ABSTRACT

A TRAINING CURRICULUM FOR THE VILLAGE LIFE COACH PROGRAM:

A GRANT PROPOSAL

By

Joe Comer

May 2015

The purpose of this project was to write grant proposal to seek funding to support the Village's Life Coach Program. The project aims to train and pay a stipend to a group of 10 Life Coaches. The funding will enable the Life Coaches to receive trainings that can help prepare them to take on a mentor role while also giving them skills to strengthen their recovery.

The program has an overall goal to prepare Life Coaches with skills that can help facilitate change with the members they work with and with themselves. This goal will be completed by organizing topics that will be covered in the training, recruiting skilled trainers, and developing materials for the training. To ensure that this training program has fulfilled the overall goal, evaluations will be conducted both during and after the program is complete. Submission of the grant was not a requirement of this project.

A TRAINING CURRICULUM FOR THE VILLAGE LIFE COACH PROGRAM:

A GRANT PROPOSAL

A THESIS

Presented to the School of Social Work

California State University, Long Beach

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

Committee Members:

Jo Brocato, Ph.D. (Chair)
Marilyn Potts, Ph.D.
Janaki Santhiveeran, Ph.D.

College Designee:

Nancy Meyer-Adams, Ph.D.

By Joe Comer

BASW, 2014, Humboldt State University

May 2015

TABLE OF CONTENTS

CHAPTER Page

LIST OF TABLES

CHAPTER 1

INTRODUCTION

Problem Statement

Having mental health services that are consumer based are essential to a recovery orientation since PSs provide agencies with an irreplaceable element of hope while reducing the number of hospitalizations for people with mental illnesses (Cook et al., 2011; Solomon, 2004). Despite the positive outcomes discovered by research, clients in peer roles have asserted they needed more training and support because they felt inadequate to handle particular situations (Moran, Russinova, Gidugu, & Gagne, 2013; Mowbray, Moxley, & Collins, 1998).

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) recorded over 18% of Americans suffering from any kind of mental illness and at least 4% of people in the United States suffer from a serious mental illness. The Long Beach Community Health Assessment (2013) data compared the national average of hospitalizations for mental illness with those of southwest Long Beach's hospitalization rates and found residents of Long Beach were twice as likely to have been hospitalized for mental illness than residents nationwide. The number of those with mental illness in the United States and the number of those taken to inpatient facilities indicated that a cost effective approach would be beneficial. Having peer specialists who are well grounded to

take on the responsibility of mentoring people with similar life experiences is needed; this makes trainings that instill knowledge and confidence to PSs.

Background

A lack of knowledge on how PSs can effectively use their experience to engage with clients leaves them at a disadvantage, which can inevitably affect their recovery and their relationships with their peers (Moran et al., 2013; Salzer, Schwenk, & Brusllovasky, 2010). Qualitative research that examined the experiences of adult mental health PSs found that trainings could have provided greater competency and confidence, specifically in the following areas: boundaries within the PS role, proper use of self-disclosure, and meeting the recovery goals of clients and the PSs.

Having tools that could help PSs build relationships while providing a service was explored in a study by Moran et al. (2013). Interviews were conducted with 31 employed PSs and verified a need to have trainings that taught gave strategies to create professional boundaries. Participants in the interviews recalled moments when it was difficult to find ways not to become entrenched in the lives of their clients due to having had similar experiences, suggesting incorporating coping skills in trainings to be a worthwhile endeavor. Mancini and Lawson (2009) reported that in their in-depth interview study of 15 PS experiences, re-traumatization was a risk for PSs due to the closeness that they felt toward the client's experiences. This study concluded *blurred boundaries* between PSs and the people they served (Moran et al., 2013).

Moran et al. (2013) found that training enabled PSs on ways to use proper self-disclosure so that their client's needs are being and so healthy boundaries can be made.

Salzer et al., (2010) confirmed this through the data collected from their survey research with 291 certified PSs in 28 states. The results revealed a need for PSs to be able to find ways to talk with their clients about their experiences with dating, finding work, and connecting to religious/spiritual resources. It is equally important to have a portion of trainings that focuses on lived experience to enhance one of the PSs' strengths, the ability to share with people facing similar dilemmas. Those in a coaching role can gain something from having that skill along with tools that allow them to support the recovery aims of their client peers.

The studies highlighted moments when PSs did not have the skills to assess with their peers the goals they wanted to reach (Moran et al., 2013; Salzer et al., 2010). Interviews by Moran et al. (2013) found that participants who were PSs requested more trainings that focused on how to communicate issues that clients presented. Moran et al.'s (2013) study suggested that future training programs find ways to integrate social work related interventions in the training curriculum so PSs have access to evidence-based practices to help in assessing client needs and recovery aims. PSs brought up a recurring theme in the interviews, stating that they did not have the means to handle a crisis; this uncovers how trainings can better assist PSs in going over the protocol for such events. The benefit of PSs learning ways to help their peers reach their recovery goals is unquestionable, but the need for PSs to ensure that their recovery remains in progress should be addressed as well.

Purpose

The purpose of this project was to write a grant to fund a training program for the Life Coaches at the Village in Long Beach, California.

Definitions

Vision of recovery: A form of care that allows clients to be part of their care by instilling "hope, personal empowerment, respect, social connections, self-responsibility, and self-determination" as defined by the Mental Health Services Act (2012, p. 5).

Peer Specialists (PS): Are employed to give peer support at a mental health agency where they receive or still receive services. (Depression Bipolar Support Alliance (DBSA), n.d.)

Member: A client who receives services at the Village (MHA Village, n.d.)

The Village: A mental health agency in Long Beach California (MHA Village, n.d.)

Life Coach: A member who acts as a peer support person for other members in the program (MHA Village, n.d.)

Cultural Relevance

The host agency serves a racially diverse population of people as recorded by the 2013 Long Beach Community Health Assessment. Data reported from Long Beach's south bay area showed that the adult racial groups who reported the most serious psychological distress were white people at 5.0% and Hispanic/Latino people at 3.6%. The two racial groups who were more likely to consider suicide as an alternative were Black/African American people at 15.2% and Asian people at 11.6% (Long Beach

Community Health Assessment, 2013). The data showed the necessity for mental health service providers to be aware of cultural differences and to understand the role sociocultural factors play. Peer based services can play an important part in reducing hospitalizations for mental illness and providing a vision of recovery. These peer specialists (PS) can gain much from a training that includes an understanding of Long Beach's diverse population.

Social Work Relevance

The Code of Ethics of the National Association of Social Workers (2008) emphasizes the need to provide quality services to clients. This makes it important to promote the best interests of clients, which according to the literature means providing training to PSs that will allow them to be successful in their roles. The Code of Ethics also respects the rights of clients to self-determination regarding their care. This makes a well-funded training program an informative resource for PSs wanting to help clients and themselves decide their recovery goals.

CHAPTER 2

LITERATURE REVIEW

The goal of this review is to find how to effectively support PS in mental health services for the sake of their recovery and the people they work with. This insight will be used as well to inform what future trainings could be useful for Life Coaches program of the Village. A review of the literature was conducted to evaluate factors that influence PSs in the field today. These factors include the following: the recovery model, origins of peer support and PSs, use of self-disclosure, self-management; barriers and supports, and current state of PS trainings.

Recovery Model

An important foundation that has influenced the way mental health services have been conducted is the recovery model, a framework that has challenged previous ways of thinking by giving clients with mental illness control over their treatment. With this in mind, it is important to consider what the recovery model is, the origins of the model, how it has become instilled in mental health policy, how it has incorporated peer support, and how has it been organized to ensure clients can reach self-sufficiency.

The recovery model includes components that allow clients to have choices over their care (Anthony, 2000). Jacobson and Greenley (2001) described recovery as a process that includes meeting the needs of both internal and external factors. The internal

factors that they described in the article were hope in one's own recovery, empowerment in one's self that gives courage and a sense of autonomy while in recovery, the separation of the mental illness and the client, and connection with social supports in the community. External factors included human rights, a positive culture of healing, and having recovery oriented services. Other factors that recovery models have emphasized are responsibility, autonomy, growth, adaptability, peer support, self-respect, and trust (Sowers, 2005). The recovery model does not require that all symptoms from a mental illness be eradicated, but only controlled enough so that the person diagnosed can cope with his/her symptoms (Anthony 2000).

The evolution of how the recovery model came to be so prominent has to do with the history surrounding it. One of the first organizations to use components of the recovery model was Alcoholics Anonymous (AA) in the 1930s (Sowers, 2005). The persons involved in organizing this movement were aware of both the internal and outer stimuli that affect addiction, making them realize that only relying on abstinence education is of little benefit to those with alcoholism. Similar techniques that were used by AA groups across the country helped create the organization Recovery Inc., founded in the 1950s by psychiatrist Dr. Low. His organization emphasized the need for clients with psychiatric illnesses to develop autonomy and encourage them to find their path to achieve success. Eventually, Recovery Inc. saw the benefit of having partnerships with different agencies with similar perspectives; this partnership is a part of why mental health policy today has been challenged to incorporate a recovery model framework (Sowers, 2005).

Anthony (2000) reported the factors that led to state governments incorporating a recovery framework as a model required for their departments of mental health. One of these factors included the Community Supports System (CSS), a model developed in the late 1970s to address the needs of those with severe mental illnesses without isolating them from the community (Turner & Shifren, 1979). CSS principles were referenced while trying to describe what a recovery model might look like for different agencies and state organizations (Anthony, 2000). Original standards of the recovery model have shown to have their connection with Assertive Community Treatment programs (Sowers, 2005), which is a team based approach of ensuring that those with severe mental illnesses stay connected with services and improve their quality of life while reducing the frequency and duration of hospitalization (Marshall & Lockwood, 1998). Jacobson and Curtis (2000) highlighted that states have incorporated recovery model knowledge in different agencies by utilizing education strategies, emphasizing the importance of crisis work and relapse prevention, and involving community members and those who use mental health services. One-way community involvement was effectively utilized by having people diagnosed with mental illness to provide the care.

Peer support is a key piece of the conversation when discussing the recovery model. Supporters of peer-run services have argued that these kinds of support systems are some of the most authentic recovery oriented services available (Jacobson & Curtis, 2000). Much of this has to do with peer support providing social connections that can fuel self-esteem, provide stability in the face of stressors, and provide useful feedback, which gives people in recovery a chance to reflect on their growth (Solomon, 2004). Noordsy et

al. (2002) reported that peer support gives an option for people in mental health services to be counseled by someone who has been through similar experiences, giving those who may have difficulties with trust an opportunity to have facilitated recovery. They described it as a relational model that helps those with mental illness find ways to develop different ways of thinking that are more beneficial. It is these characteristics of peer support that can help the recovery model's mission of guiding those with mental illness toward independence.

Self-determination was said to be "the cornerstone of a recovery process" (Farkas, 2007, p. 71). As described by Jacobson and Greenley (2001), the aims of recovery are to gradually have clients establish self-awareness so they can cope with the symptoms of their mental illnesses. In order to make it to this point, they recommended that practitioners start delving out of their comfort zone and take more responsibility for their choices, their judgments, and the tasks they take on. It was emphasized by Farkas (2007) that clients who agree to the terms of the care provider are not necessarily doing so with meaningful intent. In order to ensure that clients can find this meaningful intent behind what they choose, services are encouraged to explore with clients what they hope to achieve in their future and create opportunities for them to get closer to those hopes; this also encourages them to practice making thoughtful decisions based on what they want. This requires that service providers who give options to clients give all information available.

One way that the recovery model has been quantified in agencies is through a measurement tool called the Milestones of Recovery Scale (MORS), which scores what

level someone is in his/her recovery. The MORS measures individuals on an eight-point scale in regards to "(a) level of risk, (b) level of engagement with the mental health system, and (c) level of skills and supports" (Fisher et al., 2009, p. 247). A study by Fisher et al. (2009) tested MORS reliability using participants from the Village and the Vinfen cooperation. They found that MORS could be used as a reliable way of measuring someone's recovery; however, they stated that MORS is a tool primarily for administrative purposes.

Origins of Peer Specialists and Peer Support

One of the first starts of utilizing peer support began with Harry Stack Sullivan, a man in the 1920s who was the administrator of an inpatient facility for men who were diagnosed with schizophrenia (L. Davidson, et al., 1999). Sullivan offered men who had recovered from their mental illness a chance to give guidance to those who had the same diagnosis; this kind of intervention impacted the way service providers thought about the potential of peer support. From the 1970s to the 1990s, the deinstitutionalization led to care providers needing to find new ways to connect clients to community services that were approachable and did not rely on hospitalizations. These factors have inspired the movement to have peers in mental health services play a role in not only their recovery but also the recovery of others. Peer support has evolved into the functioning definition that is now being utilized in different agencies.

Peer support gives a kind of facilitated care that cannot be achieved by formal mental health service providers. It allows people who are diagnosed with a mental illness a chance to assist someone with a similar history (Solomon, 2004). This kind of resource

can be facilitated in different capacities. Examples of the different kinds include mutual support groups and PSs. Mutual support groups allow people to process their recovery experiences with others and gain insight into different perspectives that can help shape their vision for the future more effectively (L. Davidson et al., 1999). Employing PSs, also known as consumer-run services, allows those with mental illnesses to gain support from a paid employee who has experience coping with his/her own mental health barriers that tend to be more structured than mutual support groups. Not only do those with the mental illness receive that empathetic connection with someone else, but those individuals providing peer support can potentially receive benefits as well. The opportunity for people with a mental illness to have role models provides those individuals a chance to gain hope and motivation to strive for recovery, which according to the recovery model is a huge strength (L. Davidson et al., 1999). In order to evaluate peer support overall, it is important to consider what the reported outcomes are for the different kinds of peer support.

Outcome Research

Support groups for those with mental illnesses have been deemed both positive and negative by the research. Noordsy, Schwab, Fox, and Drake (1996) did a study over the course of 4 years with 18 people with alcohol use disorders who were getting services at a mental health and substance use treatment program. They reported the experience of the patients who participated in 12 step support groups and found there were both strengths of being a part of that intervention and barriers. Some participants of the study reported that they were able to make social linkages and find designated sponsors to help them cope

with their addiction. Another strength was the empowerment some received from helping someone in need. Barriers that existed for participants were the fear of participating in the group setting and their view that the environment in the group had a value system that did not allow participants to decide what was best for them.

Peer specialists have their own outcomes when it came to the success rates of their role with others in the field. A review of the literature by Repper and Carter (2011) confirmed that the relapse outcomes for clients working with PSs were the same as those clients who were working with traditional mental health providers and teams that were made up of all PSs had fewer clients who were hospitalized than teams without PSs. They found that those who worked with PSs did not refer to self-stigmatization as a barrier to recovery compared to others who did not have PS's. Those same people also had a stronger belief that they had a brighter future. Potential barriers as the result of the power differential between consumers and PS's were addressed by Repper and Carter (2011), as well as the ethical issues regarding setting and maintaining boundaries for the PS.

A study examined whether a PS training that certifies individuals had positive outcomes. Salzer, Katz, Kidwell, Federici, and Ward-Colasante (2009) concluded that a PS training made to certify individuals had improved outcomes in multiple areas. On the pre-test before the training, the mean score of those who participated was 62% correct; the post-test that was given after the program's completion showed a mean score of 84%. Job prospects for those who were certified were also high. Ten out of the 15 participants who were unemployed before the training program found jobs after its completion. Most (51) of the 63 participants were able to become recruited in PS positions, reported high

satisfaction from their roles, and found their coworkers and supervisors to respect them.

A systematic review of the literature revealed some of the positives that come from utilizing peer delivered services and some factors that have not shown high outcomes (Rogers, Kash-MacDonald, & Brucker, 2009). The review of the experimental and quasi-experimental studies of peer delivered services added to traditional supports showed that while there are no distinct positive outcomes for individuals who use peer delivered services, some of the studies found that there were advantages. Most studies that reviewed peer delivered services showed that peer supports in a group context had positive outcomes. The literature examining peer support in group work and the literature reviewing peer supports being implemented in drop-in centers found that they did help individuals develop better coping skills and greater self-esteem.

Research on Peer Specialists

Several studies revealed that PSs could facilitate both a client's recovery and their own. The Rand Corporation (2012) conducted research that interviewed five people who received mental health services and held a focus group of 21 staff members. The PSs who were part of these groups reported positive outcomes while working with other people with mental illness. After attending a knowledge and skill building training, a majority of the PS respondents said that they felt it was easier for them to communicate with other clients and that they had a grasp of tools that could assist them in the field.

An evaluation of 121 women volunteers who had recovered from postpartum depression and were serving as PSs was conducted by means of a survey (Dennis, 2013). One hundred and fourteen of these women said that they felt the training made them more

confident to work with people diagnosed with the same mental illness (Dennis, 2013). These women emphasized that they felt the training's strong points were its presentation style, its content, and its resource guide, which provided case examples that the PSs considered useful.

Moran, Russinova, Gidugu, and Gagne, C. (2013) uncovered through interviews of 31 mental health PSs that the training they received helped them view their recovery in a different way, feeling more hopeful and inspired by the process. Moreover, the trainees reported that the knowledge gained could benefit their recovery.

Thus, when a proper training was provided for PS in mental health fields, many of the outcomes were positive. When training is implemented and facilitated effectively, those in peer supportive roles gain exposure to knowledge that allows them to better understand recovery (Dennis, 2013; Moran et al., 2013; Rand Corporation, 2012).

Most of the above studies' participants who offered peer support found that the trainings helped them build a network of support consisting of PSs with similar experiences (Dennis, 2013; Mancini & Lawson, 2009; Moran et al., 2013; RAND Corporation, 2012). Many of the PSs were recorded to have disclosed personal information during the training that allowed them to discuss a struggle they were going through in regards to their work and mental illness (Moran et al., 2013). The safe environment in the training for PS's was said to have helped their recovery and increased their confidence level because of the nonjudgmental attitudes in the cohort. After those in mentor roles participated in the trainings, there was an increase in confidence when it came to future goals. Participants in the study felt encouraged to continue taking extra

courses at school to reinforce what they learned in the training (Moran et al., 2013; RAND, 2012).

The research shows the importance of educating individuals in PS roles not only for the sake of those they serve, but also for the recovering PS. What these show was the benefit of having educational opportunities for people in mentoring roles. It is important to consider the need for more studies to evaluate how much training programs increase the objective and subjective effectiveness of PSs.

A lack of knowledge on how PSs can effectively use their lived experiences to engage with clients leaves them at a disadvantage, which can inevitably affect their recovery and their relationships with their peers (Moran et al., 2013; Salzer et al., 2010). Qualitative research that examined the experiences of adult mental health PSs found that trainings provided greater competency and confidence, specifically in the following areas: boundaries within the PS role, proper use of self-disclosure, and meeting the recovery goals of clients and the PSs.

Having the tools that could help PSs build relationships while they were also providing a service was desired by peer supporters. Moran et al. (2013) conducted a study consisting of interviews with 31 employed PSs and verified a need to have trainings that taught strategies to create professional boundaries. Participants in the interviews recalled moments when it was difficult to find ways to not become entrenched in the lives of their clients due to having similar experiences. Interviews of 15 PSs (Mancini & Lawson, 2009) found that re-traumatization was a risk for PSs due to the closeness they felt toward the client's experiences. They concluded was the result of blurred boundaries between

PSs and the people they served (Moran et al., 2013).

Moran et al.'s (2013) findings from a qualitative study using semi-structured interviews with 31 PSs underscored the importance of training on self-disclosure when 58% of the respondents identified this as topic for which they needed more training. He suggested training PSs on intentional disclosure of their recovery experiences that can meet client needs. This can reinforce the PSs' understanding about what and when it is healthy to self-disclose. Salzer et al., (2010) confirmed the importance of training through their survey of 291 certified PSs in 28 states. The results revealed a need them to be able to find ways to talk with their clients about their experiences when it comes to dating, finding work, and connecting to religious/spiritual resources. It is equally important to have a portion of trainings that focuses on lived experiences to enhance one of the PS's strengths that allow him/her to share with people facing similar dilemmas. Those in a coaching role can gain something from having that skill along with tools that allow them to support the recovery aims of their client peers.

Other studies have highlighted moments when PSs did not have the skills to assess their peers with the goals they wanted to reach (Moran et al., 2013; Salzer et al., 2010). Interviews by Moran et al. (2013) found that participants who were PSs requested more focus on trainings on how to effectively communicate about concerns regarding the recovery process that were raised by clients. Moran et al.'s (2013) study suggested that future training programs should find ways to integrate social work related interventions in the training curriculum so that PSs have access to evidence-based practices to help in assessing client needs and recovery aims. PSs brought up a recurring theme in the

interviews, stating that they did not have the means to handle a crisis; this uncovers how trainings can better assist PSs in going over the protocol for such events. The benefits of PSs learning ways to help their peers reach their recovery goals are unquestionable, but the need for PSs to ensure that their own recovery progresses should be addressed as well.

Facets of Self-Disclosure

Self-disclosure is an issue that therapists grapple with due to the ethical issues surrounding it (Peterson, 2002). Since one value of trained PSs is that they can disclose their experiences of their recovery process, it is essential to have an understanding of the following: the elements of that make-up self-disclosure; the effectiveness of the use of self-disclosure; and the ethical considerations involved with self-disclosure.

There are a variety of ways that someone could self-disclose information. Self-disclosure was defined by Goldstein (1994) as consciously sharing information about oneself either verbally or non-verbally. Raines (1996) discussed the ways individuals can non-verbally disclose personal information to clients as including the kind of clothing they wear, the way the workspace is arranged, and their pattern of speech. The timing of certain elements of the practitioner self-disclosure varies based on the content. Raines (1996) noted that information that the client has the right to know is usually established during the first session. These details include work experience, the cost of visits, and the way they conduct services. Knox and Hill (2003) said in their review of the literature that therapists reported disclosing personal information not just to achieve short-term goals, but to benefit the whole recovery process. Therapists said that other reasons they disclosed were to help build the therapeutic relationship, to stimulate new ways of

approaching situations, and to have clients feel validated by revealing similar experiences. Clients who received disclosed information by the therapist stated they felt that therapists use this tactic to make them feel comfortable and to help them find new ways to approach problems.

The studies in the Knox and Hill (2003) review that reported the outcomes of self-disclosure had shown mostly positive results when it came to clients' experiences, indicating that intentional release of information can be beneficial. Hill and Knox (2003) uncovered through the literature that that clients felt that self-disclosure made them feel more connected to their practitioner and helped them develop a new perspective on what they were going through. Six studies that were reviewed had mixed results regarding whether their recovery was impacted by self-disclosure. Despite this, two other studies recorded a positive association between therapist disclosure and treatment outcome.

A study by Barrett and Berman (2001) asked 36 therapy clients ranging from ages 18-42 a series of question on multiple scales to evaluate their expectations of the session, personal improvement, the recurrence of their symptoms, the amount of information disclosed, and how much they liked the therapist. Their report confirmed that the participants perceived their therapists as more friendly and that their overall symptoms were reduced whenever therapists utilized personal disclosure.

The ethics that surround the use of self-disclosure should be considered in order to ensure the client's recovery is not hindered. Peterson (2002) stated that self-disclosure could potentially break ethical standards if the therapist/practitioner is disclosing information to fulfill his/her needs and not the client's. The use of self-disclosure by

practitioners must then consider if their reasoning for disclosing information is a form of a countertransference. Goldstein (1994) highlights moments that therapists may commit countertransference when service providers want their work validated by the client or if the therapist wants to relate to an experience the client has previously had.

Self-Management Barriers and Supports

Self-management for PSs requires taking responsibility for their health and wellbeing and engaging in behaviors that mitigate their distress (Lorig & Holman, 2003). Self-management practices can develop with those who have mental illnesses by addressing the barriers preventing positive change and what interventions could help people navigate through these obstacles. Identifying what barriers get in the way of self-management should be the first step.

A study conducted by Baylis et al. (2003) revealed the factors that hindered people from continuing self-care behaviors to manage their comorbid conditions. Baylis et al.'s research consisted of semi-structured interviews with 16 adults who stated that they had two or more medical conditions. During the interviews it was revealed that 14 stated that the symptoms of their illnesses prevented them from being able to get to places and access resources that would help manage their conditions. Over one third reported that complications with their medications hindered their performance due to the effects they cause or the difficulty of scheduling when to take what medicines. One half of the people from the interviews discussed how a lack of knowledge of their conditions, financial concerns, loss of control, and the dominance of one symptom over another all were barriers, as well as inadequate communication with their providers and lack of social

support. A few reported times when doctors, friends, and family members did not understand their conditions, which could make it difficult to practice self-care activities. Physical health has shown to be more difficult to maintain when one has severe mental illness. Based on a sample of 98 women and 136 men, it was found that people with mental illness were eight times more likely to be obese (S. Davidson et al., 2001). The percentage of men who reported they smoke was 68%, 54% of women reported they were smokers, and 54% of smokers would have at least 20 cigarettes per day.

This insight into what barriers are preventing people from developing self-management behaviors can enhance the interventions taught to PSs to empower them with knowledge that can facilitate their recovery while supporting someone else's. Two of these interventions supported by the research are mindfulness training and the Wellness Recovery Action Plan (WRAP).

Mindfulness is the training of the mind to be conscious of the present as opposed to ruminating on thoughts (Baer, 2003). A review of the empirical evidence found that mindfulness based interventions have helped individuals develop coping skills to self-manage physical and mental conditions. The Melbourne Academic Mindfulness Interest Group documented mindfulness having its origins in Buddhist traditions.

Shapiro, Brown, and Biegel (2007) showed through their study the effects a mindfulness program can have on prospective therapists. Their research evaluated graduate counseling students at a private university and compared three types of psychology courses. The control group consisted of a research methods course and a psychological theory course while the intervention class was a mindfulness training

intervention. They scored people using different pre- and posttests that measured mindfulness of emotions, distress and well-being, stress and anxiety, and rumination. They found that the participants in the mindfulness class had lower stress, anxiety, and rumination while also having an increase in self-compassion. This study demonstrates the impact of a mindfulness intervention can have on those in helping professions, including PSs.

WRAP has shown to be a useful tool when helping individuals with mental illness develop a plan to address internal and external forces that act as barriers and strengths during their recovery (Fukui et al., 2011). This knowledge is used to build skills to help manage psychiatric symptoms. Five research sites offered one to six groups that each taught at least four members the WRAP methodology. The results of the study showed that after participants received the WRAP, their psychiatric symptoms reduced while their hope increased. Another study conducted by Cook et al. (2011) discovered similar results after 519 people with severe mental illness participated in a peer led WRAP workshop. The ones who received the WRAP experiences reported better outcomes compared to the control group, which included scores on the brief system inventory (BSI), the hopefulness scale (HS), and the World Health Organization Quality of Life Brief instrument (WHOQOL-BREF).

Self-management has also been utilized in other formats, which include advance directives. These have been utilized in mental health services to give people with psychiatric disabilities an opportunity to decide for themselves what is the kind of care they want to receive (Amering, Stastny & Hopper, 2005).

Advance Psychiatric Directives

The effectiveness of advance directives and their implementation will be examined to see if this form of self-management has helped give those with mental illness autonomy over their decisions. Psychiatric advanced directives (PADs) have been utilized as alternative when helping people navigate through a crisis in their lives instead relying on traditional techniques (Van Dorn, Scheyett, Swanson, & Swartz, 2010). Some of the criticism of PADs is that implementing them within services can be difficult and that it is questionable if they are legally binding for care providers to follow (Henderson et al., 2010). The way that PADs have developed today comes from legal cases dated from both the 1970s and 1990s, which gave power for patients in medical services to have informed consent over the care they got even if they could not say so themselves (Van Dorn et al., 2010). Studies have shown those with severe mental illness felt encouraged to complete one after being informed on what it was: one study said 40% were interested, and a second study said 67% to 77% were interested. These two studies did reveal that those who actually completed a PAD were in the 4% to 13% range. A questionnaire and a post-questionnaire were given to a mix of "consumers, caregivers, mental health providers, and researchers" (Henderson et al., p. 1, 2010) to evaluate what effects PADs can potentially have. They found through the answers respondents gave that their were mixed opinions if PADs could be empowering for individuals, but could depend on how they are framed to the one receiving services. The respondents agreed that those providing medical services could be barrier to applying PADs if they have a lack of information on the subject or if they do not utilize effective communication.

Conclusion

The examination of this literature was meant to establish how a training program that will educate PS should fill in the gaps of knowledge while considering environmental factors, current programs in place, and historical origins. Committing to a thorough search of the literature helped to inform this grant proposal on the following: the recovery model, the origins of peer support and PSs, the use of self-disclosure, the self-management barriers and supports, and the success rates of PS training initiatives. This information collected will provide support for a grant, which will fund a training curriculum for the Life Coaches program of the Village.

CHAPTER 3

GRANT SEARCH

Identification of Potential Funding Source

Funding sources were located through multiple searches through the Google Search engine. The grant writer utilized the Long Beach State University database and could not find programs that would take the grant proposal. Key words that helped most to finding grants included the following terms: mental illness, California, Southern California, Los Angeles, LA County peer mentor, and education. Terms that were not helpful in the search included: PS, Life Coaches, consumer-based services, public health, workforce programs, and trainings. Along with independent Internet searches, collaboration with colleagues at California State University, Long Beach and the Village were used. Jo Brocato, my thesis advisor, Erin Von Fempe, the Deputy Consultant of the Village, and Connie Jones-Parker, the Employment Administration Manager, recommended places that have taken grant requests like mine in the past and provided insight on how to focus it.

Both methods helped narrow a search for a potential grant that could help provide some financial support to the Life Coaches program. The Google Search helped me uncover the full scope of what financial resources existed while consulting experienced social work professionals gave feedback on which foundations have more chance of

reviewing my proposal favorably. Once it was settled what funding sources existed, it came time to deciding which option fit best with the interests of the proposed project.

Criteria for Selection of Actual Grant

This grant proposal would be providing some financial support to an already self-sustainable program at the Village. This means that the kind of grant that would fit this project's best interest would be a 1-year grant that would give some financial support and not an amount that would exceed the already established Life Coaches budget. The foundation/organization providing the finances would have to match with the grant's goal of better reaching those with mental illness. The organization's geographic focus must include Los Angeles County and/or all of Southern California as an area they would be willing to funding toward. The organization should be offering a grant that provides temporary support and was made to give some assistance to an already existing program or non-profit agency. The organization would need to be open to requests for proposed budgets that are $25,000 or less.

Description of Funding Source and Submission Process

The small grant program of the Weingart Foundation was selected due to it meeting the requirements of this grant proposal. Since 1951, the Weingart Foundation has been a grant making organization that has been funding efforts to improve health, education, and human services. They have a particular interest in funding projects that address the needs of people who are lower income, homeless, and/or have disabilities. Organizations that apply must be located in the following counties: Los Angeles, Riverside, Orange, Santa Barbara, and San Bernadino. The Weingart foundation has

funded over $970 million worth of grants and in 2014 they funded 107 grants, which totaled $32,000,000.

The process to apply to this foundation's small grant program does not require a letter of inquiry, but does require the submission of certain documents to prove the Village's non-profit status before an application can be submitted online. They requested what specific activities or materials would be funded and a plan on how the program would sustain itself after the grant ends at the end of the year.

Needs Assessment and Collection of Data Needed for the Grant

Information on the target population and the proposed solution was investigated through a review of the literature and consultation of mental health professionals in both academia and the field. The research revealed that those in PS roles who cannot effectively use their lived experiences to engage with clients are left at a disadvantage, which can inevitably affect their recovery and their relationships with their peers (Moran et al., 2013; Salzer et al., 2010). Based on the research, an incredible need for trainings that can help PS learn how to build boundaries, disclose experiences, and serve their peers was considered for the grant (Mancini & Lawson, 2009; Moran et al., 2013). This research was discussed with the Village Deputy Consultant and Employment Administration Manager and they confirmed that having this instilled in the Life Coaches program would be beneficial to their agency's goals of improving positive rehabilitative outcomes. Due to the physical health disparities faced by those with mental illness, they found that a useful skill Life Coaches should obtain would be CPR. They concluded that

funding for training facilitators and materials for the members would be a useful investment.

CHAPTER 4

GRANT PROPOSAL

Problem Statement/Statement of Need

People with mental illness have multiple barriers to meeting their recovery goals and finding their path. Having an opportunity to take on a productive role in their community empowers them to have a sense of purpose and self-determination (Dunn, Wewiorski, & Rogers, 2008; Leufstadius, Eklund, & Erlandsson, 2009). Training and hiring consumers who utilize mental health services as peer mentors gives those individuals the opportunity for them to help others cope with obstacles in life. These trainings that provide a network of support and a better understanding of a mental health framework (Dennis, 2013; Moran, Russinova, Gidugu, Yim, & Sprague, 2011; Rand Corporation, 2012) have helped give those in peer support roles the skills and resources to be positive forces of change in their positions. These trainings can inform employed peer support of the strengths of their positions and how to use them effectively. These strengths include having personal experience in recovery and providing a form of natural support, which help peers learn how to cope with their psychiatric symptoms (Solomon, 2004). In order to ensure that these peer mentors can achieve this, they must become competent in how to help others while also maintaining their recovery. Two separate studies conducted interviews with 15-30 peer mentors working in mental health services

and uncovered that many of them reported needing to learn skills for using their life story and lived experience and that they lacked basic helping skills. A few reported they experienced a reemergence of symptoms because of overwork and the people they served had similar experiences (Mancini & Lawson, 2009; Moran et al., 2013; Salzer et al., 2010). By giving peer mentors the opportunity to learn skills to help themselves, they will also be able to make a positive impact on those they serve by helping them build insight into how they wish to frame their recovery. Funding opportunities for people in these positions to learn skills on how to perform successfully when providing service can reduce harmful outcomes.

Description of Agency

The Village is a mental health agency in Long Beach California and is an affiliate of Mental Health America of Los Angeles (MHALA). They launched their program in 1990 and have strived to provide integrative care to adults and young adults with mental illness by providing the following services: personal service plans, psychiatric care, employment, substance abuse recovery, housing assistance, financial services, and community involvement (MHALA, n.d.). The Village has designed its own philosophy and principles to guide the way their services are conducted. These principles include: encouraging members (clients) to have a say in the choices they make toward recovery; to focus on the quality of life of members; and to have members become more integrated in their community while achieving recovery. The services at the Village are available to the members all hours. Integrative care at the Village is based on founding psychiatrist Dr. Mark Ragin's four stages of recovery: hope, empowerment, self-responsibility, and a

meaningful role in life. It is a model that has become recognized nation wide as an effective approach. In 1999, AB 34 projects were influenced by the Village's approach to mental health that seeks to improve California's way of conducting mental health services.

Population Being Served

The Village will train 10 members who will be employed as Life Coaches for their peers. The Life Coaches will be chosen from interviews with staff that show signs of being independent, have an ability to work with their peers and have an interest in helping others reach their recovery goals.

Description of Project

The Village has restarted their Life Coaches program, which aims to give people utilizing the Village services an opportunity to become peer mentors (Life Coaches) for others using the same services. The proposed program would train peer mentors to engage with people with mental disorders while learning skills that will maintain their recovery. Because this program is at the beginning phase of development, it is in need of funding that can support its goal of providing facilitated trainings and resources that can guide Life Coaches to success.

Objectives of the Project

The goal of this program is to provide opportunities for Life Coaches to learn skills that can help them become mentors for those they serve while also learning how to manage their recovery. To provide this support, trainings will be provided to Life Coaches that will provide helping skills that can increase their confidence in their roles while improving the community they serve. The topics of the trainings will be based on

the comprehensive review of the research and implemented through the insight and skills of the Village staff members. These educational opportunities will include CPR, since the lifespan of those with mental illness has been shown to be 30 years less than the average lifespan due to unhealthy choices (Scott, & Happell, 2011). Trainings will outline for Life Coaches the way services are operated at the Village and will instruct them on what their peers can/cannot access.

The other portion of the training curriculum will consist of trainings on how to manage one's care. This will be given in order to help Life Coaches develop skills in managing their life and recovery. Trainings that will provide skills on how to use one's own experience while providing services will give tools to Life Coaches on how to approach situations with people with similar life experiences.

The curriculum that will educate Life Coaches on how to manage their recovery while supporting others will draw from International Association of Peer Supporters (iNAPS) national practice guidelines, which emphasize the strengths of peer supporters to engage with other peers as their equals and that the relationships they make should be reciprocal. The guidelines have highlighted the importance of peer supporters. "Peer supporters strive to build peer relationships" (p. 5), a quality that will help construct the way Life Coaches are taught to interact with members.

Objective #1: Life Coach Training Curriculum

The training curriculum will consist of training topics for Life Coaches and the dates and times they will be scheduled throughout the year. The Village will draw from similar projects that were geared toward ensuring the success of peer supporters. These

projects have been compiled on a Peer Support resource list created by the National Health Care for the Homeless Council. Subjects that will be focused on during the year's curriculum will include:

1. Operations of the Village
2. Understanding the Life Coach role
3. Ways to engage with other members
4. Tools that can empower positive self-care behaviors

Objective #2: Connecting to External Facilitators

The Village will identify people within in the Los Angeles area that can provide facilitated trainings in topics listed above. A search through compiled resource lists will be done to find organizations that have history in providing trainings in CPR, organization of the agency, self-care, and engaging peers. Once the searches through the resource lists have been exhausted, search engines will be used to find services locally available. The Village will recruit from their organization or MHALA to instruct Life Coaches about the way the Village services can be accessed and what is available to members. A facilitator will also be located to teach skills to help Life Coaches self-manage their recovery. A representative from an organization with a history of providing peer support will also be recruited to provide training for Life Coaches on how to engage with their peers in their roles.

Objective #3: Designing Training Materials for Life Coaches

Training materials will be designed for Life Coaches to reference what was taught to them. These training materials will include the key points brought up during the

presentations, including other material that the facilitators think will be beneficial for the Life Coaches future prospects. Life Coaches will be provided workbooks where the information from the trainings can be kept so they can organize what they have been given.

Objective #4: Evaluation of Life Coach Trainings and Effectiveness

The creation of evaluation form will be developed and given to the Life Coaches at the end of the training to evaluate knowledge regarding basic skills and self-care. Program satisfaction forms will be returned to the Village anonymously and will be synthesized for what was liked and disliked about the trainings. The results of these evaluations will be analyzed to decide what about the trainings for Life Coaches could be improved and what aspects of the trainings should be kept the same. The first year of having funded trainings for the Life Coaches program will allow the Village to evaluate effective ways to engage with Life Coaches and provide knowledge that can help them and the other members in the long term. At least 90% of participants will return their surveys for review and at least 60% of participants will be interviewed to evaluate the training curriculum's effectiveness.

Sustainability

A record of the training progress will be provided to future funders who support programs that give monetary support to already existing projects. Grants that can provide resources to this project will be located to continue the support of the training portion for Life Coaches.

Timeline 1-3 MONTHS

The first 2 months will be used to form linkages with organizations and recruit individuals who can provide trainings about the proposed topics. The materials for the trainings will be created and prepared. This will also be the time the trainings are scheduled throughout the next 6-8 months.

Timeline 4-6 MONTHS

The next 3-5 months will be the time Life Coaches will become oriented to the way services at the Village are provided, their roles and responsibilities, and how to manage self-care while helping others reach their recovery goals.

Timeline 6-9 MONTHS

The next 6-9 months will be used train Life Coaches on how to utilize basic helping skills to care for others. This will include topics such as CPR and how to use lived experience to effectively work with peers.

Timeline 10-12 MONTHS

The last 10-12 months will be used to spend time evaluating the surveys given to Life Coaches at the end of each of training to gain insight on how to improve the training curriculum. This feedback will then be used in the next grant proposal, which will potentially the fund the next year's training curriculum.

Breakdown of Budget

Facilitator Costs

The cost for trainers is estimated to be $1000 for the two CPR trainings and $7000 for the training on the Village operations, self-care for Life Coaches, and core helping skills.

Stipends

To encourage participation in the training curriculum and to have Life Coaches build an income, stipends will be paid to the Life Coaches for their service at the Village. Each Life Coach will be rewarded $1200 for the year.

Supplies

Printing costs will total $1000 and be used to create copies of practice worksheets, informational packets, schedules community resources, and presentation slides. Other supplies will require $2000 (including binders, notebooks, workbooks, pens, and pencils).

Travel

Travel is estimated to be $1000 since the facilitators/organizations will be from the local agencies in southern California.

Food/Beverage for Life Coaches

$1000 will be used for food and beverages for Life Coach trainings.

TABLE 1. Line-Item Budget

Mental Health America Los Angeles
The Village
1-Year Budget

	Total Cost	Requested Amount
PERSONNEL COSTS		
CPR Trainers	$ 1,000	$ 1,000
Core Skills Trainers	$ 7,000	$ 7,000
10 Life Coach Stipends @ $1,200	$ 12,000	$ 12,000
SUBTOTAL	$ 20,000	$ 20,000
DIRECT PROGRAM COSTS		
Printing	$ 1,000	$ 1,000
Training Materials	$ 2,000	$ 2,000
Travel	$ 1,000	$ 1,000
Food/Beverages for trainings	$ 1,000	$ 1,000
SUBTOTAL	$ 5,000	$ 5,000
INDIRECT COSTS @ 10%	$ 2,500	$ 2,500
TOTAL COSTS	$ 27,500	$ 27,500

CHAPTER 5

LESSONS LEARNED

Many steps had to take place in order to develop a grant that would meet the needs of the Life Coaches program. To decide how to best approach the problem and how to ensure Life Coaches are effective in their roles, there needed to be an understanding of the issues that face PSs. The next step was to consult with professionals who observed how the Life Coaches performed their roles. After that, searching for potential funding sources and developing a grant based on the research and feedback given were required. Reflection of the overall process has made the writer consider how the following elements have informed his practice in the social work profession: the process of writing the literature review; consulting with Life Coach overseers; the process of locating funding sources; the process of developing a grant; and how addressing this social issue is relevant to social work.

Process of Writing Literature Review

The literature review began with a brainstorming process that explored what surrounding issues should be researched to find what Life Coaches have not received that can make them more effective. The brainstorming process uncovered that in order to best address the issue of PS ineffectiveness, the literature review had to focus on subjects that were established to give power to people receiving mental health services. This helped inform reasoning for choosing these following subjects for the literature review: the

recovery model, the origins of PS and peer support, the outcome research of peer support programs and trainings, the research about PSs, the facets of self-disclosure, the self-management barriers and supports, and advance directives. This literature review informed the grant writer on how the history of mental health services helped give opportunities for peer support in mental health services and how this changed in the way services are implemented.

The grant writer learned how to effectively plan what would be researched for the literature review. To do this, the grant writer found through the initial research of peer support programs, common themes that can pinpoint what should be researched in order to understand how peer support programs developed they way they are today. This literature review also uncovered a need for more research on the way people in peer support roles are trained. This information helped find clearer answers on how to create an effective training program for the Life Coaches. One way to alleviate this gap in the literature was to consult professionals in the field who oversee the Life Coaches program.

Coordination with Consultants

The process of getting feedback from those supervising the Life Coach program allowed the grant writer to find what grants should be considered based on the direct needs of the Village and the findings of the literature review. This consultation helped to inform the grant writer on the need for the grant to fund opportunities to learn CPR and to have funding to provide materials for Life Coaches that can help guide them on how to access services at the Village. The grant writer became informed on the necessity of becoming informed of the physical health disparities that exist for people with mental illness and the

need to provide resources for Life Coaches, which were easily accessible for them throughout the time they serve the Village.

Process of Locating Funding Sources

To find a funding source, a search engine on the Internet was used to locate organizations that would fund the grant writer's project. It was difficult locating a specific grant that related to enhancing peer mentor programs. It was in the grant writer's interest to not search only for grants that were for peer support programs, but for larger subject areas as well. Also, becoming more specific as to where regionally the grant would be funded helped the grant writer find organizations that were serving southern California and the at-risk populations there. The grant writer learned to include other criteria at the start of the grant search instead of just including the problem area that would be addressed and what the funding would specifically cover.

Process of Developing Grant

Writing the grant required an outline of what essentials the Life Coach program would need in order for them to have a successful training curriculum. Through the creation of the grant, it was clear that research had to be done to decide how much money the budget should include and how that money would be used. The process of formulating the budget helped the grant writer learn the importance of prioritizing what can help a program become successful. In order to know what should be funded, deciding what elements of the training curriculum would help Life Coaches and the program most made it clear that funding for facilitators, travel, supplies, stipends, and food/refreshments should be considered. The grant writer realized the importance of ensuring the research

was accurate and that feedback from those in the field was taken into consideration. Developing the grant also gave an opportunity for the grant writer to reflect on the importance of finding ways that the program can experience positive growth. This made it clear to the grant writer that a section that outlines how the Village will evaluate the training curriculum's effectiveness was needed.

Implications for Social Work Practice, Policy, and Research

The creation of this grant proposal gave the grant writer a clear image of how this type of intervention has implications for social work practice, policy, and research. In terms of practice, the grant writer became self-aware of what the needs of the members are before someone should expand on an already existing program. Social workers must be aware of what benefits programs can bring to people on a micro level so gaining insight from those who have worked with the members in the past was essential to the grant's completion. When it comes to policy, the grant writer gained an understanding of how programs at the Village function based on the rules and regulations established by the Village directors. Having awareness of the laws in place and how that affects the clients who would utilize the Life Coach service made it apparent for the grant writer to focus the grant in a way that can meet the members' needs, as well as the policy needs of the Village. This awareness ensured that the social work practice of the Village did not suffer due to not following the rules and regulations in place. On a research level, the grant writer was taught the necessity of using peer-reviewed research that can inform social work practices made to support specific communities. To make sure this program still meets the best standards, being able to find common themes in the research is essential to

finding what could be improved upon; that information will help uncover how money from a grant should be allocated. The grant writer also learned the importance of having research available that explores topics that have not been widely discussed so it can improve services at social work agencies.

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