, as opposed to giving them the food. And so if you don't have an advocacy program set up, that may be something that you want to consider having your peers do.

Benefits advisement. This is something that every clinician and provider simply know how to do. [INAUDIBLE] a little test for you to test to see if, in my opinion, you really know how to do this. I don't want any of you to answer here, because I don't want to put people on the spot.

The first question is, how long should it take you to get an SSI check from the date of applying to the date of getting the check? And if you tell me that it takes years or you tell me that it takes more than 90 days, the answer

is wrong. It takes years because you don't know, when kids today say WTF, that you're doing.

Because if you know what you're doing, it's not filling out the form that's going to make you eligible. In fact, if all you do is fill out the form, that's why it's taken you years to get approval. And hiring lawyers will take longer, because the lawyers get paid from how long it takes and how much back payment there is. Lawyers aren't fast. And they'll take part of the money that you get.

So understanding how to do this and having people trained to know how to this can help clients through the process. It's critically important. Does anybody know how much money you can make and still keep benefits in New York State? The answer is more than $85,000, if I'm looking at the Medicaid buy-in program. But if you don't know that I can make $85,000 and still keep Medicaid, then you're going to give the wrong answer.

And so having folks trained who are knowledgeable about benefits, the critical services you can provide. Why? Because I'm willing to bet if you're a clinic or a social worker or an outreach coordinator or providing support services, that you're doing lots of paperwork every month to support people and [INAUDIBLE], which is a New York State sort of function.

If you're another state, the [INAUDIBLE] would be a medical buy-in or a buy-in for medical necessity. Where if you did the Medicaid buy-in for working people with disabilities, you do the paperwork once a year, and it's the same kind of paperwork. And then you don't have to do paperwork every months. And it costs the client zero, zilch, nada, nothing if you happen to get Medicaid.

And so if you don't have people who are experts on this, having peer staff go for training is incredibly powerful. It's more powerful having peer staff get the training, the people who've lived there and been through the experience themselves and learn the tricks and tips.

Now, if you don't know how to do this, my office offers several times a year a tips and tricks workshop, which is a day and a half. You can come to that and get some preliminary training. If you want more extensive training, you can talk to the University of West Virginia or University of Virginia and Cornell University, who all offer what's called [INAUDIBLE] training, which is extensive week-long class on benefits advisement that's done online.

So March 23 and 24 is the next one. We'll be doing the [INAUDIBLE].

So March 23 and 24 is the next [INAUDIBLE] tips and tricks training on benefits.

10 hours.

And it's 10 hours of [INAUDIBLE] credit if you're a social worker. And CRC credits are also given away.

[INAUDIBLE]

The benefits advisement is one of these things that is a very powerful tool and powerful to engage clients. When we talk about building clinical alliance, one little thing that clients have is clients don't come to us because they necessarily want clinical services. A client comes, that's usually because has made them come to get clinical services.

What clients want is to have money in their pocket to be able to go out and do things. If you have staff that can help them do that, you won't have problems with clients coming for treatment. Clients tell you they won't come because of travel and transportation. Travel and transportation is a red herring, and I say it's a red herring because-- coming up I'll give you an example. We're going to talk more about that a little bit later.

But if I was all of you in this room or all of you online anywhere, and I was to take your wallet, your keys, your cell phone, or your [INAUDIBLE] and say that I would give you $1 million if you could get to Washington, DC by tomorrow afternoon-- so for those of you living in Washington, DC, [INAUDIBLE]. Would you be able to figure out a way to get there? Well, of course you would, because you're highly motivated to do so.

When clients say they're not coming, they're not motivated to come. Quite frankly, they don't care two hoots about what you're offering. If they did, they would be there. So thinking about all the things that the clients find valuable, but benefits advisement is a way to get clients to come for services and to build greater clinical alliance, because we might be the best clinician in the world, but if the client isn't with us and we're not able to engage them, then all of your clinical skills are for naught. And so being able to get the client in our presence, work with them, means in part providing the things that they find valuable, not necessarily their own [INAUDIBLE].

For career clubs, then the point is something that's not, again, necessarily intuitive, but I'll tell you the story of somebody who just came to my drop-in center-- I'll call her Debbie-- [INAUDIBLE] could type 100 words a minute on an IBM Selectric typewriter. And those of you that have never seen a typewriter, well, the IBM Selectric, you had a little a ball in the middle that used to spin around really fast. She could type 100 words a minute on such a thing at virtual 100% accuracy, which is an incredible skill to have.

Could we get somebody hired doing that back in the days when we used lots of typewriters? The answer was yes. We could get Debbie lots of jobs. Debbie regularly quit the jobs. Why? Because she said there are a bunch of women there who talk about their husbands, their kids, their grandkids, the vacations they've had. I've been hospitalized for the last 15 years. I don't have any of that stuff. I don't know how to talk to them. I don't have a [INAUDIBLE]. I don't have anything in common with these women. Yet they're all part of the pool that's doing this work. And I don't know how to deal with it.

And even more important, Debbie would come home form work, and the first thing her parents would say, how's the work? Did you take your meds? Was everything OK? Were there any concerns today? Did you get out of control? Is everything all right? Are you sure everything's OK? Did you need help with anything? Everything's all right? [INAUDIBLE] I hope you're [INAUDIBLE]. You're putting all this [INAUDIBLE].

Debbie said it very clearly. I know how to be crazy. Right now you're not telling me to be crazy. They don't know how to tell me to be successful. She needed a place to go to be able to talk about, not the job, not the work-- she could do the work-- but she needed a place to go talk about how to change the voice inside her head and her family's voice that was outside her head about how to have other people see her success. And we don't provide those choices typically for our clients. So job clubs might be the perfect opportunity.

So think about providing a place, not to talk about the job, but to talk about how you fit in. How do you disclose, if you disclose? Having talked to people with your experience with living in a hospital, well, Debbie, where'd you go on vacation for the last couple years? Oh, I uh, um um-- well, Ward C we had a [INAUDIBLE] woman. Not something that's comfortable if you don't have other people to talk to about how you're going to do that. So something to think about in terms of an opportunity you're offering.

Clothes clubs. Now, this is something, if your clinic or organization doesn't take advantage and partner with the various state communities [INAUDIBLE]. But many of our clients are living below poverty and don't necessarily have all the clothes that they need or would benefit from and particularly at change of season.

Upstate New York, it gets really cold. We've had a pretty mild winter this winter, but now we happened to have a little bit of snow. Even down here on Long Island, you've all had some. How do we help clients have what they need to survive? Being able to connect them to places where they can get those needed benefits to be able to survive can be critically important.

Community meals and kitchens. Now, this is not intuitive, because I'm really not talking about just feeding people, although feeding people is a good thing. If you've ever tried to live on the [INAUDIBLE] benefit rate, by the time you pay your rent, you might have $50 left after you've paid your rent, your utilities and everything else you have to pay and to buy food for a month. $10-- a little more than $10 a week-- $12 a week. How do you buy food with that?

I venture to guess, most of you, unless you've lived on that level before, probably couldn't figure out how to do that without living on ramen every night. And that's not necessarily how we intend to live on. I know those of you in college did it for years. I've got it. I was there too. But it's not necessarily where we want people to be.

One of the things that we often talk about in clinical services is how do we get people to engage? And we often

say that we teach. We teach coping skills. We teach psychosocial skills. We teach interpersonal skills. But the question that I'm going to ask you is the question that I have our licensing folks asking all the time. When you [INAUDIBLE] ask people to practice those skills. You teach them when you [INAUDIBLE].

How many of you have asked your clients to host a progressive dinner? Think about what a great way to build a natural support system for folks, to build interpersonal skills, to practice them, to be able to do this in a way that doesn't have them have to pay to go out to dinner, which they can't afford to do. But everybody can afford to make a dish that they can share with others and then invite others to their house and practice the socialization that, in theory, in our clinical settings we're teaching people.

But are we actually asking people to practice those critical skills? And then are we asking them to give us feedback about how did it go? Get strategic. How could you do it better the next time, instead of talking about things that aren't real world and if they can translate that into the real world?

Let's make this real. Let's think about how we could promote what comes up at community meals and kitchens, not necessarily within the program, but again it's a way the peer staff might actually help a group of clients organize a progressive dinner. So who's going to plan the dessert? Who's going to plan the appetizers? Who's going to plan the entree?

How do we do this? So who's going to host it this week? And we vary that so everyone starts developing this natural skill of socialization and building a social support system made up of peers, not paid support staff.

Computers and internet access. I hear today regularly how staff tell me that, you know, our clients are too sick to use computers. Yet, they want you to get a job. You can't get a job at Wal-mart unless you can sign in and out on the computer. You can't be the greeter at Wal-mart-- simple as being a greeter at Wal-mart-- [INAUDIBLE] job. But you can't do that if you can't use a computer.

And yet when do we make advantage of computers available for people, and all of your programs that are doing in support of employment, how the hell are you conducting a job search without a frigging computer today? Jobs aren't advertised in the paper where you go and hand in an application. It doesn't work. We're all online. And if we're not helping clients develop this skill of making systems available to them, then we do a disservice for everybody.

Now, if you think about this in a clinical setting, you want to engage people? Years ago-- and I will admit this program was probably ahead of its time-- we [INAUDIBLE] the program out called [INAUDIBLE], and it was working with homeless individuals. We got computers in the waiting room for the client. Why? Because then the homeless people could communicate with their families, who they often lost touch with if they had email.

Many of them, surprisingly, have email. But they didn't have a place to go and use them. So the clients started coming in regularly before their clinical appointments to use the computers. Guess what the no-show rate dropped to? They had over a 50% no-show rate before they started. Guess where it was after we implemented the computers? 4%.

We offered a service and people loved it because [INAUDIBLE]. So you might think about that as, again, part of your approach-- develop engagement and ongoing support. Is it a billable service? Well, not exactly. But if you think of it as is it supporting our clients developing less reliance on us, then the answer may be yes. All right.

Crisis support, warms lines. [INAUDIBLE] and licensing is that if you're a clinic provider and I call your program at 7:00 on a Friday evening, telephone system is saying, you've called ABC Clinic Services. If this is a psychiatric emergency, please dial 9-1-1 or go to the nearest emergency room. That's not a crisis alert system, folks.

At least in New York State, you're required to have a crisis response system. And so thinking about when do people need crisis? It's not Monday through Friday 9 to 5. It's when people who are around and lonely on Saturday night at around 2:00 in the morning when the voices start getting to them, and there's nobody to talk to. Having a human being to talk to can reduce them going to the emergency room because they're out of control.

So part of your goal with managed care is to reduce over-reliance on the [INAUDIBLE]. Thinking about how you might implement a warm line system doesn't mean a lot of high-touch, high-tech. It's simply somebody for folks to talk to when they're lonely and they're focused on their illness rather than focused on the quality of how their life could be. Again, a good use of peer services.

Food pantry and nutritional services. We're going to talk about the benefits of this, but many people don't know it. Most communities, if you volunteer your time, even a few hours a month, you can sign up for food baskets, which include fresh fruits and vegetables and often fresh meats at a discounted price. Why aren't we helping all of our clients do this? This is good for our clients. It builds social skills. They build a resume by volunteering, and they get food and produce that's beneficial to them in a way that it could be really helpful. [INAUDIBLE]

Forensic/jail diversion. Well, I don't know where many of you around the country [INAUDIBLE] but half of our clients have had contact with the forensic system. And if you've been a mental health concern any length of time, you've probably been picked up at one time or the other by the police to take you [INAUDIBLE] for evaluation.

Those experiences are often traumatic, and the experiences of living with a forensic background often complicates everything from getting housing to thinking about job opportunities. Yet there are many programs and supports available to help people specifically with that. So how we might think about that differently and offer specific support.

Well, this is one that I was talking about earlier. Is having a criminal conviction a bar to employment? We'll talk about that more in just a minute. The answer is no. And in New York State where we do criminal background checks, is having a criminal conviction a bar to employment? The answer is no. For peer staff, the answer is no. For everybody else, the answer is, yep, probably is.

But if we're hiring somebody, would being a convicted murderer be a bar for employment? What did you all think about? What's the answer? Being a convicted murderer. I know you're struggling about trying to say, well, [INAUDIBLE] would probably say no but why?

[INAUDIBLE] a peer? [INAUDIBLE]

Well, no. Could that be a bona fide occupational requirement? Being a convicted murderer?

Yeah.

It could be.

How?

Because you're looking for that [INAUDIBLE] background.

So why would I be looking for that specific background?

[INAUDIBLE] for the client to [INAUDIBLE].

Right. So we know somebody with the same background. If I'm working with other people who have serious felony convictions, including murder, do you think somebody who has committed petty larceny is going to have credibility within that group?

No.

Who's going to have credibility? Somebody that's been there where they are, who's been convicted of the same kinds of things. Having someone with that background who has now recovered and received peer training and education support may, in fact, be a bona fide occupational requirement and add value to the clinical intervention that we're going to provide. Why? Because they will be believed and heard by the group that we're targeting the intervention in ways that other people won't. So we've got to comment online.

Someone says they work with a peer who was a convicted murderer and was the most effective peer that the person had ever met.

Absolutely. And in fact, we've got a number of peers who work globally for me in a variety of settings who actually have that background. And in New York State, we'll talk more about how to deal with background histories of people, including that, because you do have a background check.

So what if the background check comes back and says this? How do you address that? Well, you can address it legitimately. We've dealt with the Justice Center and provided extensive training for them where they will recognize this as a legitimate occupational requirement.

Housing is something that you all are very familiar with. You need people who provide housing supports. A lot of the problems with housing are people have problems with their neighbors, with their roommates, with others. This is where peers can provide normalized interaction.

If you live with others, whether they're your spouse and your kids or whether they're a paying roommate, you have issues with your spouse sometimes? Well, the answer is yes. Living with anyone is stressful. You've got to learn how to negotiate who's going to do what and how it's going to happen. And helping peers normalize that as a normal human function and intervention then is going to be critically important if you ever [INAUDIBLE].

Literacy training and education, something we might consider. Parenting is important. I talked about this earlier. In a study that I did a number of years ago, more than half of the women of childbearing years in the [INAUDIBLE] system were parents. And less than half of them had custody of their kids. And yet we provide no intervention for them at all. Why?

So if you're providing clinical services, and you want to make them relevant, maybe thinking about what's the role of this illness within the family and how we think about it as the family providing the [INAUDIBLE] support and services. In fact, if I look across the board, what we billed and paid for services, we do virtually zero collateral counseling and zero family counseling, physically speaking.

And yet if I hear clinicians saying we're overworked and underpaid or I hear [INAUDIBLE] say we don't have enough supportive services or we're paying for too many high-end supportive services, what better way to lower the cost of [INAUDIBLE] through the [INAUDIBLE] of helping support the family to normalize and stabilize and provide the counseling and supportive support, I often [INAUDIBLE] collateral therapy as part of a clinical intervention, sending the client [INAUDIBLE].

Rep payee services. Well, this is one that, although I don't suggest most programs get involved with it, it is a necessary evil for many of our clients, particularly if they have a chemical substance use history. And you may need somebody to help coordinate this service. If you're having trouble finding rep payees, in my experience, there's a universal service that almost always will say yes, and you don't necessarily have to be a member of the

religion. They're just Catholic nuns.

Nuns are often called Sisters of the poor. They provide and minister services for poor and indigent people. Many of them, in fact, will provide rep payee services free of charge for individuals who are disabled. In fact, if you're having trouble finding a rep payee, talk to the Mother Superior at a local convent. It may, in fact, buy you some support services and actually [INAUDIBLE] to receive free support and services. [INAUDIBLE] have to be a member of the Catholic faith, you just have to be somebody who is willing to retain the services.

Just social services are also [INAUDIBLE] in many other religious congregations, but they usually will charge a nominal fee. The nuns, for whatever reason, don't. So if you can find the nuns. Nuns are becoming much more scarce. And those of you that grew in Catholic schools, I apologize for the experience. I understand if you're familiar with the *Blue Brothers Penguin,* it's here. Got it. I understand-- well, it's a valuable service if you can think of offering and having somebody to help coordinate it. Social/rec activity. Yes. Question.

How about if the client is undocumented?

If the client's undocumented, you're not going to get Social Security, which means you're not going to need a rep payee. So having somebody work with them to either get documentation and get other kinds of support. And there are many faith-based organizations that provide support for undocumented individuals. And I suspect that's going to become increasingly important, given our current national discussions.

Social/recreation activities. [INAUDIBLE]

How do you get past the roadblocks of agency's liability insurance refusing to allow persons with criminal records to be hired?

And so I want to talk about that this afternoon. So the question is how do you get past an agency's roadblocks and insurance issues for hiring someone with a criminal record? So I'm going to talk about that when we're talking about people with histories. And I will talk about that, because you also have to get through the clearance process for an agency to give you clearance. So I'll answer that question and provide a lot in-depth in just a bit.

So social/rec support groups. We talk about, and there are a whole host of other support groups that you might bring in to your setting, if you don't already have these, or you might begin to have peers kind of document the EAs, the NAs, the AAs of the [INAUDIBLE] groups, the LGBT groups, the Hearing Voices, Recovery-Inc.

All of these are valuable support models, but somebody needs to know where they are, how to integrate with them. Again, that's where you might have your peer staff be the coordinator of those kinds of activities. A wellness recovery education and management.

Volunteer referral. So I want you to think about who needs more help and services? Somebody that sits in their home all day with nothing to do or somebody that has an active life and is busy doing lots of things? Who needs more professional help and services?

The person that sits in the house.

The person that sits in the house. Why? Because they're bored. The old euphemism is idle hands are the devil's workshop. If you're idle all day and let your mind focus on the worst of what's going on in your life, and that's where you woke up. If you're busy all day, you don't have time to focus on that, ergo the quality of your life is better.

So thinking about helping people get out in the community, even if they're not willing to think about paid job, regardless of your type of clinical setting, thinking about having someone coordinate volunteer activities may, in fact, help reduce your overall medical spending.

Who goes to the hospital more? People that sit at home, do nothing but focus on their illnesses. Who goes to the hospital least? This is documented in the literature-- people that are actively employed or actively and gainfully engaged in meaningful daytime activities. Notice as I said meaningful daytime activities that is not mental health programming.

Recovery coaching. Something that can be very valuable. And some additional roles, we've talked about some of these others already. So I'm going to end before we take a lunch break here. You know, sometimes I pretend to be normal. But it gets pretty boring, so I just go back to being me.

I want to use this slide to drive home a point. If you're hiring a peer, don't expect them to be normal. Now, that doesn't mean that they get to be wild and insane and bounce off the walls and you have to peel them off the ceiling. But you hire them because they're a peer. Expect them to be a peer. Don't expect them to necessarily conform to all the other rules. Because if you ask me to conform to all the other things, can I do that? Yes, but then you don't have a peer anymore.

You hired the person as a peer, make sure that you're supporting them as a peer. And that's kind of where we're going to go this afternoon. So I want to kind of prep you for what we're going to talk about this afternoon. So I'm going to answer the question about hiring and how to get through the selection process, how do you get through whether somebody's got education experience and those types of things?

How do you deal with criminal histories? How do you deal with someone who's over in debt, who is maxed out on student loans and other things? There are a variety of supports that you can offer to help free up some of this

[INAUDIBLE] to make your ability to provide support [INAUDIBLE]. We're going to talk about how to supervise and how to deal with the red herrings that we talked about this morning.

So why don't I give some lunch break instructions and then we'll break. So I think those of you that are here and, in fact, those of you at other settings online, we could be done earlier this afternoon rather than later. I would like to shoot to have you all out, because I know it's late in the week, and people always appreciate being able to get out a little bit early. Let me finish around 3:00. To do so, is an hour and 15 minutes enough for lunch?

[INTERPOSING VOICES]

The room said yes, which means those of you online at the remote facilities, the answer for you whether you agree or not is yes. So an hour and 15 minutes it is. So we'll take a break for lunch. We'll come back at 1:00. We'll get started promptly at 1:00, and we'll try to get you out of here no later than 3:00 or a little bit after, depending on how [INAUDIBLE] we are. So thank you. Have a great lunch, and we'll see you back right after lunch.

[SIDE CONVERSATION]

OK. So welcome back one and all. If you're at the remote sites, we're going to go ahead and get started. And then some people may not be back exactly yet, but I want to be consistent with our time, and we'll try and get folks out of here at a reasonable time.

This afternoon is going to pick up a little bit in pace, because I wanted us to all have a fundamental understanding of where we are before we get started, and then as we talk about solutions and kind of where we're going.

So let's jump right in and talk about-- we talked a bit about the bona fide occupations requirements. And this is just going to stress these [INAUDIBLE]. You know, sometimes pretending to be normal gets pretty boring. So I go back to being me. I don't mean to say that we should be hiring people or the people that we hire are less than.

What I mean and I really want to stress, and we're going to talk about it before, you hire people because of their uniqueness and their role as a peer and have experienced the psychiatric distress and all of that. If you take that world view out of them, then they're really not a peer anymore. So think about preserving that uniqueness. And we'll talk more about exactly what I mean by that.

So knowledge, skills and ability is what is part of the bona fide occupational requirement. So when you think about what knowledge, what skills, or what abilities do we want in a person for a particular job, that's the beginning plate by which we're going to write the job description, we're going to write the job announcement, and we're going to write the job requirements.

So if we think about knowledge, there are a couple places that we can go. And if you're not already familiar with them, we set up the Academy and Peer Services, which is an online training program. Many of you at the remote sites or elsewhere around the country, this is a free-of-charge online training that's available for any peer, regardless of the state that you live in, that will lead-- at least in New York-- to being able to sit for and take the Certified Peer Specialist credential and being able to get provisionally credentialed. And then once you've completed your 2,000 hours of service, you get formally credentialed.

Here are the web links, both to our Academy of Peer Services, our peer certification process. And lastly, [INAUDIBLE] is a link to the Governor's Employment First Commission. The Governor and the State of New York had established a requirement, if you will, that we as the State of New York set a leading example by increasing the employment rate of people with disabilities by 5%.

We actually [INAUDIBLE] and [INAUDIBLE] all of the contractors that work for the State, that you will participate and assist us in looking to hire qualified competent applicants with disabilities, by hiring at least one over the next year as you have openings and relevant opportunities. So you may want to take a look at that.

Let's talk about the challenges of hiring, because I often hear from people, won't some of them be qualified applicants? Or we don't know where to find qualified applicants. Or we don't know anybody that would meet our qualifications. So let's talk about this a little bit. If you're not able to find qualified applicants, then you're probably looking in the wrong places.

So if you're looking to hire peers, how can you tell me you don't know any peers when at your clinic you serve hundreds, if not thousands of the people, who might otherwise meet eligibility requirements? That's like you can't find an apple on the apple tree. Well, if you're looking on the orange tree, you'll never find an apple. You might want to look at the apple tree.

If you're telling me you can't find peers, but you operate a clinic, have you looked what's inside your clinic for people who have the potential for skills or competencies that you may be looking for, that with the right support, might make a really good person?

Part of the challenge of hiring is that many people who have lived experience may not necessarily interview well. So some of it is they not only lack clout but don't necessarily have the right political skills. And so when I even talk about interviewing, if you're hiring someone who's never had a professional position before, and I know what we just did in the hospital-- I just went through it-- we actually had lunch up at the peer-run cafe up here and asked several people how they were doing. I got the clinical report of the day. Why? Because that's what we condition peers to do.

You're in a hospital or clinic setting, I ask how you're doing, you give us all your clinical report. Well, you know, is spite of [INAUDIBLE] badge, I'm really not the psychiatrist on call today. And I'm not really asking that. I'm just saying, how's you day? How are you doing? You know, what's going on? Que pasa. What's happening?

And yet people are conditioned, as a result of being in the public system, to sort of on cue, if you ask how you're doing, they give you the clinical kind of prescription. So being prepared for that and understanding that you may have to work with people to help them understand when is it appropriate to give that and when is it not? That may be part of your-- in sports, if we use the sports analogy-- your farm system. How are you going to grow good potential candidates working toward major league team? And so you may want to think about how do we get doing that?

We also need to make sure that people may not have the right clothes, and we often talk about, and we've talked about clothes closet before, how do you help people present as professionals if what they've done is live in a housing program or lived on the streets for the last 20 years? They may not be able, nor have the wherewithal, nor even the fashion sense to be able to present as a professional.

So having a peer help coach them, mentor them-- or even a professional help coach and mentor them-- may help you to get an ideal candidate that otherwise does not appear to be ideal. When we're interviewing peers, especially if you've never interviewed peers for the first time, you're going to need to take into account that an interview process to them is usually a clinical intake process.

So don't be surprised if they start giving you clinical information. And if you look at the clothes that people are wearing and how they present, I would suggest what you're going to look for is a diamond in the rough. How are you going to carve away the other bedrock to get to the diamond? And that if you really find the diamond in the rough, that's going to be your best ideal candidate. It's not going to be one that's fully polished and brightly shining. It's going to be the rough gemstone that you're going to have to work with a little bit to make it a good fit.

[INAUDIBLE] problem with hiring people in clinical settings is we have a bias towards how many initials you have after your name. And in academic settings, we actually have a bias to the more papers you've published or the more letters after your name, the more exalted you are. And in clinical settings, the physician or the senior physician or the medical director is the most exalted and all the other professions kind of look at them in that regard.

But I want to remind all of you that education is something that is a new sort of invention. Does anybody know who this person is?

Hippocrates.

Hippocrates. Do you know who Hippocrates was?

Philosopher.

He was a philosopher, but Hippocrates is noted for one thing.

[INAUDIBLE]

He's the father of the medicine. And physicians actually swear to a Hippocratic Oath, which is based on Hippocrates. Did Hippocrates go to school? How many degrees did Hippocrates have? Anybody know? Zero. Hippocrates was a student of some of the philosophers from the day, but there was no formal school process. [AUDIO OUT] that was the [INAUDIBLE].

Now, we think about peers as needing-- if we get bias in this academic bias, having all these credentials, but Hippocrates had lived experience. And the experience of being mentored and coached by people like Aristotle and Plato. But Hippocrates didn't graduate from a prestigious college and university and get his work in a prestigious institution, yet Hippocrates was considered the father of medicine.

And so when we're looking for peers, what I would suggest that you look for is not necessarily the academic credentials, although having someone with advanced academic credentials and other assets may be beneficial. But really what you're looking for is the life lived experience and the ability to translate that in a variety of settings.

Let me just come with life experience. In New York State, we have a variety of ways, even in State service, that we can recognize people that don't necessarily have the formal academic studies to be qualified for a variety of peer and other positions. But I'm not suggesting that one is better than the other. I'm suggesting that both are equivalent.

And that if you look at [INAUDIBLE], life experience was what made some of our leading academic professionals and leading thousands of years, we still recognize Hippocrates. And yet he didn't graduate summa cum laude from some prestigious university or institution. That's a bias that we have.

And so when we start looking at peers, we need to make sure we check our bias at the door. And we're looking for the core competencies. If I'm looking for a brain surgeon, quite frankly, I don't really care how many schools you graduated magna cum laude from. But I care about how many successful brain surgeries have been completed.

I'm not really going to look at their academic standing. I'm going to look at their success rate and their mortality rate. When I'm looking for peers, I'm going to look at what's the lived experience, and what is their ability to translate that in ways that [INAUDIBLE] peers to support the clinical mission and function that we're charging them

to support.

Now, one of the other possibilities that we have at hiring people-- this is one of our other problems-- is that people with mental illness are often invisible. Well, why are they invisible? They're invisible because of some of the reasons that you all talked about earlier-- stigma and discrimination.

So stigma and discrimination are alive and well, particularly for mental health conditions. And I use the example of the newspaper headlines, being able to lead with it, but it's even more fundamentally so in acute [INAUDIBLE]. Many people will not disclose or don't publicly disclose because of fear of ridicule and contempt from either the people they work with or their friends or others in the community.

Now, in my position, it's pretty well known that I'm a peer. I speak of that publicly. I often talk about my own experiences. And throughout today I've mentioned there are aspects of what I'm dealing with in an ongoing fashion. And you would think that in my position, being a Special Assistant to the Commissioner and working with the Governor's office on a variety of tasks that I wouldn't experience that.

I actually had a clinician who we were looking at in a county, who we were investigating a case of abuse. And I was sending one of our chief psychiatrists up to do to a clinical consult to investigate a pretty serious case of sexual abuse by a psychiatrist. And I asked for a copy of the clinical record. And the county person didn't want to provide it.

So I told my staff that was talking to them, tell them we're going to withhold their COPS funding. The COPS funding, it's a Medicaid add-in that DH provides the counties. Quite substantial, withholding that. Got their attention. So I got the immediate call from the County Commissioner, who began by telling me I didn't have the authority to withhold his funding. Oh, yeah, you can believe that if you want, but understand we need this thing.

The next question to me, well, did you take your meds today? Now, here I am at my level and, you know, the one thing that you all want to know about any good bureaucrat is you really don't want to piss off a good bureaucrat. Because the bureaucrats know how to make life hell, totally appropriately, within their authority of being a bureaucrat.

Well, OK. If someone's going to challenge me where I sit with my publications, and I've got more than 30 juried publications, books, and others, I've got a pretty good academic resume, that it's comparable to most people's, and I'd put up against most anyone. Someone's going to challenge me on that, imagine the poor person in your clinic who applies for a job, who someone then begins talking about-- what's your diagnosis? Did you take your meds today? Are you sure that isn't going to be too stressful?

Like the Debbie conversation we had earlier. Are you sure this isn't stressing you out? But I answer that question

every day. Well, hell yeah, you're stressing me out. Stop. In this case, I was fortunate because when they sent-- the County Attorney sent a letter to the Commissioner that I was threatening the county, the Commissioner asked me, John, did you threaten them? Yes, sir. I did. The Commissioner said, good job. Keep up the good work. Thanks so much.

You need to understand that just because someone is a peer doesn't mean they're not going to do right thing and push issues and agenda. And you need, as a supervisor, to be prepared to support that if that's part of their job. And so part of my job is holding counties accountable, which means that it doesn't matter what my personal experience is. Am I acting professionally, and am I holding you to a standard that I should be expected to hold anyone to? In this case, I was.

The clinic was not performing a contractual obligation. I explained to them, and they wanted to pathologize me. Very risky thing, because when you start diagnosing someone, and you're not even using the DSM, and understand that I can go to the Office of Professions, and I'll have their professional license questioned, not particularly good process.

And so understand that this invisibility, if this kind of discrimination happens to me, imagine how it happens to people in your clinics if they start applying for roles and become visible as the visible consumer. If you're going to hire peers, you need to make it safe for them to have those conversations, in the same way that the Commissioner said, did you threaten them? Yes, sir. I promised them what the consequence is. The Commissioner's response? Good job. Keep up the good work. You need to be prepared to do that, otherwise you're setting people up for failure, and you're setting your system up that way.

So the question you asked this morning is what about liability? So do we have real liability of hiring peers? Do we have real liability of hiring peers? Yes? No? How many people think yes? You're a quiet audience. You all have been sedated by food. All right. So about half said yes. How many people say no? Only a few people say no.

Well, there's always liability in everything. There's liability for the color of your hair, the color of your eyes or what color clothes you wear today. I can sue you for virtually anything. And if we're fearful about suits, then we won't do the right thing. So what's the real liability? If I hire someone for their credentials and their background, and the background is consistent with what I need for legitimate clinical and business reasons, what's the liability? Zero.

Now, liability is not zero if they do something bad. But I just told you about the experience of a psychiatrist sexually abusing a client. No liability for that? This is a psychiatrist. Some people just do bad things. There's liability for anyone if you hire [INAUDIBLE]. Let's be real. And liability from your insurance carrier is if you don't have a good job description, and you have not identified what you want this person to do and why you hired a peer and what

they're adding value to the function is. And, yes, you're going to have liability, because you're hiring somebody without reason to be doing it.

So why would I hire somebody who might have committed murder? If they're working on a ward in our hospitals or in our forensic criminal justice system with other murderers, that would be a valuable occupational requirement. So it's not what the person's background is, it's what you have them doing. If I hired a murderer working with vulnerable people, and the person wasn't rehabilitated, hadn't gone through, hadn't changed their life, didn't work on improving themselves, then there's real liability there.

But if this person has really turned their life around and is talking about recovery and modeling all the things that you want, then what's the liability? There's perception of it, clearly. We all take our biases as human beings and say, yeah, I don't know. This is-- oh, no. [INAUDIBLE] And that is saying no, this person had the skills that I need and I want because of that experience. Because they're able to talk to others that have been where they are and not the light version.

So when you go in the criminal justice setting, there are the light criminals and the heavy folks. And they all know who's who. And the light folks aren't going to have much credibility with the heavy folks. If you're going to impact the people, then you need somebody who's equal and has that experience to have an impact. That would be a qualified occupational requirement.

Liability is what you perceive it to be or what you make it. If you want to say you're reliable, then I will tell you you're always going to be [INAUDIBLE] for my ability and [INAUDIBLE]. If you're going to do the right thing, you need to think about what the right thing to do is and come up with justification for doing it.

If you've got a clear coherent justification, most courts of law and most legal proceedings will defer to a sound process that is well justified, based on bona fide occupational requirements. And the liability is zilch. So this is exactly what you make it. If you see liability in places, you will in fact have liability. If you decide to do the right thing and justify and document it, you will minimize your liability or limit it. So a question.

So if you were hiring someone and you put in the description that you're hiring, let's just say a murderer-- ex-murderer--

Well, I wouldn't put in the job description I'm looking for an ex-murderer. I would put in the job description that I'm looking for someone with extensive forensic experience, having experienced the criminal justice system, including serious felonies.

OK. Is this person-- are you also putting in where they are in their recovery?

Well, no, because recovery and treatment, if you think about this-- so I want you to think about this [INAUDIBLE]. If we ask a physician when we're interviewing a psychiatrist for a position, doc, where are you with your recovery and treatment? Would we ever ask that question?

No.

Yet, I will tell you, many psychiatrists get into psychiatry-- and they will tell you this-- the chief forensic psychiatrist that I worked for as commissioner in Maryland for a number of years, Dr. Silver, would regularly say he was the most screwed up person he knew. That's why he got into forensic psychiatry. He would say this publicly. I'm not repeating anything that he didn't say. Yet, we don't ask that question. Why not? Because it's not a legitimate question.

What we're going to look for is somebody who's stable, not asking that question, but how are you able to role model recovery? What have you done to further your recovery? That is actually part of the experience that I'm going to look for. What have you taken advantage of to role model recovery? Can you tell me how you would explain that?

One of the questions that I ask [INAUDIBLE]-- and we're interviewing right now several positions around the state in a couple of areas that I'm looking for staff for-- once the initial review committees recommend people to me, one of the standard questions that I'll ask is, so tell me how you would role model recovery for someone who says you understand what I've been through. You admit it. Tell me how you're going to do that. What are you going to say? How are you going to respond to that?

What I'm really listening for is a person to tell me what their journey was and what they've experienced and be able to use that knowledge to help someone else who might be stuck. [INAUDIBLE] have you thought about a 12-step program? You know, there's a drop-in center across the way. Have you ever been to a [INAUDIBLE] program before? Let me tell you what my experience with the [INAUDIBLE] were.

That's what you're kind of looking for. I'm not going to ask, so tell me how many times a week you go to see your therapist. How long were you in psychotherapy? Well, what medications are you taking? Those are illegal questions and lots of different reasons why they're illegal. But asking about, so tell me how you're going to role model recovery, somebody's telling you they're stuck, how are you going to help them get unstuck?

That's where I'm listening in my ear or what's your experience been? What services have you used? What supports can you recommend? How are you going to translate your experience to help this person who's stuck? Yes, ma'am.

[INAUDIBLE] Can you have [INAUDIBLE] when you are interviewing for [INAUDIBLE] can you ask them and they

tell you [INAUDIBLE] are you still receiving [INAUDIBLE] services? I mean--

What difference does it make?

Well, if they say--

So if I'm hiring a clinician, do I ask, you know, we have an obligation-- or I'm going to tell you legitimately here in this hospital, we have an obligation for infectious disease control. Do I ask have you ever had influenza? Are you taking anti-viral medication? No, because it's not relevant to the job.

So the fact that you're in treatment today is irrelevant to can you do the job or not? The question is, where are you in your recovery? Are you stable? Do you have stable housing, support, friends, [INAUDIBLE] other settings? That's what I'm looking for in any employee. Doesn't matter if you're a peer or not. And we think about peers as something unique. So we get focused on their diagnosis and their treatment. The diagnosis and treatment is immaterial to is this going to be a good employee? The question is, do you have the life skills that I'm looking for?

What I'm looking for in most peers and most kinds of things that we talked about are, at what parts of the system can you explain from a personal level to someone? Can you talk about what a clinic is like? Can you talk about what being an inpatient is like? Can you talk about what being on forensic quarter is like? Can you talk about going to the [INAUDIBLE], what that's like? Have you been through [INAUDIBLE]? Oh, dear god. Do you know what that's like? Can you explain that to someone and help them when they get stuck in life? That's what I'm looking for.

I'm not looking for, you know, which anti-psychotic, have you been diagnosed, and what is the level of therapeutic intervention, and what's your blood serum level? No. That's a clinical aspect. That's not an employment aspect. As a clinician, I might go through what your blood serum level is, if it's something we should measure. That's as a clinician. That's not as an employer.

When I'm an employer, even if I'm a clinician, I take off the clinical hat, because I'm an employer. I don't diagnose employees. If you do, you've crossed the line. We don't diagnose employees. Even if they have observable clinical behavior, they are not our client. We're not treating them. We diagnose performance issues as a supervisor. That's what we diagnose. And that's what we deal with. So all of this has to be about work, not about your illness.

Now, if you start acting out and having problems with doing the job, am I going to comment that you're having problems doing the job? Yes. Might I comment that you get some help with dealing with whatever is interfering with your job? Yes. And that's exactly how I'm going to say it. I'm not going to prescribe the anti-psychotic to you. I'm not going to prescribe medication to you. I"m going to say that you need to get some help in dealing with you

performance on the job or you risk being fired and further disciplined. That's the difference.

This is about job performance, not about diagnostic criteria. When I start asking about anything that sounds clinical or diagnostic, I've crossed the line. If I'm asking how can you role model and describe the parts of our system from a personal viewpoint, that's about modeling recovery. That's the kind of skill that we're actually looking for, in my opinion. Is that helpful? OK.

So liability is one of these things that is as real as you make it. If you start calling your insurance company and say, well, you know, I'm a little anxious. We're thinking about hiring a peer, and I'm really not sure what the liability is. And we don't know what it would mean to have somebody with a clinical background. And what's your insurance company going to say? Well, let's up your rate, because if you're anxious, then we should be anxious. If you simply hire another staff person that has the professional qualifications that you need, why are you contacting your insurance carrier?

It's a business decision. You don't call and ask, can I hire a psychiatrist? I'm going to get you've never had to ask-- you'd never ask that question unless you're looking at liability for the psychiatrist, and then you'd cover that as part of your umbrella insurance. That's a different conversation.

So recruitment strategies. If we're going to recruit peers, well, the easiest way to recruit peers is go to places where peers are. I'm not going to go to the local supermarket and put an ad in the local penny saver to hire peers. I'm going to go to mental health associations. I'm going to go to clinics. I would go to independent living centers. I would go to peer-run drop-in centers. I might go to NYAPRS.

I'm going to go to places with contact with lots of peers. I might even contact the Office of Consumer Affairs and have them send out an [INAUDIBLE]. That's part of your strategy. I may look at colleges and universities. Why colleges and universities? Well, almost all colleges have a curriculum support center for people with disabilities. It might say that I'm looking for someone with lived experience. That's something that they can help connect us referrals to. Job fairs kind of make sense.

Here's one that, again, I talked about kind of growing your own support system if you're into sports, sort of the farm team analogy, why not start with an internship program? Well, take some of the people that you think are most promising and ask them would they like to intern? Would they like to participate in a different kind of way to help then begin acquiring the skills and help mentoring them to be prepared for something more. Great opportunities there.

Understand that if you do that, here are a couple tools that you may have to be aware of-- Ticket to Work program. If you're not aware and your organization participates in Ticket to Work-- in New York State we call that

the NYESS system-- you could be eligible to receive up to $25,000 for hiring someone with a disability. $25,000 in cash for hiring someone with a disability. That's pretty significant.

I don't get $25,000 for [INAUDIBLE] anything, and you're giving me $25,000 for just hiring somebody? Pretty good incentive. But can you use that to offset some of this and give some job training and other flexibility? Yes. Now that, if you understand Ticket, is paid out over a five-year period of time and presumes that the person is working at or above substantial [INAUDIBLE].

New York State Job Bank is another one of these possibilities. The Job Bank is through the Department of Labor. Why do we focus on the job bank? Because all of our NYESS service providers that are recommending people with disabilities use that for their job searches, which will then link you to people with disabilities for recruitment.

So what are the barriers to hiring? Well, there a couple barriers-- competency, training, [INAUDIBLE]. Demonstrating skills. Here's where you want to look at the person's background. That's the person who's in peer support already. Have they already been certified? Have they gone through the Academy of Peer Services?

Acquired knowledge. One of the ways to kind of tell that somebody might be a [INAUDIBLE] without them overtly saying it is to look at, does somebody have a chronological resume? Meaning March to April, April to May, May to June it tells where I was each year, each month of that, or do they have a functional resume? Often people with the functional resumes have gaps in their employment history. The reason they have gaps? They were institutionalized or they were receiving intensive services.

Now, when I'm looking at resumes, I'm actually looking for that when I'm looking for peers. When I'm looking to hire everybody else, I'm discarding those, because I don't want those folks. So if you've got those kind of gaps, chances are you were either fired or not telling me about previous employment or in jail or prison and not telling me about that.

Disclosure considerations we're going to talk about a little more, and entitlement considerations we'll talk about some. If you're going to hire peers, you need to understand what the effect of entitlement is. If I'm going to hire a peer and that person's been on SSI or SSDI, what is hiring them going to do to their SSI or SSDI? Or more importantly, what's it going to do to their Medicaid card? If you can't answer that, the chances of you successfully hiring a competent peer goes way down.

Now, here are some things that are [INAUDIBLE] I'm not going to describe what all these are, but 1619b guarantees Medicaid eligibility up to what's called the state threshold amount. And New York State is a little more than $43,000 a year. Significant total if we know what it is and how to help somebody use it. And there's no application process for it. A [INAUDIBLE] plan, plan to achieve self sufficiency can actually help someone

exponentially. New York State, we have less than 100 of these filed over the last year, meaning that most of you don't know what one is, let alone how to fill one out.

Ticket to Work can be helpful. Medicaid buy-in for working people with disabilities. Section 301 says that I can stay on disability benefits until I graduate from your part of the treatment system. [INAUDIBLE] benefit, for particularly hiring a client who's currently in clinical services at our clinical setting.

Loan forgiveness we're going to talk about. 55B and bonding is our eligibility [INAUDIBLE] 55B is disability hiring for New York State government. And bonding is something available for people who have forensic backgrounds and criminal convictions, where the Federal government or State government will bond, meaning we guarantee with an insurance policy that they'll do the job and not violate the law.

Huge benefits if you're looking to hire people with disabilities. Understand what those are. Can you find out more? Contact the Department of Labor, [INAUDIBLE] in New York State. They know about many of these and can help you or where are the independent living centers that can help you with entitlements. Or come to one of our entitlement trainings.

Social Security is as complex as you make it. It's sort of like liability. If you think it is so complex then oh, dear god. These rules are beyond mere mortal comprehension then they are, in fact, beyond mere mortal comprehension. Actual Social Security rules are actually not that complicated. They're quite simple if you understand a few of the basics. Most people do not.

I recommend that you take a brief training on it or get someone who's a benefit specialist or if your agency doesn't have a benefit specialist and you want to hire a peer who's going to be your benefit specialist, work with one of the independent living centers or other peer organizations around the state who also have that capacity to help you in hiring the right person and getting them through the entitlement issue.

Student loans. Here's one that we often hire people who have extensive debt and are not a good risk for employment, because they're not even good credit risk. These folks have lots of risk for doing lots of bad things. We can help make that go away. Most of you, I'm going to bet, are not aware that around the country, if you have a Stafford student loan and you are on SSI or SSDI, you can ask that that loan be completely forgiven. Wiped out. Zero debt, simply by virtue of being on a disability entitlement program like SSI or SSDI.

Understanding that will actually help you find really competent successful individuals who are struggling because they're trying to repay the debt. Freeing them up from that student loan debt can actually make them be more self sufficient and make them a valuable employee. And now they've got a new role model and where they can talk to others about the value of doing that very thing.

Hiring dos. Evaluating each candidate based on the job performance, which kind of goes to your question earlier-- so should we ask about their clinical background? No. We're going to ask him whether you can do the job or not. [INAUDIBLE] clearly define, well, what is the job? And if you don't have a clearly defined job, then you're going to hire somebody who will fail.

Because if you've not defined the job, then I'm going to define it, and if I'm not really energetic and highly motivated and creative and hopefully take risks, guess what I define the job as? Nothing that you've defined the job as. So don't be surprised when I do nothing, because that's what you defined the job to do-- nothing. You need to be really clear on why you're hiring someone and not just hiring someone who says that they've got some peer experience. Well, what is it exactly that you want them to do?

And under the law, what you have to do is consider the person can do the job with or without what's called reasonable accommodations. So one of the examples that I use when we're doing Social Security training is, can a quadriplegic be a piano mover? What do you all think? Somebody's quadriplegic. They're paralyzed from the neck down. Could they be a piano mover?

No.

No.

How many of you say no? How many of you say yes? Well, what if you didn't know? This isn't right. This isn't like the *Price Is Right.* Let me [INAUDIBLE]. I don't know. I know this is a trick question. I know you're going to get me somehow. [INAUDIBLE]. No. Let's try again. How many people say yes, a quadriplegic can be a piano mover? How many people say no? All right. So it's about 50-50.

The answer is, a quadriplegic without accommodation clearly can't be a piano mover by themselves, because they can't move a piano. Are there technologies that would allow someone in a wheelchair to move a piano? Yes. There are hydraulically driven, what are called exoskeletons, where I can pick up-- I, personally-- could pick up a house by myself. All this hydraulic stuff, yes, but not much different than a motorized wheelchair, which has a bunch of hydraulics built into it as well.

So could they do it? The answer is yes, with accommodation. And that's what we need to think about. Can the person do the essential element of a job with or without accommodation? We always have to think about, well, with accommodation. What does that mean? That's going to mean different things to different people. And as always, you have to recognize that there are a thousand different ways to do something. And so if you want something done a particular way, do it yourself, because only you will do it exactly like you want it done.

If you want something done successfully, allow people the flexibility to figure out the best way to do it. And give them the guidance and support to do it in a professional way. But don't be so overly prescriptive that only you can do it, because that's exactly how they would do it.

Understand that everyone is different and unique, and they're all going to take different tasks to the same end, in the same way that the people that we serve find different routes to recovery but not all the roads to recovery are the same. They're very unique for each individual person.

Some people are going to take a lot of twists and turns and sometimes go backwards and have to start over again. Others are going to find a straighter path to it. And everybody is going to take a slightly different road that's going to have different vistas and views along the way.

Other don'ts. Don't assume that a certain person's jobs are more suited to a person with disabilities. The old adage that the agency would look at is, they come into an office and see if the person with disability is running a copy machine. It seems the copy machines and mail rooms are the jobs most often delegated to people with disabilities, regardless of their qualifications and credentials.

So when you think of hiring a peer specialist, think about how you're going to use them. Don't think of them as a case manager extender. Think of what's the value in that role, and how do we use the uniqueness of them being a peer, not just for the grunt work that nobody else wants to do? Don't assume that the person either does or doesn't want a particular job because of either apparent or nonapparent disabilities.

And don't assume that the person doesn't have the requisite education and experience. Well, you know, if you just looked at my medical history, you would say, oh, dear god. Why would anybody hire him? He's exhausted three lifetime maximums for mental health coverage. And if you look at my academic or my publication history, you're going to say, well, why doesn't everybody hire him? Just look at his credentials. And both things are equally true. So don't assume one or the other without looking at the total package of what you're getting, because it's not one or the other.

Now, interviewing, one of the things that you might think about asking for a peer is how might they share their story? One of the most common problems with hiring peer staff who have not been adequately trained or don't have experience. And I'm not saying that it should stop you from hiring someone. But you should be aware of, do they know when it's appropriate to share their story or are they sharing their story with every client?

What's the value from sharing your story? And who's getting value from you sharing your story? Are you getting value from sharing your story, because it makes you feel good to tell the client how successful and great you are? Well, that's not clinically appropriate. Equally, it's not clinically appropriate to withhold sharing it from someone who

is really struggling or stuck. You may share pieces of it without sharing your entire story.

You could say, you know, when I was receiving services, I encountered something similar. And he found out these things, and I found some other people found successful. So having then, do they have a good understanding of when it might be relevant to share a story? And you might think of a clinical example in the same way that we give a clinician sort of a clinical case scenario and ask them for a workup on how they'd work it out.

One of the things that I often ask people about, if I'm personally interviewing, is what's the greatest barrier to recovery? How did you overcome it? You know what I'm really trying to get at is, not their diagnosis, but what did you struggle with the hardest, and what did you do to overcome it? That can be a very powerful, very powerful tool.

Now, families or other peers that are stuck, if you got stuck, and you figured out how to climb that mountain in spite of it being snowy and icy and everything was falling down on you, and there wasn't a clear path up to the top, and yet you figured out a way to get there? That's valuable, especially if you did it successfully.

Now, I'm not necessarily caring what the narrative is. What I'm looking at is, did you overcome it? And how are you able to articulate that? I often ask people, and I virtually ask this-- so those of you who may talk to me for a job in the future, may want to remember-- I always ask, so who can recover? And I'll tell people up front this is a trick question. And don't tell me that you think everybody can, if you think that's the answer that I want to hear. Because if you tell me everybody can, I'm going to ask you how. Because you can't tell me how they can, then they can't recover.

What I'm really listening for is, are they holding out hope for everyone? Because, quite frankly, the most psychotic person might be able to recover if you hold out hope for them. Now, I was reminded by one of the folks here today of a particularly common case that we had here who, by holding out a little bit of hope for a different outcome with the person and doing some things that were not clinical, actually produced a tremendous clinical outcome for both the individual and the parents in a way that was not thought readily apparent prior to that.

Well, again, not so much that the person says that everybody can recover, because that's a Pollyanna-ish answer. But understanding that people struggle and that recovery is a different path for everyone and reading listening to, can you hold out some possibility for people that have given up on themselves when [INAUDIBLE] has given up on them or maybe the clinicians have given up on them? And how would you evoke hope when other people have given up? Kind of what you're listening for.

And then given changing roles, where would you go for support? We talked about that earlier. And the example I used was, now myself, when I used that in a good example, I needed support to think about holding [INAUDIBLE],

who was a member of our drop-in center. And I thought going to the drop-in center for support was a good thing. I was role modeling exactly what I hoped people would do.

But I didn't realize that they didn't perceive me as one of the club anymore. And they needed to be able to see me as invincible. My needs didn't outweigh their needs. And you need to be clear that the person is able to assess the difference between what it is they need and what does the group need?

So fingerprinting requirements. Here's one that, going to break, lots of people asked me about. So we have someone come back with a criminal conviction. And I said to you that there is a unique process for peers, but when you're applying for a position, if you get the letter of denial you need, as a provider, to write that in fact this is a peer position. And here's why I'm looking for someone with that experience.

If you write that that can provide [INAUDIBLE] to the Justice Center, they will evaluate that differently, because it's a peer position and the requirement that you're looking for and the population served is directly related to the experience this person has. If you don't provide that back, we will then evaluate this person as we would anybody else and say this person's not eligible to work.

Now, how do go about doing that? Well, you need to understand the background. And we actually have a tool that can help you do that. If you're looking to hire peers, you may want to have somebody who's available and can help them. It's everything you needed to know about criminal history background checks with volunteer or employment service.

This a walk you through the background check process. It will explain to you that if you get the letter of denial, which you should expect to get, that your next step is to write the justification letter and have the person hiring write the justification letter that says this is my peer position, and here's why I'm looking for these qualifications. Here's the population this person's going to be working with. Here's why that background fits this population, and we're not putting a predator with a bunch of vulnerable people.

How are they going to look at it? Well, what they're going to look at is evidence of rehabilitation and good conduct. How can you show that if you've got somebody that has this experience? You're going to show all the self-help support groups they've gone to. You're going to talk about all the trainings they've had. You're going to talk about the anger management classes that they've gone to.

You might get letters of support from family, friends, rehab counselors, and others. You're going to look at, can you provide the kind of clinical documentation that says this person's really been working hard on their recovery? That's what they're looking for.

Examples. Certificate of Relief for Good Conduct. Letters of recommendation from current and former employers.

Recommendations from other individuals. Letters showing they've participated in ex-offender [INAUDIBLE]. Letters that show that you have [INAUDIBLE] attended other training or other programs, that you have finished the Academy of Peer Services, those kinds of things. That's what the Justice Center is looking for.

How have you rehabilitated yourself? If you just say I was in treatment and I'm better, you're not going to be approved. You've going to have to spell it out, and you're going to have to work with the client to spell it out. I'm not saying the client's not the best fit and may, in fact, be the exact right person that you need. But this is going to take a little effort on your part and their part.

Some other examples of documents showing your professional participation-- are you participating in the community? Are you part of your church? Are you part of your faith community? Can we show that? Have you completed a drug or alcohol program? Have you completed anger management courses? That's all that the Justice Center is looking for-- signs of rehab and recovery.

Bonding programs, I already talked to you about earlier. And here's the federal bonding programs. So if you have an ex-convict or a convict who's not able to be hired, the bonding program can be a good tool to help think about that. If you're concerned about your agency's liability, if you've [INAUDIBLE] by the Justice Center and have a bond for them, may be enough to satisfy your board's concerns.

There is a correctional law called 23-A, which requires in part New York State agencies can consider people who have criminal convictions and other things as long as it is part of the duties and not direct conflict to it. So in New York State, we're not just telling you it's a good thing, we're also demonstrating and walking the walk and talking the talk at the same time. So we're making our own agencies consider the same process.

So once you've hired somebody, what are you going to do? So the first step is we need to orient them. And you should think about orienting the peer staff in the same way that you orient non-peer staff. And there are a couple of things that you want to be clear on. First is, we want to make sure they're oriented to their new role or position.

If they're receiving services with you, you want to make sure that the boundaries are clear. And I'm going to talk more about boundaries again, as I promised, in a bit. We want to make sure that they have a good experience and that the supervisors are oriented to the unique nature of peers.

Now here's one that doesn't make sense. Several people asked me, well, are we saying peers should be able to do whatever and be less than other professionals? No. But there are some unique issues. If I'm hiring a peer because they're part of the peer community, all their friends are people who receive services, and they're at programs with people who receive services, and they receive services, then I'll hire them say, well, you can't can associate with any of those people anymore because that would be a conflict of interest.

Well, now you've told them they can't live a life. You've just told them they can't have a life. They've got to give up their entire life and have no friends, no supports, no anything else to be hired. And when I say that it gets to be boring being normal, so I've got to just go back to being me, this is what I'm talking about. You're hiring them because they're a peer.

Now, you need to be clear, and they need to be clear that they are not going to be serving friends as part of their case load. That would be inappropriate. They're not going to be serving people that they have relationships with as part of their caseload.

But can a peer date another peer? Well, staff can't, but if the peers were dating before, why would you stop them now? They're [INAUDIBLE] consideration. If a peer is married to another peer, are you going to say they have to get divorced before you can hire them? There are some unique considerations here that you have to think about differently than you would think about for other staff.

The boundary issue is one that is very complicated. And it's only very complicated because we pretend to make it complicated. It really is quite simple. We all serve people that we're in relationships with. There needs to be a clear boundary and break line there. You can't have relationships with people that are in your services or in your clinic unless they were preexisting relationships. And if they were, you should disclose those at the time of hire and talk about how you firewall or separate you from providing services related to that individual. But you don't think you can't have any and then you fire the person for having relationships, which is why you hired them in the first place. You hired them because they're part of the peer community.

So this is one that you need to orient the supervisor to up front, because there are a couple of variations you're going to have to make to your boundary set of rules for them to make sense for somebody who has lived experience and is in the broader peer community. Because otherwise, you're not going to be able to hire anyone. And if you do hire them, they're going to fail, because you told them to give up all the rest of their life to then give 100% to what you're asking them to do. Question.

So two things-- first off, what about [INAUDIBLE] The second part is I've experienced some on previous jobs where the peer specialist [INAUDIBLE] their own personal cell number [INAUDIBLE]

OK.

[INAUDIBLE] So I called the patient and [INAUDIBLE]

Well, the latter may be OK or not OK, depending on the circumstances. Nepotism is hiring people who are family or related. That's illegal, period. There are no exceptions to that, period. Period. None. Nada. Any questions? I

made the exception. We don't make exceptions to violate the law for good practice. What we do is make exceptions for what is reasonable and makes sense. So can somebody give out their personal cell number? Well, I have relationships with a number of peers, some of whom are in this room. You all have my personal cell number. Is that inappropriate?

Clients.

These people are clients. They're clients of the public mental health system. [INAUDIBLE] responsible for public mental health system.

So if I'm one of the group [INAUDIBLE] right, I'm a peer specialist, and I'm one of the group, right, and some of them have my phone--

So why did I give my cell number when the issue is not that they have my cell number? Do they have my cell number because we have relationships outside the group, and if they do, then why are those people in my group?

[INAUDIBLE] that was my question. Are they then just peers, what-- you know, how that [INAUDIBLE]

So that's a discussion to have with the supervisor. I can't answer why the program allowed or didn't allow that. It may have made sense. Do some people use their personal cell phones for business? The answer is yes. If I'm a case manager, does my client have my cell phone if he needs to contact me? In some cases, yes, that's part of the business requirements. They contact me on my business cell phone.

If I'm using my personal cell phone for business purposes, in the agency I've only carried two. I've also carried three, as I was doing for a while, then that may be appropriate. I can't answer the question of what you're asking, because I don't know why they did that.

Right.

Generally speaking, what I would say is, if I'm giving my numbers out in a group that I'm operating, for personal reasons or for us to meet up personally after the group, then that's a boundary issue. That's a [INAUDIBLE] boundary issue. It's what we're defining today. If I'm giving my cell numbers out for people that I'm the case manager or partially responsible for, because everybody [INAUDIBLE] if I'm the case manager or has my number, well, that's a very appropriate issue. I can't answer that, because both things would be valid answers. Is that helpful?

[INAUDIBLE]

Sure.

Thank you.

I have a cell phone, and I was offered a second cell phone. And I work in the outpatient clinic. And I have several times gotten a phone call--

Sure.

--as well as their parole officers, probation, what have you. So I [INAUDIBLE] rules. They will do whatever. They will call me in the evening and [INAUDIBLE] their meds. They're going through a crisis, whatever, there's a lot going on. So [INAUDIBLE] the director of the clinic, my supervisor, whomever, they're [INAUDIBLE].

Right.

[INAUDIBLE]

Right. But [INAUDIBLE]

How about [INAUDIBLE]. Being that said, to work in an outpatient setting or just to be a peer, period, is stressful. So that's what works for me.

So the boundary issues are boundary issues, period. What complicates this is preexisting relationships.

Correct. That's right.

So say I'm going to give my phone number out for us to go out to dinner on Saturday night. No.

Well, you're not supposed to hang out with the clients after hours.

Hanging out with them. Let me help explain from where I sit. So if I'm explaining what I see as the State's sort of rules around this.

Right.

So can I hang out with peers in a place where there may be other peers, even some of whom use our program? The answer is, if I'm hiring a peer who goes to peer functions in the community, the answer is going to be always yes. It's impossible to say I can't hang out with any other peers ever, because then you're saying you can't be a peer. So can I go to NYAPRS and hang out with peers? Yes.

But [INAUDIBLE]

It's not different. It's the same thing. So you need to understand what is the value behind it and the motivation behind it. So I'm telling you, from where I sit, what the answer is. You can argue with me, and we'll talk about that afterwards. But I want to be sure that people understand that part of what hiring peers is about. You can't say, well, you can't ever show up in a place where there are peers who receive services [INAUDIBLE], because that would mean I can't live my life.

If I've been part of the peer community, I've been going to the drop-in center for years, and I'm now graduating from the drop-in center. But, you know, I ran a drop-in center for more than a decade. I've gone back to the center a couple times. If you said, well John, you know, you're running part of the public mental health system now. You can never go back to a place where there are people who you provided services to. Well, then I can't go to anyplace.

That would not even be reasonable to say to somebody that you can't [INAUDIBLE] your clients in understanding this is not a reasonable discussion, the fact that you can't disclose, and you have to [INAUDIBLE] is reasonable. The fact that I'm not going to be trolling for personal relationships, absolutely, not just reasonable, but mandated.

So we're not going to exploit relationships. I'm not going to invite clients where I'm providing direct services into my home unless I'm having a large public function where lots of other people are coming. And they happen to be part of a different group and just happen to be coming. That happens. That particularly happens if you're dealing with peers. If you're dealing with psychiatrists, well, maybe not so much. It would be like telling a psychiatrist you can't ever hang out with other psychiatrists. You don't go to the APA because, what, you might see another psychiatrist or not? That's silly.

So saying to a peer, well, you can't go to another place where the peers are, it's just equally as silly. So we have to understand what is it that is the situation? And the supervisor really needs to look at the nuances of that individually. And there may be examples where it's absolutely not justified.

And there are examples where it's absolutely reasonable to expect. NYAPRS is a perfectly good example. Am I going to encounter other peers that I have gone to programs with or are part of providing services, who are now going to interact with me in a different way? Yes. You mean you can never go to NYAPRS? Well, I hope not. I hope you can go. It's an example. OK?

For this orientation, the supervisors of this unique nature, that's the biggest stumbling block for supervisors is that we apply the same boundary rule we apply to everybody else, then we make it impossible for people. Now, there are some special considerations that you need to think about. So on that--

Just when people have questions, remember to repeat them. People are--

Oh, sorry. OK. I'll go back and remember to repeat. My apologies for those of you online. So special consideration. Hatch Act Lobbying Days. If you're applying for a government position, there are a number of Federal laws that prohibit you from interacting with other people in lobbying the government that you now work for. You need to understand that. Even though you're a peer, these laws, there aren't exceptions just because you're a peer. So understanding what the legal requirements of the Hatch Act and other prohibitions against you lobbying become.

Social medial considerations. This is one where there's no easy way for me to say this. If you're easily offended, I'm going to tell you I'm sorry about that. The easiest way I can describe this is to explain a real circumstance that we had.

Young people today are often not sensitive to their social media contacts. We had a psychologist who worked at one of our centers who had a Facebook account, and her Facebook name was Babylicious. And Babylicious had pictures that would make-- let's see--

Girls Gone Wild.

--*Girls Gone Wild* blush. And she had her resume up on the same page. Not a good thing. Yet peers don't often think about the consequences of those kinds of boundaries. And actually I would say that's not even a peer issue, because in this case it wasn't. She wasn't a peer. She was a PhD psychologist.

Young people don't think about this. So if you're going to hire young people, you need to think beyond just peers but about the implications of what's on your social media pages. Now, you will not find Babylicious now. If you do, it's not the same Babylicious that we had to counsel.

But Babylicious is a real person who did work for the State and may still work for the State-- [INAUDIBLE] this [INAUDIBLE] correct-- who we had to deal with because they had all of her information on there in a way that included photographs that, as I said, would make *Girls Gone Wild* blush. Not a particularly good thing when you're dealing with clients. And regardless of your professional [INAUDIBLE] to peers. This isn't unique to peers, this is unique to people.

Appearances and gratuities are things that when you're a peer and somebody gives you a little bit of money for helping them out, it is probably a good thing, particularly if you're living on entitlements. When you go to work for an institution, absolutely generally prohibited, as are gratuities. Helping people understand that in advance. Critically important and particularly if somebody has been living on benefits.

Media relations is not something people often think about. So somebody comes up, throws a microphone in front

of you, what do you say? Let me ask you, so what's going on? People tend to start and answer the questions because they get blindsided without realizing the correct answer is no comment or ask our agency. So helping people understand that, yeah, for everybody.

Last but not least is sitting on external boards. Many of our peers, if they've been around the peer community for a while, sit on a variety of different boards and organizations. And particularly if they've gone to government, that may be a consideration for us, because they may be sitting on the board of an organization that we license, regulate, or fund, which then becomes inappropriate.

Training with other staff members. So if you're going to hire peers, you need to make sure that the staff buy into this and understand the value of why we're hiring peers as well. If not, [INAUDIBLE]. So staff will go to the clinical responses of, ssh, John, wasn't taking his meds today. [INAUDIBLE] seems to be compensating. Let's maker sure we call. You know, those kind of whispered conversations happen. If we don't all buy in and understand what's the value and why we're hiring people.

Now, how can you begin to address that? Well, one of the ways that if you're a supervisor, you might address that is ask your new peer staff present with you to all of your other staff. Do you want to elevate the position and make sure that the staff understand that you see them as valuable and then make the presentation with you to everyone else. Elevate their position and importance.

I think it's really important, especially when hiring peers, is to make sure the supervisor is their point of contact. Because I have seen other clinical staff read notes that peers have written and question them in the hallways and other places. And so the peer thinks you're going to have to [INAUDIBLE] about that. It's not appropriate. [INAUDIBLE] not affecting peers.

So the question or comment was, it appears writing notes or other things, that staff are questioning them in the hall. So instead of questioning others about notes or comments that they write in the case notes or other places, well, sometimes yes. Sometimes it's appropriate. If they start questioning it and saying, well John, did you take your meds today? Because that note looks pretty sloppy. Well, that's inappropriate and may be crossing the line of discriminatory or creating a hostile work environment.

So having a supervisor that understands that and having staff understand what are the boundary issues, we don't talk about clinical considerations when we're talking about employees, period. Period. No gray area there at all. With an employee, we talk about job performance or lack of job performance, not a clinical expectation.

So training other staff members. We sort of talked about this. You know, staff members often see-- and I see this with peer staff all the time-- I am personally responsible for 147 peer specialists in our psych centers, 12 I think

regional advocacy specialists. And that's just in my portfolio and one of the sets of projects that I have.

I often see direct supervisors will tell me, well, you know, we need to give them a little bit of leeway, because they're a peer, after all. Well, bullshit. I didn't hire them for that. They're an employee. I'm paying them the same rate that I pay any other employee. I'm not discounting their job. They have to perform their job in the same way that everybody else does.

If you're going to be a supervisor, the absolute worst thing you can do is give them special dispensation because they're a peer. Then when you're telling all the other staff is their [INAUDIBLE] up to you, and their job doesn't really matter because it really isn't that important. And if you're going to start out saying that, you might as well say you're not going to hire somebody, because you're better off not hiring anyone.

Hold people accountable. They either perform or they don't. If they don't, write them up. Doesn't matter that they're a peer. Doesn't matter whether they're not a peer. You get no special exceptions because you're a peer. None. And to gives special exceptions sends a message to all the rest of your staff that these people aren't the same as the rest of you. They're [INAUDIBLE], which is one of the great catch 22s in this process, is so many people begin by making exceptions and excuses for staff because, oh, well, they can't do that. They're a peer.

Well, if it's part of your job description, it's part of your job description. I'm really sorry for your job description. You don't want to do it, fine. Get a different job. Making exceptions for staff is the worst way to undermine somebody and make their perception among all of your staff that they are not equal to anybody else in the office.

Here's just a real-life example here. So I told my supervisor that he can't do a performance evaluation on me, because I trigger.

So [INAUDIBLE] is saying a real-life example is telling your supervisor you can't do a performance evaluation because that will trigger you. Well, if that triggers you, then under the Federal law, you are not a qualified competent person with a disability, because you are-- and I'll quote right from statute-- you're not able to perform the essential functions of the job, which is including getting feedback on your performance. You're not able to do that, you're not covered under the ADA.

The ADA says to be covered, you have to be a qualified individual with a disability, able to perform the essential functions of the job with or without reasonable accommodation. That's right out of the statute. If you can't do it, find a different job, because I'm not going make an exception for you. Because that sends a message that all the rest of my peer staff are not as valuable as everybody else at that same grade level, because they're not working at the same grade level. That's a real catch 22 to be very careful of.

Ongoing supervision and support. Maintain the unique advantages. Why did we hire a peer, and why are we

looking for that peer advantage? Make sure that when you are changing the job, and jobs changes over time all the time because the work environment changes. We now have fewer staff to do more work with. Make sure that you are thinking about what that issue is.

Boundary issues we've already talked about. They are a complication if you don't think about the uniqueness of the peer role. Peers are [INAUDIBLE] other peers, period. [INAUDIBLE] peers. If they don't, then they weren't part of the real peer community in the first place. If they were truly part of the peer community, they're going to tell all the peers that they are in the program or not in the program. So we need to think about what does mean? And do they understand it? Does staff understand where is the white line that they need to be careful of so they don't step over it [INAUDIBLE].

Insuring the professional development. We often hire peers and say, oh, they're here. OK. Teach them the job. That's great. I'm all done. We don't hire other staff and don't continue to help them grow and increase their skills and better their performance. And you are a great supervisor if your staff get hired away, because they're all being promoted, in my opinion, as having somebody who just lost two of my staff to promotions recently. And so that's a good sign that you're helping people grow and develop in ways that other people are seeing the value of them.

Reasonable accommodations is something that you have to provide if the person provides documentation that it is, in fact, reasonable. Now, I've heard all kinds of requests for reasonable accommodations. I had somebody once tell me that their reasonable accommodation request was to not ever deal with me as their supervisor, because I would trigger them, because I would hold them accountable. Well, that's not a reasonable accommodation. You might want it, as Commissioner [INAUDIBLE] would say, but you're not going to get it.

So understanding what's a reasonable accommodation, there are a couple places that you can go if you're not familiar with what are reasonable accommodations. The first is, there are both formal and informal reasonable accommodations. And in the state there's no such thing as an informal one. If you request reasonable accommodations, it's the whole process, you have to fill out the paperwork. You have to provide medical documentation.

You work for a private organization, it may be simply talking to your supervisor. Well, I need Thursday off to go see my therapist. Can I work overtime to make up the time difference? Yes. Can you get paid time off to go see your therapist? No. That is not a reasonable accommodation in any sense of any organization. Period. Can other People request it? No.

Can people request a quiet office if they hear voices? Yeah, that might be a reasonable accommodation for some,

if people request. Having a door on their office so they could separate from noises or visual or other hallucinations that they may be experiencing. Yes, that might be reasonable.

You have to look at the individual circumstances. If you're not familiar with accommodations that make sense, Job Accommodation Network is the gold standard nationally in providing feedback [INAUDIBLE] foundation. The Job Accommodation Network is operated out of the University of [INAUDIBLE] in West Virginia, under Federal contract. AskJan-- J-A-N-- dot org is the web page of the US, and they are the United States' leading authority on reasonable accommodations for all different kinds of disabilities.

Talked about reasonable accommodations. People get kind of held up on, well, reasonable accommodation will cost us a lot of money. According to the 2003 survey by Dixon, Kruse, and Van Horn, less than $500 for most accommodations for most anyone, regardless of the type of disability that they have. And 73% of employers report that employees with disabilities didn't even request accommodation. So just because you hire somebody with a disability doesn't mean you're going to have to do that.

But there is a double bind here. This, I want to make sure that you all understand, because if this is not readily apparent until you hire someone who is a peer, and then they're neither fish nor fowl. So if you hire a peer specialist in your work site, unless you've really worked with your staff, and the staff are really accommodating, the staff will not perceive them as part of the staff. And yet the peers, who they used to be part of the peer community with, won't see them as part of the peer community either.

So they're neither fish nor fowl. You can't get to either. Well, which group do you belong to? Well, that one. All right. And so we need to help make sure that people understand that when we hire, their roles are going to change within the groups that they've been in, whether they perceive or not. Their perception by other members of that group will change. And you're going have to work to accommodate them within the office environment so they're fully reflected as part of staff.

We have staff that I've had over the years, who were accepted into the offices in which they worked. They were invited out. They're invited to people's homes. They're invited to parties and other things with other staff. And then I've had staff who are part or have been part of offices where they've never been invited to anybody's house. They've never been invited to a party that the office has unless the party is at the office, in which case I'd argue they're really not part of the staff. The staff don't perceive them as part of their group. But how do you think about that? As a supervisor, it's one of the things that you need to do.

So one of the ways that you might do that right up front when you're hiring a peer, assign a mentor to them. Somebody in the staff who's not a peer, who's going to help mentor them in all the ways of the staff.

Now, I'll give you a personal experience that I had when years ago, when I was hired by the State of Maryland, the Personnel Director to the State was really pissed off that the State was going to hire a peer. And so he gave me an office with our Deputy Personnel Director, thinking that I'm going to piss him off. We're going to make him share an office. I'm going to make those two people kind of work together, and they're going to get on each other's nerves, and I can get rid of both of them at the same time, even though the Commissioner was hiring me.

Turned out that was the best thing he could have done, because my good friend Margaret and I are good friends still to this day, even though I've not been in Maryland now for 17 years. I've been in [INAUDIBLE] almost. And she was extremely valuable in helping me understand the culture inside of government that I would have never had had I not had a mentor in somebody there. And that would not have developed on its own. So his punishment? It happened to backfire on him. He left before the two of us ever did.

So thinking about how do you set that up as part of the recruiting strategy might be something that you think about intentionally, rather than backing into it accidentally, of assigning someone to help mentor a new peer, and I would encourage you to think about this for any new staff. Having a mentor to mentor them to the culture of your work environment is good for any new staff member, regardless of whether they're a peer or not. So question all the way in the back.

Yes. The question is about [INAUDIBLE] And peers who [INAUDIBLE] we've got a situation [INAUDIBLE] where [INAUDIBLE] facility where they [INAUDIBLE] services here. A person was hired as a temporary staff. That person was [INAUDIBLE] invited to staff parties. Staff supervisor [INAUDIBLE] Is that appropriate to--

So somebody that's a resident of the housing project being invited to staff parties is, to me, someone boundary-ish. But that's something I'd talk to the supervisors about, because there may be something unique that I'm not seeing in that. But, to me, it immediately sounds like a boundary problem. Boundary violations aren't boundary violations just because one of the peers goes you may need to get a pass on boundary violations. But you need to evaluate them no differently than you [INAUDIBLE] for other staff. That just sounds like it's not.

But this double bind is something you should think about-- how do you set up [INAUDIBLE] or networks in house. If you're in a private not for profit or for profit, you may want to think about the effects on health insurance. Again, this is not readily apparent, but if you're hiring somebody who has extensive pre-existing conditions, who's on lots of medications-- at the height of my illness, I took 27 pills a day. Those pills on the open market cost $1,800 a month. This is more than a decade ago, because that was the last time I took that many, thank god. But $1,800 a month is a lot of money. If I lose my coverage under Medicaid and have to go on private insurance, what's the co-pay for that? It could be quite expensive.

So to think about can somebody afford to come to work for you, you're going to have to think about [INAUDIBLE]

the health insurance questions. If you have private health insurance, you need to think about what are the deductibles? What are the coverage gaps? Is there a strategy?

In New York State, we have an excellent strategy called the Medicaid buy-in for working people with disabilities. Provides full Medicaid coverage, running up to $85,000 a year, at no cost to the individual and allows them to use that as a gap filler for any other insurance that we might maintain, free of charge.

In other states, you may or may not have the Medicaid buy-in available to you. But you need to think about that as an option to make sure that the individual you're hiring understands that, because otherwise when they start looking at what your health insurance paid for, were there deductibles, and you have a $2,000 deductible on catastrophic care, [INAUDIBLE] eat that up in a month's time. Yeah, they're probably not going to say yes to this kind of employment arrangement.

Trust. This is a two-way street. Peers need to trust that the supervisors understand the unique nature of the peer and not compromise that but also not undermine it. Peers often will say, well, I've given my word to somebody that I won't say anything, and that's also a trust violation. When you are staff, you are staff, period. Someone can't tell you something in confidence because you're their peer staff. You are staff. There are no confidences here.

And helping people understand that up front clarifies the role issues and the worrying of what's the role that you're in. That also is what complicates the pre-existing peer relationships, are people that you have been in services with, because they perceive you as being able to keep confidences that you should not be keeping if you're part of a clinical team. So dealing with that up front is particularly important.

It also is important that the rest of the staff respect and trust the peer. You will either support that by holding peers accountable to the same standards minus boundary, or make a little [INAUDIBLE] exceptions there, but the rest of that, you're going to hold the peer staff accountable for the same issues that you hold other staff accountable to. HIPAA violations are HIPAA violations. Period. There aren't any exceptions to that. High-tech concerns are high-tech concerns. There aren't many exceptions to that.

Boundary issues. There may be some unique issues around that, that if you violate a boundary issue, that is a [INAUDIBLE] to that. Making sure that you hold everyone accountable in the same ways builds trust is all of the staff, that we're not hiring a junior or less than or subservient kind of position. But that these are held to the same standards that all the rest of the staff are held to and vice verse.

So whenever you're dealing with disabilities, it is important for all staff to understand that you don't ask questions about the disability. That makes the workplace uncomfortable. If the person is willing to disclose, if you've got somebody like me who's, you know, answering questions about this all the time for education and other purposes,

it's not because I'm-- I don't know what the right word would be, but kind of showing them on that without trying to tell a story? No. I only do it if it's educational and if we're specifically doing it to educate populations. That's different.

But to have staff just come up and start asking questions about your diagnosis and other things makes people very uncomfortable, unless that's part of their job of dealing with other staff in the office. So when staff understand where the boundaries are, this is also critically important.

Working alone. This is a death sentence to peers. So working alone, if they're the only peer that you have, sets people up for failure. Why? Would you have a social worker work by themselves and not have access to other social workers to bounce ideas off of or to work as part of a team? No. Typically not. It might work for one but then they've got teams to bounce back to and consult with.

I think it's true of peers, if they don't have somebody else, then being the single or only one of anything in an organization sets you up for possible failure. Your organization may not be able to hire more than one peer. But setting up a relationship with an outside peer organization could provide the support and value to help mentor your staff and help educate and might provide the balance for them when they're given the difficult assignments.

Overtired, overworked, overextended. We regularly hire a peer-- a peer, one and only one-- and we put the Superman cape or Superwoman cape on them, and we expect them to be on every single committee and part of everything for work structure. And why aren't you at every single meeting that we have? And we've got 47 JCAHO subcommittees to prepare for the upcoming [INAUDIBLE], but you're going to be alone. My god, why aren't you there?

Nobody can be everything to everyone at the same time. And when you expect Superman or Superwoman, you've created a system that is doomed to failure. Now, you may, in fact, have a living, breathing Superman or woman who is able to leap tall buildings with a single bound and able to do most of what you're asking them to do. But if you don't ask other staff to be on every single committee or organizational structure, then you shouldn't ask your single and only peer to do the same thing.

I would then set up to invite other peers that you serve to serve on those committees. May be, in fact, a valuable role. But then them being the only person who serves and to never build a community for support or be able to delegate does two things-- it sets up that they're a Superperson, not able to actually do what normal people do. And it sets up that we reinforce that they are extra special in the most specialist of words. That ultimately devalues them as a real part of the team.

That is probably the most common mistake that I see providers make of having one or two and having them

appear to be everything to everybody all at the same time. You can't do it. So when I start seeing a person whose scheduled on every single committee, and I'm really worried that you've got unrealistic expectations, and they're going to fail. And they're failing, not because they're not confident, but you set them up in a way that's impossible for them to succeed. Because they're going to perceive in their own mind that they are so omnipotent and important that you can't do anything without them, which means they won't invite others and empower others.

And part of the best value of having a peer is that they won't take this on themselves, but they empower other people to take these roles. So think about how you're going to use your peer to empower the people who work for you and others [INAUDIBLE] leadership opportunities rather than create Superman or Superwoman and assign them a cape and hope they may grow into it and/or not affected by the kryptonite that's going to be throughout the environment.

[INAUDIBLE] the strategy [INAUDIBLE] the flip side of that [INAUDIBLE] is that we have a lot of dedicated very energetic peers who volunteer, who are [INAUDIBLE]--

So Tony is saying the flip side of this is peers who volunteer to be everything to everyone, which is equally true. So having realistic expectations and not overextending yourself. We need a balanced work life and a balanced home life. If you don't have people who are balancing this appropriately, if you're trained to do everything for everyone, you can't do that and succeed. You can for a short period of time. But you will burn out very rapidly. And the value of nurturing and hiring someone is we want someone who's going to be here for the long haul, not the short sprint.

So serving on too many committees, we've kind of already talked about. Inflexible job duties. Again, I kind of talked earlier about if you've got a particular way you want something done, do it yourself, because you're the only person that's going to do it exactly that way. More importantly, giving people the opportunity to figure out what's the best way for them to accomplish the task, even the [INAUDIBLE] action task or often you will be amazed at the solutions people find.

Peers speaking up. If we're hiring peers, one of the things that I find in supervising lots of peers is that the more initials people have after their names, and this is true throughout our clinical settings, the more fearful people are of speaking up to them. So whether it's a social worker, whether it's a psychologist, whether it's [INAUDIBLE] or [INAUDIBLE] or other clinical or nonclinical staff, the Chief Psychiatrist comes in, the Chief of Service comes in, the [INAUDIBLE] in our facility-- she's the Deputy Director of the hospital comes in-- and nobody says the emperor has no clothes.

If you're going to be an effective staff, you have to be willing to speak up AND as supervisors, you have to give people not only the permission but the political cover to speak up and say the right things, even when it's politically

uncomfortable. Because otherwise, if all you're doing is hiring yes people, then you really don't want peers. A bobblehead would work equally well and doesn't speak back. Let's get the bobblehead and bounce around the head and move that up and down quite successfully for you.

Potential traps. Tokenism. The spokesperson. You hired the one and only peer and you make them spokesperson for all the rest of the world. Peers, even as long as I've been doing this, don't purport to speak for everybody else, because I don't know everybody else's experience. I know lots of people, and I can certainly talk about the breadth of experience. But I can't talk about everyone's experience. No matter how good anyone is, they're not the spokesperson for the world

Cooptation. Paternalism. Marginalizing. These are all easy things that as a supervisor you can do inadvertently by doing some of this. Overcoming the challenges. You may need to deal with illnesses or time off. That's one of the things about dealing with people who have histories. Expect that they may periodically have a relapse and may need some tuning up on their meds. It's part of the typical nature of a serious or chronic condition.

Whether you're talking about mental illness or whether you're talking about cancer or whether you're talking about [INAUDIBLE] we don't look at this differently for cancer survivor of giving them flexibility and time off. But yet if somebody with a mental health condition needs off of work [INAUDIBLE] different way.

How do we deal with disclosure? Well, telling somebody that Johnny has a mental illness could be [INAUDIBLE] a decision, and he should need to figure out how he's going to disclose that to the other staff and what he or she wishes to disclose. Boundary issues we've already talked about. Entitlements.

And pathologizing behavior. I think you've heard me say this repeatedly throughout the day, is that we look at a staff person's performance, we don't apologize the behavior. Even if I think there's something clinically motivating it, we don't pathologize the behavior. It's the behavior that we deal with.

So if you're hiring peer staff, here's a list of core competencies that you might look to include on a job description. [INAUDIBLE] some to work for you. These are some examples that you might think about using, everything from basic recovery concepts to active listening and communications skills.

Understanding reasonable accommodation and the ADA. Lots of people talk about the ADA, but most people don't realize ADA does not apply to Federal government. Yet lots of people say that [INAUDIBLE] ADA. And then they'll tell me, well, [INAUDIBLE] ADA [INAUDIBLE] the ADA doesn't apply. The Federal Rehab Act does. So if you're going to use these terms, make sure that you understand what you're using and that you're using them appropriately, otherwise you're going to confuse people and actually cause harm with people that we serve if we don't [INAUDIBLE].

Group facilitation skills. Understanding [INAUDIBLE] support. Understanding core competencies and, most important, know when to disclose and when not to disclose. [INAUDIBLE] training. Helping people to develop core competencies in peer areas is critically important. So have your staff trained in [INAUDIBLE] model. Have you conducted dialogs with skilled training? Have you talked about substance abuse issues?

Have you used spirituality and religion? One of the great things about having peer staff is to engage people in support communities. The largest support communities in the world are the spiritual support communities. Every organized religion provides support for the members of that organized religion in ways that government can only begin to imagine social supports and service.

And some religions, Mormon is one, for instance, they have bishop's storehouses that are better prepared than FEMA for natural disasters. In fact, FEMA borrows from their warehouses to respond to natural disasters. How we think about engaging people in their spiritual or religious practices can add a lot of personal support for people than what we all think about. That's a skill that peers might absorb.

GLBTQ issues is another one that we don't often think about [INAUDIBLE]. And then personal safety plans and suicide prevention. This one gets a little complicated, because peers don't tell each other's secrets. And secrets are not healthy in this clinical relationship, period. And peers feel compromised when they're asked the hold a secret. So having that conversation right up front so that we understand what are the issues and things of that [INAUDIBLE].

Peer staff providing training for non-peer staff. I've already talked about the value of [INAUDIBLE] way to help strengthen their prestige position in [INAUDIBLE] organization. And staying up to date with latest information. Help give peers the same opportunities for CEUs and other ongoing support.

One of the great supports that you can offer any peer to [INAUDIBLE] around the state or in their own network and feeling a part of something bigger than themselves. INAPS, which is the International Association of Peer Supporters. It's an organization that [INAUDIBLE] nationally to support peer specialists. As well as Alternatives, which is a national conference of people with psychiatric illnesses. They talk every year, typically [INAUDIBLE] every year. They have a great [INAUDIBLE] giving people those opportunities [INAUDIBLE] opportunity [INAUDIBLE].

So [INAUDIBLE] says, that's my story and I'm sticking to it. Let's see if there are questions or concerns or comments. Let me do a couple things before I jump into questions. Those of you that are looking for the social work CEUs will need to complete the post test. So for those of you that are psych facilitators at our [INAUDIBLE] rated sites, now's a good time to pass out the post test if people need them so that they can complete them in

order to get their CEUs done.

Let's see if there are questions here, and--

John. The proctor is willing to grade those tests today.

Yeah. So I was going to answer that. So proctors at each of the sites, you will need to grade the tests as people complete them. And you'll need to send the tests in [INAUDIBLE] receive credit for their ongoing [INAUDIBLE]. We need to grade them so people know how well they did. [INAUDIBLE] Are we going to pass them around? Joe, why don't you get them started. You can monitor the chat [INAUDIBLE] questions from any [INAUDIBLE] locations. Questions from the audience here? [INAUDIBLE] questions. Yes, sir.

[INAUDIBLE] peer specialists [INAUDIBLE]

So the answer and the question is, is there [INAUDIBLE] question about boundaries where people get [INAUDIBLE] describe boundaries when they're hired either by state staff or private organizations and institutions? The answer is yes and no. So the answer is if you are supervisor of peer staff, I would recommend that you have a discussion with your new hire upon hire to be clear on the boundary issues, because the best handbook [INAUDIBLE] by themselves will not look at the unique circumstances of each individual. And the boundary issues are going to be [INAUDIBLE] in the same way that reasonable accommodation has to be unique for the individual. There's no way that I can cover every scenario [INAUDIBLE]. I just can't do it.

Thank you.

So other questions as people are taking tests? So Bill, one more.

How can you convince a clinical agency to invest in peer services that are not billable?

Oh. The question is, how can you convince-- so for those of you at Creedmoor, if I can ask that you just hold down the conversation, as we're still webcasting. So remember, we've got 20-plus other sites. So a whole bunch of conversation [INAUDIBLE].

So the question is, how can you convince a clinical organization to hire peers? Well, twofold. Peers are cheaper than psychiatrists. The easiest way I can convince people to hire peers for nonbillable services is clinics and other places provide lots of nonbillable services to make sure that people are safe. Am I going to have a psychiatrist do that or am I going to have a psychologist do that? Am I going to have a social worker do that or am I going to have a certified peer specialist do that?

Peer specialists are the cheapest and may be the most qualified and efficient at doing them. So there's value in

sometimes being the cheapest. It may also be that they are the most clinically qualified to provide the nonclinical nonbillable services. And so I would start with that. Then I would use the research that I showed you in the earlier part of this, about what is the value for hiring certified peers from a clinical perspective that has been well researched and documented in the [INAUDIBLE]?

So other questions for [INAUDIBLE]? Yes, ma'am.

[INAUDIBLE] How do you [INAUDIBLE]

So the question is, how do you answer if another staff person who's not here comes and asks you about your diagnosis, medications, and those kind of issues. Well, I think it depends on what you are comfortable with as a peer and what your goal and role is. In my role, the biggest part of my role is to be an educator. My role is probably different than many of yours, because I'm-- for lack of a better word-- the chief peer for the state. In that way, I have different responsibilities than other peers may have.

But I see any time someone asks me questions, it's open opportunity to educate them about the appropriateness or inappropriateness of the question and also educate them about stigma and discrimination. And so if I was a direct peer staff, and I gave you the [INAUDIBLE] example-- that was a true example. I had a county commissioner ask if I had taken meds today.

My response was, this is not clinical conversation. If you want to begin to diagnose me, then you've exceeded your boundaries as a clinician. If this is a contract discussion, and as your contractor, I'm telling you what you have to do. And quite honestly, his next question to me was, you know, when have you [INAUDIBLE] in treatment? And that was really the wrong questions to ask me.

Now, he did ask the county attorney and others [INAUDIBLE] saying, well, I should be fired for threatening them. I wasn't threatening them. I was telling them the consequences of them not fulfilling their contract. The consequences of not fulfilling any contract is we stop paying them. Period. No question of have I taken my meds. It's an inappropriate conversation on meds.

If a coworker asked me that question, then I'd probably have a different level of conversation. I would probably be trying to help them. So why are you asking me this question? Is there someone in your life that you're concerned about, and you're trying to understand how to help them? Because usually that's the case.

And if you open up the inquiry, they will share with you all kinds of things that you would have never known about. So if you think of any opportunities that you have as an opportunity to educate people, then you're going to open up possibilities that you wouldn't see otherwise.

If instead you see discrimination and stigma everywhere, that's what you're going to see. If instead you see opportunities for hope and education, that's what you're going to see. I choose to see, well, what if I educate this person about the appropriateness of their question, and what if they're really asking a question about their son or their daughter or their [INAUDIBLE] or husband or their mother or sister? Well, oftentimes, when I ask the followup question, it really is about somebody else in their life. And they're trying to understand how to help them. Then we can have a serious different kind of conversation. That helpful? OK, good. [INAUDIBLE]

[INAUDIBLE] inappropriate for [INAUDIBLE] where you receive services? [INAUDIBLE]

So what I said was, is it appropriate to work where you receive services? The global answer in health care generally is yes. Do you need boundaries? Yes. So I can't provide services to the same group that I received services from. There are a whole bunch of prohibitions about I can't provide and receive services at the exact same time.

But it may be possible if the clinic has multiple sessions or I'm running an evening and weekend group or [INAUDIBLE] during the week-- I go during the week, but there's an evening group that I'm going to run that's not people that I normally interact with or in my group, there may be ways to structure that. So that would be a question-- conversation with the clinical supervisors on can we do this or not? Does it make sense? Can we put the boundaries in place to keep everyone safe and healthy and ensure that this is an appropriate clinical response? So [INAUDIBLE] look like we had an online.

Can a CPL 330.20 be hired as a peer?

Well, the question is, can a CPL 330.20 be hired as a peer? Well, the answer I think that I explained earlier is the answer is yes, of course. Now, in order to be hired as a peer, you're going to have to demonstrate that you are a person in recovery and that you've done all the appropriate things to get through, then of course you do. You can be hired as a peer and, in fact, having been a 330.20, if your job is to work with other people who are 330.20, that may, in fact, be a bona fide occupational requirement and actually could benefit.

So what's a 330.20? A 330.20 is the legal status in a criminal procedure that requires someone to be evaluated and deal with clinical diagnosis. Well I won't get into the other details, but it's part of what people commonly call insanity [INAUDIBLE]. OK? Other questions?

What is the best practice when the peer raises the discussion of symptoms or medication?

So what's the best practice when a peer raises discussions about symptoms or medications? Well, I'm assuming that this is what are your symptoms or what medications do you take as a peer, which is one set of questions. So I'm going to answer this a couple different ways, depending on how you look at the question.

So people ask me and have asked me over the last lifetime now-- I've been doing this work 40-plus years-- is, well, what medications do you take? And the answer is it's not important. What is important is for you to find medications that work for you. Because what works for me may or may not be appropriate for you, and it may or may not work for you. So I don't ever answer any personal questions about medication, ever. Period. None. Nada.

It's not because I'm uncomfortable with it. It's because there is not a good clinical answer that I can give other than medications are a tool. Medications can be helpful if you find the right ones that work for you. And what I take isn't necessarily what's going to work for you. Because you and I are different human beings. We're different body structures. We have different backgrounds. We have different experiences, and we have different diagnosis.

Another question that I commonly get asked is what's your diagnosis, which is not something that I ever answer. I will tell you what symptoms I've experienced.

I would say [INAUDIBLE].

But what I will say and what I commonly answer, which is true, if anyone has been in the system as long as I have, I've had virtually every diagnosis in the book, which is true. Depending on what clinician I've gone to, I've had a diagnosis [INAUDIBLE], and that's how I would expect peer staff to answer this, because the people you're working with, what's the value of you sharing that? There is no value of sharing your particular diagnosis.

What is valuable is, over your lifetime, you'll receive lots of different diagnoses, and what's valuable is that you work to reduce your symptoms. The diagnoses, quite honestly, are useful [INAUDIBLE]. Let's not talk about diagnosis, and let's talk about what you experienced. So what did you experience? Let's talk about what's helpful to reduce that symptom.

So am I going to share and disclose my diagnosis or medication? The answer is no. Personally, I would never recommend that a peer specialist or another peer staff ever disclose those things, not because it's something you should be ashamed of or embarrassed about. But there's no value in the person you're working with getting that information. No.

And remember that if I'm disclosing, it's not for my benefit. It has to be for the benefit of the client that I'm working with. And because I don't see any value in ever disclosing that, maybe you can give me some weird hypothetical where it might be useful, but I never in my 40-plus years have done that. So, Joe?

Do you think the principles and practices discussed today are relevant for youth and family advocates as well?

Well, principles and practices for youth and family advocates? Generally speaking, yes. And a lot of the same

considerations we [INAUDIBLE], because they share the same experiences of discriminatory practices or behavior and are going to need support in some of the same ways.

And as I said through much of the day, some of those things that were recommended for peers, we recommend for any staff that you hire, regardless of whether they're a peer or not, because it [INAUDIBLE] practicing. Depends on who you're hiring. So the answer is globally yes or a youth advocate, there are some additional nuances [INAUDIBLE] educational settings that you're going to need [INAUDIBLE]. But this training was not designed and intended for youth advocates or [INAUDIBLE].

So it looks like we're in a lull for questions. So thank you all for coming and spending the day with us. I hope you found this helpful. And I wish you all great success in hiring peers and getting people to be part of your peer workforce. So thank you and keep up the great effort.

[APPLAUSE]