Montana's Peer Network
Peer Support and Mobile Crisis Outreach Project
January 2014-June 2015

Introduction

In January 2014 Montana's Peer Network began a cutting edge pilot project that involved peer supporters (recovery coaches) and mobile crisis outreach, entitled Recovery Coach Pilot Project. This pilot project was designed as a prevention program intended to get in front of mental health crisis calls in the community. To achieve this we worked directly with law enforcement to identify individuals in the community that were at high risk for crisis through repeat interactions such as: multiple 911 calls, any type of mental health related event, or suicide attempts. Before we started this project we identified that law enforcement often has more insight into future crisis events than behavioral health professionals. This is not always the case but is the case more often than not. This white paper is intended to give a breakdown of the pilot project including the project goals or intent, data and outcomes, how we did what we did, case study, staffing, funding and what we learned and how we take this work forward.

Overview of pilot project's intent:

- Provide 2 community based recovery coaches to Gallatin and Park County, Montana as an alternative option to more costly/intensive crisis services
- Peer Supporters respond as needed and when appropriate to those in "crisis"
- Coordinate with community resources/stakeholders to reduce high cost impacts of crisis on the community system
- Demonstrate community based peer support is effective
- Legitimize peer support profession

Community Demographics (census.gov and wikipedia.com)

- 97,308 approximate population of Gallatin County Montana
- 39,860 approximate population of Bozeman the largest city in Gallatin County
- 95.1% white
- $52,833 median income
- 2,602 square miles

- 15,880 approximate population of Park County Montana
- 7,034 approximate population of Livingston Montana largest city in Park County
- 96.1% white
- $42,426 median income
- 2803 square miles
- 5.6 people per square mile

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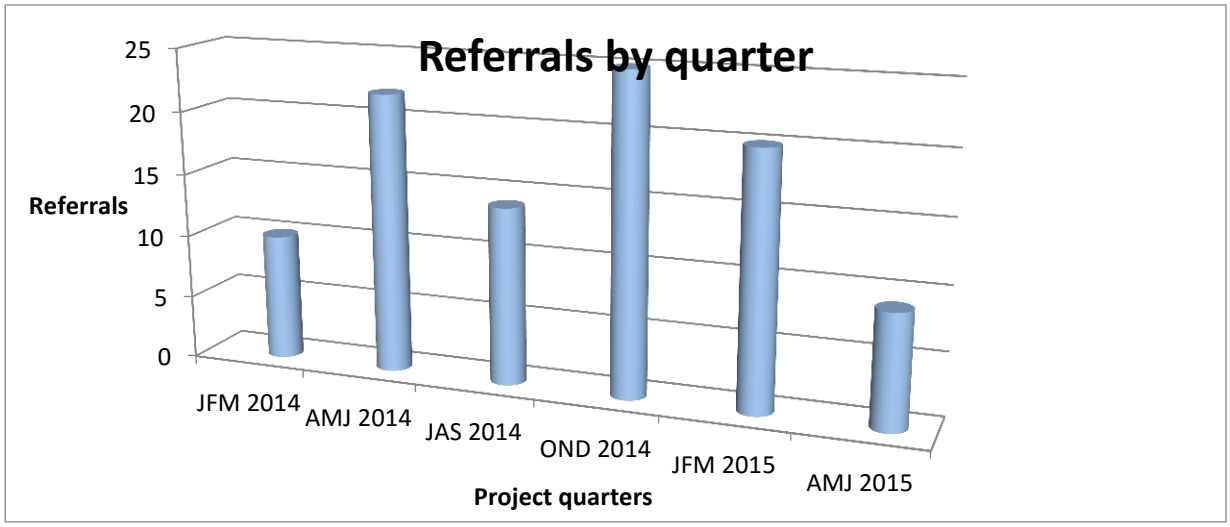
Outcomes

Overall the pilot project was well received by, law enforcement, state of Montana, project participants, community organizations and individuals. Subsequently Montana's Peer Network has been asked to speak on this project in a number of communities and other states.

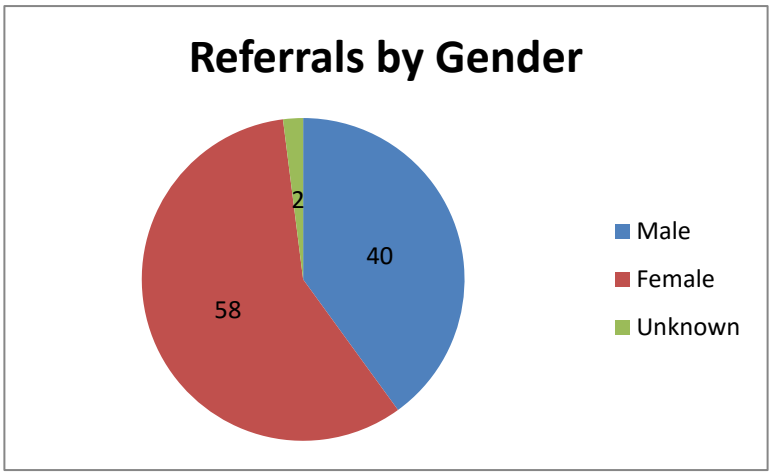
There are a number of data points we would like to highlight in this pilot project. The one most people are interested in is listed below. It includes a breakdown by quarter, the number of referrals in that quarter. How many contacts peer supporters made with the individuals referred and how that contact was made, face to face or other which represents phone, text and email. With modern technology and comfort level with social media phone and text contact was strong in this project and many times was as effective as face to face. We did not track contact hours per quarter only as a running total for the project.

		Total referrals	Total Contacts	In person	Other	Hours of Contact
Totals for Project		**100**	**1008**	**470**	**563**	**907**
First Quarter	JFM 2014	10	51	37	14	
2nd Quarter	AMJ 2014	22	123	62	61	
3rd Quarter	JAS 2014	14	192	86	106	
4th Quarter	OND 2014	25	225	85	151	
5th Quarter	JFM 2015	20	219	117	115	
6th Quarter	AMJ 2015	9	198	83	116	

Our peak quarter was the fourth October, November, December 2014, followed closely by quarters 2 and 5. Quarter 3 was an anomaly that puzzled us for many months afterwards with

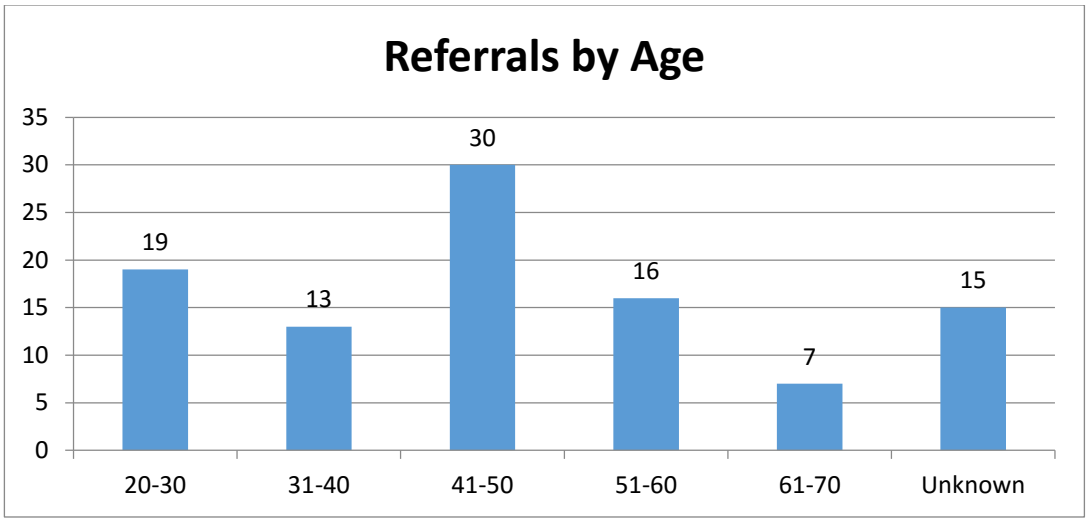


only 14 referrals. After looking into possible explanations we discovered external factors outside our control were the cause. These are explained in detail in the Limitations and Obstacles. Even though we had a significant dip in the number of referrals in quarter 3 we had a high number of contacts with previously referred individuals. Starting any program from scratch takes a bit of time to "start up" and conversely closing down a program takes a bit of time too. Thus quarters 1 and 6 represent that statistically with a much lower number of referrals. The program ran the strongest quarters 2 through 5 and we were quite satisfied with this data overall.



Of the 100 referrals to MPN 58 were women, 40 were men and 2 were unknown because we were never able to make contact with them.

When we broke down demographics by age we found the majority were 41-50 years of age or (30%).



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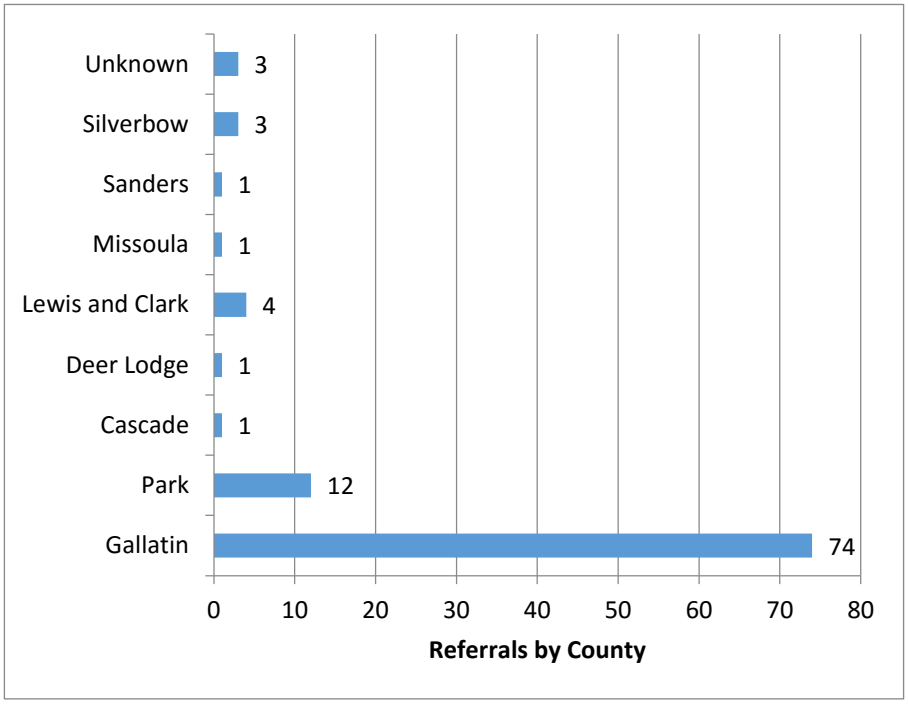
Outreach:

In the early stages of this project we did a great deal of outreach. We met with the Sheriff of Gallatin County and found he was very supportive of the project. Once we had the go ahead from the Sheriff, the peer supporters attended shift briefings to meet with deputies and officers face to face in order to explain the program and answer questions directly. This also allowed for face to face contact between the peer supporters and law enforcement officers. We also outreached to agencies we thought would utilize our service such as mental health center, community health center, crisis center, drop in center, state run psychiatric hospital and chemical dependency center, domestic violence shelter and crisis line program. This meant attending staff meetings at agencies, emails and phone calls to directors explaining the organization and answering lots of questions.

Below is a breakdown of the 100 referrals we received to the pilot project by county. We have shown this because once the project was underway we outreached to the Montana State Psychiatric Hospital whom we have a strong relationship with as we have been facilitating recovery groups at for over three years now. We asked them if they would like to participate by referring individuals that were discharging to our catchment area and they agreed. We also outreached to the Montana Chemical Dependency Center and they also agreed and thus we received referrals from counties other that Gallatin and Park.



Maintaining frequent contact with referring agencies and all emergency service providers was essential and required a great deal of time and energy. It has been said that an individual needs to hear something 6-10 times for it to really stick in their mind. Peer support is no different. It is our responsibility to provide education and promote peer support. This may even require a separate staff member who can present the project, share successes, take questions, and make peer support part of the routine. This can be done by the individual attending law enforcement briefings, Local Advisory Council meeting, Emergency Services meetings, presenting in the community, and many other avenues. Networking in this way will allow others to promote peer support and

specific projects further and potentially open up opportunities which were previously unexplored. This project had some difficulty with collaboration amongst emergency service providers. Frequent contact could alleviate some of the resistance and help alleviate the tendency to fall back into old routines.

Before the pilot project officially started we began outreaching to agencies in the community looking for partners and educating them on this new community resource. The other component to the project early on was hiring staff, protocols for referrals and data collection procedures

What we did:

- Once we received a referral peer supporters respond to the individual's home within 24 hours to offer support and resources. We made no judgements. We simply offered assistance to the individual. We let the individual know who we were, who referred us to them and that we were in recovery. We also let the individual know our service was free and then asked how we could help. Some were accepting some were not.

- We offered weekly one on one peer support to those who chose peer support as part of their recovery. This looked different with each individual. For some we met at a coffee shop each week, for others we met at their home and for others we went for walks. Only one individual chose to meet at our office throughout the life of the project.

- Weekly peer support recovery group open to the community

- Developed resource packets: Early on we developed resource packets we called CIT Packets (Crisis Intervention Team Packets) to be given out to individuals being referred to us and even more importantly for those not wanting to meet with us. We compiled over 50 local, state and national recovery resources. On the outside of the packet we placed a label that stated "You have been identified as someone that may be in need of extra support. In this packet you will find resources you may find valuable." We chose our words carefully as to not label or stigmatize the recipients of the packet. Once completed the resource packets were disseminated to law enforcement, hospital staff, crisis stabilization center. These packets were also made available to those referred to our organization.

- Collected data from those we worked with including: health and well-being, recovery markers, quality of life, recovery process and meaning of life. Those who completed

these questionnaires were given a stipend of $25. Completed surveys were sent to Dr. Nathan Munn at Helena College for collation.

Protocols and Referrals

The initial question in regard to referrals was, how would we accept referrals? We needed to set up the protocols and procedures for agencies to contact us when they identified someone that was in need of support. What we discovered was it was easier to start with when not to call Montana's Peer Network. The reality is with only two peer supporters we cannot respond to every crisis call. So there had to be limitations and safety was priority number one.

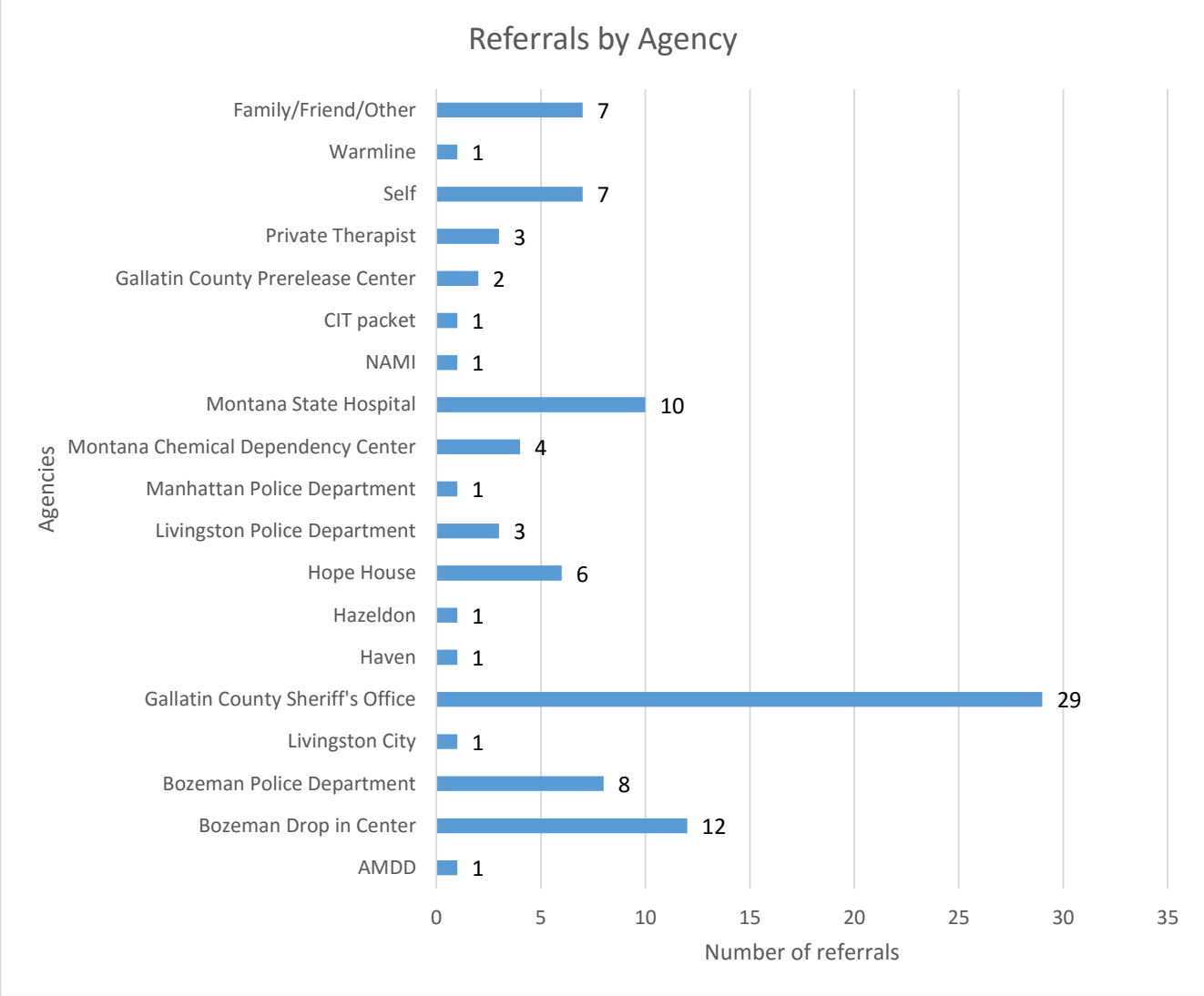
Parameters we established - **When not to call peer support**:

- If the individual is a danger to themselves or others and are being taken into custody
- If law enforcement was arresting the individual and they were booking them
- If the individual was under the influence of any substance and could not follow instructions
- If the situation is dangerous and the safety of the peer supporters is a concern

If the individual was being taken into protective custody that typically meant they were headed to the crisis center where they would receive an evaluation and care. At times we would get a referral from the crisis center after they are stabilized. But this was minimal. Below is a chart breaking down where the referrals by agencies.

Safety is of the utmost importance for peer supporters engaging in community outreach. This should be kept at the forefront when designing a program. While those with mental illness are more likely to be the victims of crime there is an increased risk to recovery coaches performing community outreach.

- Regular contact with law enforcement including responding with law enforcement if needed
- Responding in pairs
- Phone communication when on site alone
- Situational awareness 360 mindset
- Trusting instincts
- Training



Gallatin County Sheriff's Office was the best partner we had on this project and that is reflected in the highest number of referrals. The Bozeman Drop in Center and Montana State Hospital had the next most. The Bozeman Police Department got involved with the project at about the one year mark and provided 8 referrals. An interesting note we had 7 self referrals, these were individuals that came across our organization s website or literature on their own contacted us and let us know they wanted to actively engage in peer support.

In the end we received 18 referrals per month that in turn breaks down to 4.5 new referrals a week all the while we are meeting with the referrals from the past weeks. We have no doubt that the longer a project of this type would operate the larger the list of agencies would be due to increased community.

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> *"Having someone like (a peer support) was/is a life saving experience."* Exit survey comment

One aspect of peer support that we discovered around the one year mark was there was a sweet spot for the type of outreach work we were doing as peer supporters. Simply if the referral was already in recovery or was ready to begin recovery we were in the sweet spot.

As an example, let's call her Sally and she is referred to MPN for peer support. She has had a few encounters with law enforcement and we get a call from the Sargent on duty. We respond to Sally's home, introduce our self and offer support. When we first meet Sally part of our job was to build rapport with her but the other part was to identify where Sally was in the stages of change, Pre Contemplation, Contemplation, Planning, Action, or Maintenance. If Sally appears to be in Planning, Action or early Maintenance stages we are in the sweet spot for recovery and peer support is highly effective. This is why the job title "recovery coach" fits so well to this type of work. If Sally appears to be in contemplation we also have something to work with. But if Sally appears to be in the early stage of pre-contemplation, or more likely in some stage long before pre-contemplation (the "I don't give care stage") then we found peer support is not going to be all that effective because recovery is not even part of the equation and no amount of peer support will change that. In the 12 step world this is the "They have not reached bottom yet stage."

If Sally didn't appear to be ready for recovery we didn't just walk away, we simply took a different approach and changed expectations regarding how the relationship might develop. We still attempted to build rapport with Sally, but as peer supporters we were not expecting Sally to engage at a high level. We made the offer for support, resources and allowed Sally to make her own choice.

The graph on the right shows the percentages of individuals based on their number of peer support contacts.

20% had no contact and 24% had just one contact which totals 44% of the referrals

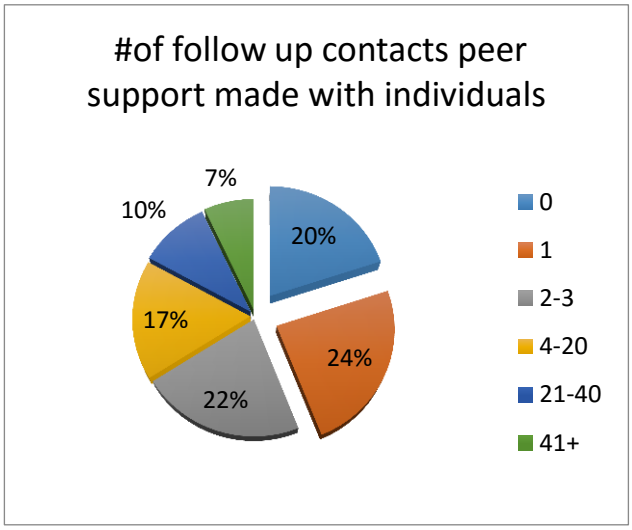
56% were willing to engage with peer support at some level

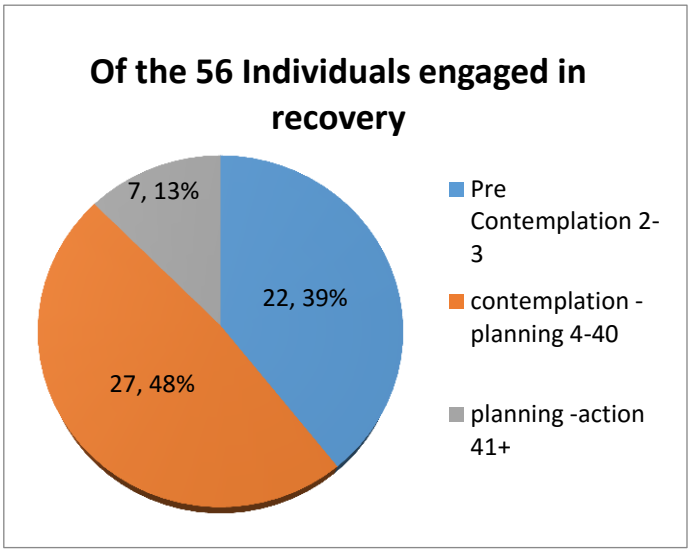
22% met with peer support 2-3 times

17% met with peer support 4-20 times

10% met with peer support 21-40 times

7% met with peer support more than 41 times over the life of the project





This chart on the left looks at the 56% that engaged with peer support. This is the group of individuals that could be identified in the stages of change. We have matched these numbers with the stages of change to better demonstrate this correlation.

39% engaged with peer support 2-3 times (pre-contemplation)

48% engaged with peer support 4-40 times (contemplation- planning)

13% engaged with peer support more than 41 times (contemplation-planning-maintenance)

If course there really is no way to know what stage a person is in definitively these are only our best guesses. We think of peer supporters as agents of recovery, if we are doing our job than our focus should be within the scope of recovery and wellness.

Referral Case Study:

A woman that felt she was in crisis went to Hope House, Bozeman's Crisis Stabilization Center. When she arrived, there were three people ahead of her waiting to meet with the Crisis Response Team for an evaluation she began to escalate and the staff was unable to deescalate her while she was waiting. While at the crisis stabilization center she asked for one of MPN's Recovery Coaches by name. The staff called and left a message for on her behalf. The woman then called directly and left us her recovery coach a message. After calling she told staff that she was getting more upset by being there and that she was going to leave. The center staff told her they would have to call the police if she left. She left anyway and went to the emergency room at Bozeman Deaconess Hospital because she felt safer there. When our Recovery Coach returned her call, the woman was at the ER and the Recovery Coach offered to come visit her. She accepted. The woman talked to the Recovery Coach for two and a half hours at the emergency room waiting for CRT to arrive for an evaluation. The woman and the Recovery Coach talked about what had her upset, how she had coped in the past, and what she felt would help. After a couple of hours, the woman had calmed down and felt well enough to go home, walk her dogs, and go to bed. She hoped that the CRT therapist would agree when he arrived. When CRT did arrive a few hours later they spoke with her and agreed she was ok to go home. The woman made plans to meet with the Recovery Coach the next day.

Referral Case Study:

A man was referred to our program after 29 calls to law enforcement over the previous six months. He was paranoid, depressed and high risk for suicide. He was unemployed, in danger of losing his home and his wife and children had left him. MPN had 41 contacts with him at his home over the next few months offering support and resources. Over those months he began engaging in therapy, a medication regiment and found two jobs. The number of calls to law enforcement decreased to 6 including the initial referral to MPN over the next six months. The individual eventually chose to reconcile with his wife and rejoin his family. Peer support was no longer needed.

Referral Case Study:

I met Sue (name changed) at a crisis stabilization center after a referral from a peer supporter that worked at the drop in center. Sue told me her story, expressed feeling very helpless, and cried often. She had been in institutions continuously over the past year and had been hospitalized repeatedly over the past twenty years. We made a plan to meet after she got home. We began to meet weekly and she would talk about her week, any challenges that had come up, and how she had dealt with them. Over time Sue was increasingly able to handle life stressors more effectively by learning coping skills and recovery tools through peer support. At the end of this project, she had gone 9 months without a hospitalization or crisis center stay. She was applying for part time work, volunteering, studying to get a driver's license, budgeting her money, living independently, building new friendships, mending relationships with family, setting boundaries, and asking for what she needed.

On average we spent a little more than 1 hour with individuals per contact. We did not find any correlation between the amount of time spent with an individual on the initial contact and willingness to engage with peer support or readiness for recovery.

Exit survey Q & A

Q: What was the most helpful part of having a recovery coach?

A: ***Support, having someone to talk to that's been through what I'm going through with my addiction.***

A: … very insightful. Similar background helped. She took her time to help when I was in a bad place and became a good friend.

Staffing for the pilot project

Hiring the right person is important for any employer. Qualities such as reliability, good communication skills, the ability to take direction and work as part of a team are all good standard hiring practices.

Here is what we found we needed when hiring a peer support recovery coach for this type of project:

- Peer support candidate must be in long term recovery (stable)
- Peer Supporter should already have a self-care plan in place
- Be able to articulate their own recovery story and the tools utilized to get there
- Drivers license and a reliable vehicle
- Eligible for auto and liability insurance
- Be able to pass a law enforcement background check
- High level of professionalism
- Ability to work independently at times responding to calls and make sound decisions

From the start of the planning process for this project we wanted to have robust training and support components for the peer supporters. Crisis work requires a great deal of support when you consider the nature of the calls one may be responding to. Repeat exposure to trauma, secondary trauma, high emotional states, and suicide attempts can result in burnout, vicarious trauma and triggering in peer supporters.

Training and support for the Recovery Coach

- Peer Support 101 Training (40hrs)
- Trauma Informed Care (30hrs)
- Crisis Intervention Training (40hrs)
- Compassion Fatigue (7hrs)
- Managing Emotions under Pressure (5hrs)
- Clinical Supervision (3-5hrs a month)
- Wellness and Recovery Planning (5hrs)
- Suicide Prevention Training ASIST (16hrs)
- Flexible Schedule
- Weekly Coaching
- Paid Vacation and Holidays

We found 20 hours per week of direct one on one peer support was a good fit. The other 20 hours was utilized for training, support, supervision, documentation, outreach and office work. This allowed for more balance in the work week for the peer supporter. This also allowed for the two peer supporters to split the week allowing for one peer supporter to always be available. We rotated weekends for on call purposes and only took calls directly during regular business hours and into the early evening. We were advised in the very beginning by law enforcement that the majority of the calls in the overnight hours were involving drugs, alcohol or criminal activity so there was no need for us to be available. We did not set a hard time for cutting off referrals it was at the discretion of the peer supporter on call.

Limitations and Obstacles

Limitations: Peer Supporters are not super heroes. We cannot swoop in and save the day. It is imperative this is stressed to the peer supporters and to those making referrals. If Sally (our mock individual) has been heading in and out of crisis for years often termed a "frequent flyer" peer supporters are not going to be able to change Sally by walking in the door and declaring our self. This is long term relationship building that requires many meetings and a lot of courage and willingness (stages of change) on Sally's part. Peer supporters are there for support.

The next limitation is the skill set of the peer supporter. Even with the large list of trainings and ongoing support peer supporters are very limited. In order to be a licensed therapist one has to attend a college or university for 6 years. The training for peer support is measured in hours or weeks not years. Each peer supporter brings a finite set of skills to work each day and this has limits. Those limits must be recognized by the peer supporter, clinical supervisor and employer. With some of the referral peer support was the only connection the individual had to a mode of treatment. This proved to be very challenging. Some individuals have "burned bridges" with providers, others refused any other form of treatment and sadly some could not afford treatment. This put a tremendous amount of pressure on the peer supporters. In our opinion peer support should be a complement to other treatment modalities, such as therapy, support groups, medication, etc.

Obstacles: In this early stage of project development was encountered obstacles such as "How were we going to do this exactly?" There was doubt from a few partners that we could even do this type of project. We also encountered the "You will be overwhelmed by referrals", comment more than once. We took note of these obstacles and moved forward determined not to be deterred. We held tight to the belief that this would be effective and that being the lead dog is the most difficult position to be in requiring the most courage and strength to persevere.

We also experienced some external factors that were outside our control such as:

- Referring agencies have their own routines (a pilot project is new concept and time is needed to integrate into the usual routine)
- Referring agencies have their own priorities or projects (It's not about you)
- Referring agencies have turnover, new staff are unaware of pilot project program

From the very start of the project we intended to pilot the project to include Park County Montana. Sadly that never came to fruition. We faced many obstacles when attempting to get the pilot project off the ground in Park County. Many of the challenges in Park County were outside our control. The agencies that partner in a project of this type have to be organizationally ready. We found this frustrating and demoralizing at times. Many of the challenges were external to our organization and out of our control such as:

- Lack of community collaboration in addressing mental health crisis
- Community agency staffing issues
- Minimal CIT training
- Readiness for recovery oriented model including peer support

At the start of the project, we had anticipated utilizing data collection from agencies we were working with. It proved to be a difficult collection because some calls may have been originally logged as one thing and then turn out to be a mental health call. Also, there was no way to log our involvement.

The collaboration amongst emergency service providers was varies. Some were very excited about the project beginning and then never utilized our services, some worked with us well from the very beginning and continued to the end of the project.

Funding the Pilot Project

The funding for our pilot project was granted by the Montana Mental Health Trust via Health and Human Services Montana. We had an 18 month contract with Health and Human Services. We provided a quarterly report to Health and Human Services Montana and were reimbursed quarterly. This proved very satisfactory for the purposes of the pilot project. The cost for the pilot was $118, 000. This includes two full time peer supporters, supervision, training, support for the supporters, and mileage reimbursement for travel, insurance and administration costs.

In our opinion new or future programs should have some type of community contribution or matching funding. In Montana Health and Human Services is charged with providing services to those with "severe disabling mental illness". While this would cover the majority of individuals referred to the program there is a large number of people in the community this description would not fit. Our opinion is mental health issues are related to the overall health of a community and how a community chooses to care for its own citizens. Mental health is often pushed aside or left for someone else to pay the tab. Crisis events are costly to the city, county and state. Prevention programs work and if more programs were put into place, it is our belief that we could reduce the overall cost, save more lives and have healthier communities.

Diversion dollar savings are difficult numbers to tally. In the 18 month project our estimate is $298,502. This is calculated by tracking dollars not spent.

- Decrease in number of law enforcement responses
- Days at State Psychiatric Hospital
- Days at local Crisis Center
- Psychiatric Evaluations

Money spent by a community on the front end saves more on the back end of crisis events in terms of repeat utilizations. In other words treatment works, people can and do recover if communities have the services available. If that doesn't happen or services are not available people "fall through the cracks" and enter a cycle of repeat crisis events. These traumatize the individual, jade first responders and cost more because they are repeated over and over again. A reduction in ER visits, crisis stabilization center stays, psychiatric hospital stays, and law enforcement calls helps the entire community. This should be considered for all future programs.

A Peer Supporter personal experience on the impact of the pilot project:

"For me the biggest impact this project had was seeing it work, really work in the community. It was effective in so many ways. It represented recovery and peer support well, we were seen by agencies as a reliable resource they could turn to and most importantly we made the difference in people's lives."

A Peer Supporter's personal experience working in the pilot project

"*One important thing I learned throughout this project was how powerful it can be to just be present with someone, being compassionate and nonjudgmental. I had many instances where I met with someone in mostly silence and they called me later to thank me and tell me how helpful it was. I have noticed in the shared silence is where an individual can find the courage to direct his/her own life. I met with a lot of different people, all in different stages of recovery and situations in life. I did not need to be an expert on any situation or even have a similar lived experience. I just needed a willingness to sit, listen, learn, be compassionate, and nonjudgmental.*

Providing recovery coaching one on one in the community can take a lot of energy. Some meetings were easier than others. To do well in these interactions, it was important for me to have excellent training, know myself (my biases, my triggers, my attitude and emotions for the day), trust my instincts, and not be afraid to ask for help from my director and/or clinical supervisor. Just as it was for the individuals I worked with, talking out situations helped me to find the right direction to go."

Conclusion

The utilization of recovery coaches to outreach to those in crisis can be replicated most anywhere, particularly in conjunction with law enforcement. A full project of this nature does take a bit of time, planning collaboration and resources. Yet, it seems to us that we have to start looking at mental health crisis very differently and trying on different approaches to find something that works. The status quo is no longer acceptable.

We want to thank the Addictive and Mental Disorder Division, Health and Human Services, Montana, Montana Mental Health Trust, Montana Peer Support Task Force, Gallatin County Sheriff's Office, Bozeman Police Department, Bozeman Magazine, Michelle Jermunson, Lynette Rodi, Conan Green, Stacey Wheeler, Jim Anderson, and all of the individuals who stepped up, supported us and worked hard to make this project a success.

If you would are considering a project similar to this one, or are starting your own version of this pilot project we are available for consulting. You can contact us at Montana's Peer Network, 406-551-1058 or Jim Hajny, Executive Director, jim@mtpeernetwork.org.