Note to Participants: Because of time constraints, you will need to complete this assignment prior to the training. The Take Your Heart to Work Peer Support Specialist Participant Manual, Section I, Parts One- Seven, Personal Recovery is a State of Mind and Section ll part Twelve, History of Mental Health are to be submitted to Toya Hooper, peerrecovery365@gmail.com before the training. This is a prerequisite online assignment that was listed on the application. There are 19 questions highlighted in yellow. Some questions require written answers, some require reading and understanding and your opinion. It will not be graded, but your active participation in class is required and based on the assignment.

**Please answer on a separate document or at the end of this document using the question and page #s for clarity. You do not have to copy this document.**

Assessment for understanding the definitions and concepts will be covered within the 40-hr face to face training. Do the best you can and do not worry about a grade, there is no grade.

**Section I, Part One: What is Peer Support?**

1. Research the meaning of peer support and find 2-3 perspectives. Write a report sighting the authors and references. Examples: Shery Mead, Mary Ellen Copeland and Pat Deegan, Peer Support Websites including [www.pss.unc.edu](http://www.pss.unc.edu), bhs.unc.edu
2. Develop your own perspective ideas on the meaning of peer support and how you believe it is different from therapy and other health care.
3. Based on your findings, give an example that demonstrates you have received peer support. Was it helpful or harmful? Explain.
4. Based on your findings, give an example that demonstrates you have given peer support. Describe your experiences

Section I – Online Assignment (Continued)

1. Pg 5- Introduction to self-care
2. Pg. 6, # 1-3 Self-monitoring Summary-Add your thought to the discussion questions and answers.
3. Review and update your personal WRAP
4. Pg 7 Code of Conduct, Ethics & Values Introduction-Be very familiar with the Code of Ethics (North Carolina Certified Peer Support Specialist (NCCPSS) on pg 8-10. Know this acronym and the website.. [www.pss.unc.edu](http://www.pss.unc.edu)
5. Pg 11-14 Core Values of PSS-Read and understand. Be ready to discuss and give in put in class..put your thoughts in writing.
6. Pg. 16- Boundaries- Write and know the definition of boundaries, violations and troubleshooting tools
7. Positive Role Model-Read introduction of Recovery Values and answer in writing the 6 questions on this page 20.
8. Pg. 21-Recovery Environment and wellness identity. How can you develop with the person served?
9. Pg. 22-23-Qualities of an Effective PSS-Be familiar with the qualities and identify those that will be difficult for you to embrace.

Section II Part Twelve: History of Mental Health

1. Pg. 24-41-History of Mental Health. Read and focus on the Consumer Movement and the Reform beginning on pg 36-40.
2. Answer in writing the 4 questions at top of Pg. 25
3. Review activity on pg 26 and be able to explain respecting different perspectives, active listening and ability to summarize.
4. Define stigma pg. 33 and write 2 ways you as a PSS can reduce stigma in your community.
5. What would be an appropriate approach for a Peer Support Specialist to take with a person served who talks about suicide. Pg 34.
6. Make a brief timeline sighting the main Legislative events beginning in 2001-2013. Pg. 40-42.

**Take Your Heart to Work**

**SECTION I**

**PERSONAL RECOVERY IS A STATE OF MIND**

*Quality is not just a chart, or a standard, or a specification— It’s a state of mind, a commitment, a responsibility, a spirit.*

*It’s a way of doing, being and living.* Don Galer

**Section I Learning Objectives**

*At the end of Section I, prior to the start of the classroom portion of the training, participants should be able to:*

**1.** Identify ways one is able to become personally responsible for one’s wellness and why it is important;

**2.** Increase one’s self-awareness regarding recovery beliefs and values;

**3.** Understand how the 5 Key Concepts of Recovery plus 2 (Medications and Physical Health) are instilled in the Core Values of Peer Support Specialists (PSS);

**4.** Believe that the concept of peer support and traditional treatment can be

 integrated;

**5.** Embrace the qualities of a PSS and become a recovery role model in the

 community to dispel stigma;

**6.** Set and display professional, peer standards for one’s self;

**7.** Know where to find additional, updated recovery information;

**8.** Be willing and able to discuss with appropriate knowledge the process of Recovery and peer support.

**9.** Be able to explain what peer support is and how it is different from

 tradition

**Section I, Part Two: Taking Care of Yourself.**

 5. Introduction to self-care –read and understand

Building on the Five Key Concepts Plus Two of WRAP developed by Mary Ellen Copeland, we have come to understand the importance of commitment to our own personal recovery strategies by systematically monitoring our own wellness. Our own issues with wellness may compromise our ability to be effective in our positions, so we will notify others around us when we are experiencing “signs” of moving away from recovery. The sooner we address what is happening, the greater likelihood we have of returning to our wellness. At all times, we will prioritize personal support, wellness, and Recovery. “Practice what you preach!” Let’s talk:

Those of us who are Wellness Educators have found that we are often able, and very naturally, to focus on supporting others’ wellness while putting our own on the back burner. As a Peer Support Specialist (PSS), it is our personal responsibility to take the steps necessary to keep ourselves well. We can inadvertently find ourselves slipping into “When Things are Breaking Down” before we realize it, often times denying it until we are in a full blown crisis.

The recovery process is different for everyone. Each of us is on our own unique journey. We do know from WRAP that people who are the most successful in recovery need to have Hope, Personal Responsibility, Education, Self-Advocacy, Support, Medication Management (if necessary) and attention to Physical Health.

Having defined and updated our WRAP and how we can use it to manage our wellness in all parts our lives, now let’s look at how we are able to communicate with our supervisor when things are breaking down.

6. # 1-3 Self-monitoring Summary-Add your thoughts to the discussion questions and answers.

7. Review and update your personal WRAP

**Summary: So how do we assume the responsibility to monitor our own wellness?**

**1.** One way to do that is to be “up close and personal” with our WRAP. This involves making changes as we grow and learn new ideas. By being up close and personal with our WRAP, we are demonstrating that we not only believe in the RECOVERY process but we are living it to the fullest.

**2.** We are also able to teach ourselves to humbly ask for help. This is a difficult thing to do when we are the Wellness Educators or the Peer Support Specialists. Our supervisor or other co-worker with whom we have a mutual relationship is an example of an individual to ask for support. Some agencies have a quality assurance process. For example, a form filled out by the employee and sealed and kept under lock and key by the supervisor. It is to be opened only in case of an emergency. The form includes emergency contact information (supporters) and a crisis plan (WRAP). This is an excellent way to be assured that your wishes are carried out even when you are not able to carry them out yourself.

**3.** Another way to take care of ourselves is to build relationships with the people who mean the most to us by communicating honestly with them when we have issues. In peer support, we come together sharing ideas and information. It is about being mutual. It is not about giving advice. In addition to that, the concept of peer support can enrich relationships with everyone in our lives. We will talk more about effective communication in Section II.

**Section I, Part Three: Code of Conduct**

8. Code of Conduct, Ethics & Values Introduction-Read.

Be very familiar with the values and Code of Ethics (North Carolina Certified Peer Support Specialist (NCCPSS) on pg 8-10. Know this acronym, (NCCPSS) and these website: [www.pss.unc.edu](http://www.pss.unc.edu) and bhs.unc.edu .

As a part of maintaining our wellness, we perform all job responsibilities within the agency where we are employed. All agencies have a Code of Conduct that

is unique to the organization in order to meet national accreditations body

standards. As employees, we are required to know the agency rules and regulations and work within those parameters. N*ote: This is an emerging field with few specific references.*

**What is a Code of Conduct?**

We could define a Code of Conduct has a system of rules that govern the way we are to behave. Sometimes called a Code of Ethics, it is usually included as part of the employee manual. These are guidelines for acceptable and unacceptable behavior:

1. ensure that the people we are supporting are not harmed or exploited in any way;

2. protect us as Peer Support Specialists by allowing us to know up front what is expected of us (i.e., through our job description); and

3. safeguard our agency by laying out the professional behavior that is expected.

It is important that we perform all of our job responsibilities in a manner that is consistent with the Code of Conduct of the agency where we are employed. We also need to perform our jobs consistent with the PSS Code of Conduct for that agency, too. In some areas, these Codes of Conduct may overlap and in other areas they may be quite different.

**Ethics vs. Values**

One way to look at the difference between ethics and values would be to say that values are what you *believe* and ethics are how you *behave (or how you put your values into action).*

**CODE OF ETHICS FOR CERTIFIED PEER SUPPORT SPECIALISTS IN NORTH CAROLINA**

A Peer Support Specialist, as a person in recovery from a mental illness and/or substance abuse challenge, plays a unique and vital role in supporting each individual in his or her journey of recovery. The Peer Support Specialist is responsible for providing an array of support services and interventions designed to inspire hope, support personal responsibility, promote understanding, offer education, and promote self-advocacy and self-determination.

**VALUES**

� People have the right to be treated with dignity and have their individual human rights respected

� Self-directed recovery is possible for everyone, with or without professional help

� Sharing our recovery experiences fosters mutual relationships, reduces isolation, inspires hope, and strengthens the ongoing recovery process

� Individuals have the capacity to live full and meaningful lives they envision for themselves

� People have the right to make their own choices about their treatment even if others think their decisions are wrong

� Peer Support values the importance of community building and natural supports (family, church, NA, AA, friends, etc).

**CODE OF ETHICS**

Attention to self-recovery is critical to the performance of duties as a Peer Support Specialist(s) (PSS). When changes in recovery occur, the Peer Support Specialist will take personal responsibility to seek support.

PSS are honest in their interactions; keeping it simple keeping it real. PSS relationships are mutual learning experiences.

PSS have a responsibility to help individuals find their own voices and to advocate for the principles of human dignity, self determination, and empowerment.

PSS honor commitments made to peers.

In dealing with peers, PSS strive to always explore and ask open ended questions rather than making assumptions. PSS explore alternatives and options with peers rather than giving advice.

PSS support people to make their own choices, honoring self determination. The PSS does not put his/her agenda ahead of the peer’s agenda

PSS negotiate within the relationship with peers in order to facilitate peer choice and shared power.

PSS avoid power struggles and favoritism.

PSS will not exploit, devalue, manipulate, abuse, neglect, or ignore a peer.

PSS and peers will not loan or borrow anything from each other; especially not money. PSS will not establish romantic relationships with peers and will refrain from intimate or sexual activity with peers.

PSS avoid dual relationships; when they are unavoidable, appropriate boundaries are established within the relationship with the support of the supervisor.

PSS will not violate a peer's confidentiality except when required by law.

Accepting or giving gifts, if allowed by the agency, must be clearly related to the peer's recovery process.

PSS do not take peers to their homes; any exception to this must have written agency approval.

PSS do not hire peers to work for them if they are currently receiving services from their agency.

PSS's documentation in the agency record is person-centered and done with the peer whenever possible.

PSS take responsibility for their own professional development and are proactive about expanding their knowledge and honing their skills with continuing education and training.

PSS have a responsibility to educate themselves about available community resources and to establish helpful contacts in the community.

PSS do not make medical diagnoses.

North Carolina Peer Support Specialist Website:

<http://pss.unc.edu/>

**Section I, Part Four: Core Values of PSS**

1. Core Values of PSS-Read and understand. Be ready to discuss and give input in class..put your thoughts in writing.

These topics will be discussed and will hold varying degrees of power, truth and acceptance for each participant. The purpose in this exercise is to dig as deeply inside oneself as possible to achieve self-awareness by coming to terms with Peer Support Specialists’ Core Values.

You may find some of the following practices and characteristics pertinent to your personal abilities as a PSS.

❧ 1. Recognizing that all people have rights and choices

What are some of the rights and choices that we all have? What are some of the rights and choices we (and those we support) have been denied? Why is it important to have conversations around rights and choices with the people we support? How do we help support people to self-advocate for their rights and choices? Refer to the Bill of Rights handout.

❧ 2. Not defining differences

Is it important not to put the focus on or define differences of individuals? Explain. Why is it important to see all people as “People First”? How are we similar as people? What are the ways in which you are able to demonstrate that we, as people, are “more alike than different”?

❧ 3. Focusing on each individual’s strengths and talents

Explain why it is important for us to support people in identifying their strengths and talents. Give an example of how you would support someone to explore their strengths and talents. What steps would you take to support a person to develop a wellness identity and share his/her strengths and talents in a practical and realistic way?

❧ 4. Recognizing multiple perspectives and truths

How do people form their perspectives? Does an understanding of cultural values serve us in a discovery and recovery process? Explain. What is one able to learn from other peoples’ perspectives? Do you believe that each of us “holds a piece of the truth”? Explain. How do we give significance to someone’s perception of the truth …when it is very different from our own viewpoint?

❧ 5. Defining and redefining what “help/support” and “safety” mean

Who defines “help/support” and “safety”? Can you support a person without discussing the meaning of these terms? Is it different for each of us? Is it possible to reconcile definitions? Explain. What happens when a person does not feel safe or valued? How do we develop an environment of safety?

❧ 6. Meeting people where they are

How are open-ended questions useful upon first contact? Is it our job to give our opinion, even if we think we are right? Explain the difference in convincing someone to accept your opinion and giving informed choices to the person served.

❧ 7. Avoiding assumptions and presumptions

How can we prevent ourselves from making judgments about those we support? What may I experience when a person assumes something about me, especially when it is not factual? What do I sense when I am presumed culpable without investigation?

❧ 8. Transforming crisis to an opportunity

Share some of your experiences of when you were able to turn a crisis into an opportunity. What are we able to learn and share with others from our crises? How does this relate to being authentic? Does this relate to “telling our story”? Explain.

❧ 9. Creating self-awareness and empowerment

What are the steps you would take to learn more about your authentic self? How do we become self-aware on the inside and on the outside? See “Mobius Strip” handout. Is empowerment a result of self-awareness? Explain. Are we able to support others to become empowered or more self- aware if we are not? Explain. Is the importance of “telling our story” relevant?

❧ 10. Connecting individuals to the community

Is it important to connect people to their surrounding communities? Is isolation a factor in recovery? Explain. How and where do we connect people to their communities? Connections are about whom and what?

 ❧ 11. Providing goodwill in the community by modeling recovery in all settings, resulting in reduced stigma

Is it important for us to “model recovery” while off the job during our personal time (i.e. having dinner at Ruby Tuesdays, making an appointment with a person in crisis and not keeping it, storming from a community meeting)? Does our individual behavior have an impact on generic and collective stigma in the community?

❧ 12. Integrating recovery, peer support and traditional treatment

Is it possible to integrate recovery and traditional treatment? What would that look like in a social setting detox, Mobile Crisis Unit or Assertive Community Treatment team? How do we stay grounded in peer support when we are the minority in a multi- disciplinary team setting?

❧ 13. Layering networks of support that are both paid and unpaid

Give a list of potential supports that are both paid and unpaid, without expectations from either group that may do harm. How are these ideas able to become included to best serve the person at the center of the person centered plan (PCP)?

 ❧ 14.Adhering to the principles of trustworthiness by maintaining trust What is trustworthiness? How do we maintain trust with those we support? Is the word “mutual” a central concept in this regard?

❧ 15. Demonstrating commitment to personal recovery

Do you have a WRAP that works? How do you self-monitor your wellness? Are you able to naturally and freely share this part of your “story”? Explain. How do you step down from your work when you are unwell? Is it acceptable to continue working as a PSS when you are struggling? Explain.

❧ 16. Using “Person First” / “Recovery Language” to communicate

sensitivity and engender mutual respect and connectivity

Do you intentionally use recovery oriented language in all settings? Are you able to use recovery oriented language in an inclusive manner? Do you view people from the perspective of having an illness identity or a wellness identity? How do you view your own identity, as an illness identity or wellness identity? Why is that important? When someone asks, “What ARE you saying”…..how would you respond? How is this done effectively with whom you interact when they may prefer to use clinical terminology? What happens then to the person at the center of the PCP when s/he hears different types of language? Is consistency essential?

 ❧ 17. Instilling hope in order to assume personal responsibility through education and self-advocacy, thereby creating the opportunity for support

Do you believe that hope is the first step in the recovery process? How would you explain the magnitude and the meaning of the Five Key Concepts of Recovery to others? How do you feel about supporting an individual in CREATING hope? How would you support a person in establishing hope when it becomes apparent that there seems to be little hope in that person’s world? Would you embrace the reality of the person served or project your own expectations….shaped from your own experiences and environment? Which Key Concept (KC) has been key to your recovery and wellness?

**Section I Part Five: Boundaries (Limits)**

1. Boundaries- Write and know the definition of boundaries, violations and troubleshooting tools

**Boundaries** are ambiguous and require good judgment. We set them to protect and maintain our emotional, mental, spiritual and physical health.

They are:

❧ The unseen lines that you won’t cross

❧ Undefined physical and emotional distances

❧ Parameters that make you unique

❧ Self-imposed and self-defined

The **definition of boundary** is the ability to know where you end and where another person begins. Another term for boundary is **limit.**

The amount and type of boundary (limit) responsibility you have with a person differs according to the **type of relationship**:

❧ **Friendship**-A person that you know, trust and one with whom you have a close personal connection-your ally, your equal

❧ **Colleague**-A fellow member of a profession-

o power and authority may be equal or may not be

❧ **Peer** (person served)-As a PSS we have equal power with the person served and we have no authority over the person served

**Boundaries are Helpful**

Boundaries facilitate relationships and protect the safe space the individuals have negotiated. Boundaries build trust and are essential to express one’s authentic self.

**Boundary Violations:**

❧ Any behavior or interaction which damages the relationship

❧ Any behavior or interaction that results in victimization

❧ A betrayal of the sacred covenant of trust

❧ Occurs when Peer Support Specialists’ (PSS) personal needs are met

rather than the needs of the person served

❧ If violations occur, the ramifications may be widespread and relationships may be damaged or may be ended

**Four Elements characteristically appear in Boundary Violations:**

**1. Secrecy**- involves keeping critical knowledge or selectively sharing information.

**2. Role reversal**- occurs when person served takes care of the PSS

instead of placing the person served needs first.

**3. Double-bind**- consists of messages that contradict each other while discouraging the receiver of the messages from noticing, creating a conflict of interest. It implies a threat, a sense of guilt and fear of possible abandonment by the PSS. It constricts the person served from using all available options and thus limits growth.

**4. Indulgence of professional privilege**- involves using information obtained in the relationship with a person served for the benefit of the PSS. Exerting authority over the person served. Having access to information does not constitute a right to obtaining it.

**Boundaries: Are We Helping or Hurting?**

∙ There are more gray areas than black and white ones when thinking about boundaries. PSSs can make more considerate decisions if they will take time to think about some of the basics of boundaries.

**Some Warning Signs of Boundary Violations:**

❧ Choosing sides

❧ Making exceptions

❧ Keeping secrets

❧ Giving or receiving gifts

❧ Borrowing or lending money

❧ Feeling as if no one but you has interest in the person served

❧ Feeling no one but you will be able to assist the person served

❧ Feeling responsible for the progress or failure of the person served

❧ Owning the successes or failures of the person served

❧ Confiding personal or professional issues or troubles about the person served to anybody

**Trouble Shooting Problem Spots:**

**Time:** When, where and how often you meet with a person served can become a troublesome issue. *If it feels wrong, it probably is*, but ask yourself the following questions to help clarify the situation:

1. How much time am I spending with a person served?

2. Does it vary from that spent with other persons served?

3. Am I spending “off duty” time with the person served?

**Location:** If a person served wants to talk or meet somewhere other than a center approved location, you may be starting to slide toward a questionable boundary as well as possible policy violation. Try asking yourself:

1. Is the location of the interaction appropriate to the relationship?

2. Would you provide peer services to other persons served at this

 location?

3. Is there a legitimate need to meet?

4. Have I made the meeting known to others and documented it?

**Gifts:** Accepting or giving a gift can get tricky. If you are unsure ask yourself:

1. Does the gift giving create a sense of obligation on the part of you or the

 recipient?

1. Do you do this routinely as part of your job, regardless of the age or

 gender of the person served?

1. Is the gift of such a personal nature that it would only be to or from

 specific people in certain types of (non-professional) relationships?

 4. Is there a department or center policy regarding gifts?

**Asking for Help**

At all times, if you are unsure about a situation or confused about whether an interaction could be interpreted as a boundary violation you could:

❧ Consult your supervisor

❧ Refer to the agency directives

❧ Consult the quality assurance coordinator

❧ Consult other colleagues

Adapted from South Carolina Department of Mental Health Peer Delivered

Services and Minnesota Board of Nursing, January 2000.

***Definition of Limits:***

**Our personal limits are different from boundaries in that we set them for ourselves and they can change according to what kind of relationship we have with the person. The relationship may change as we get to know someone.**

Adapted from Workbook for Basic Training on Peer Support developed by Stephen Pocklington . . . with gratitude.

**Section I, Part Six: Positive Role Model**

11.Positive Role Model-Read introduction of Recovery Values and answer in writing the 6 questions on this page 20.

**Recovery Values**

One of our responsibilities as Peer Support Specialists is to continually work toward being a consistent, positive role model in whatever setting we find ourselves. We are able to model Recovery in our speech and in our actions. This involves demonstrating Recovery values. Recovery values are principles that promote recovery.

The most important Recovery value we promote is **Hope**. We want to continuously express the message of hope. There is hope that people are able to get well and stay well. Hope is available to everyone. Our lives are testimony to this. Review the Key Concepts of Recovery and how each relates to the other.

 **Answer these questions:**

❧ What are some of your most important values?

❧ How have they changed over the years?

❧ Has being in Recovery influenced your values? In what way(s)?

We are able to reflect recovery in our attitudes, the way we feel about ourselves, other people or a situation. *There are no predetermined beliefs about anyone’s recovery possibilities. A positive attitude to hold is that recovery is possible for everyone and to view them with a wellness identity.*

**Answer these questions:**

❧ Who were some of your role models while growing up? What did you admire about them?

❧ Who are your role models now?

❧ Give examples of how you could model the attitudes and actions of peer support.

12.Recovery Environment and wellness identity. How can you develop a wellness identity with the person served?

**Recovery Environment**

It is important that we promote a Recovery environment in our workplace, home and community. **A Recovery environment is one in which everyone is welcome. No one is excluded. All people are valued and respected.** They are not reduced to their diagnosis or struggles. We meet them on their journeys, wherever that may be. We are not dismissive or display an attitude of giving up on somebody’s recovery if they are not where “we” want them to be or make the choices we would. Instead, they are appreciated for the unique, wonderful human beings that they are. **In a Recovery environment, emphasis is placed on how we are similar as people as opposed to how we are different.**

Peer Support Specialists are able to promote a Recovery environment in the workplace by intentionally making it welcoming and by using **Recovery Language** (RL). For some people, the time they spend at work each day with co-workers or people seeking services is what brings them joy and gives their lives meaning. Be aware that we are an integral part of a Recovery environment. The way we are with others helps set the tone of the environment.

As a PSS, we strive to first understand others and then work toward being understood. Stephen Covey speaks of this in his book, “The 7 Habits of Highly Effective People.” We intentionally are open and supportive to other’s ideas and focus on the positive. Being a team player is important and results in harmony, creativity, and a strong sense of ownership with feelings of connectedness.

PSSs are able to promote recovery by working to reduce stigma. We can do this by promoting Recovery values and by using Recovery Language. One way to do this is by assisting our peers, colleagues, and others in the community to see people from the perspective of a wellness identity as opposed to assigning them an illness identity.

"We have to get the word out that mental illnesses can be diagnosed and treated, and almost everyone suffering from mental illness can live more normal lives."—Rosalynn Carter

**Section I, Part Seven:**

**Qualities of an Effective PSS**

1. -Qualities of an Effective PSS-Be familiar with the qualities and identify those that will be difficult for you to embrace.

There are certain qualities that an effective Peer Support Specialist possesses. They:

❧ Emphasize ability versus disability

❧ Are aware that diagnoses may be changed, may be similar, and may even be missed by professionals

❧ Are willing to want to share one’s own Recovery story (self-disclosure) in an effort

 to bring Recovery to another individual

❧ Model Recovery in every facet of community life (lead by example)

❧ Have the ability to listen, communicate, and connect; to disconnect and reconnect when necessary

❧ Have the ability to ask for support when there seems to be a disconnect and to reconnect

❧ Are aware of maintaining personal boundaries

❧ Have compassion

❧ Are trustworthy

❧ Have the ability to be intentional in thought, word and deed

❧ Are present in the moment (mindful) and relinquish the need to control

❧ Maintain confidentiality

❧ Work at being non-judgmental

❧ Have the knowledge and ability to respond rather than react

❧ Practice proactive thinking that results in behavior that reduces impulsivity and habitual negative reactions

❧ Have insight to inner strengths and weaknesses

❧ Seek to gain new knowledge and information through trainings and experience

❧ Are able to complete required forms and other documents

❧ Other qualities from class . . .

1. History of Mental Health. Read and focus on the Consumer Movement and the Reform beginning on pg 34-40. -

**Section II, Part Eleven: History of Mental Health**

*The world will little note nor long remember what we say here, but it can never*

*forget what they did here. … It is rather for us to be here dedicated to the great task remaining before us--that from these honored dead we take increased devotion to that cause for which they gave the last full measure of devotion-- …*

President Abraham Lincoln

The Gettysburg Address

It is with much reverence that we begin this section. Many have gone before who left us abruptly, never to be seen or heard from again. Others of us do not know the torture and feeling of imprisonment which were part of the

American 18th , 19th , and 20th centuries. The landscape is changing.

Some smuggled letters are just recently being found, held and embraced by loved ones from past generations. These are the whispered family stories of Uncle Jack and Granny Bessie that are coming to us decades, perhaps, centuries later. This history has been hidden because the stories were either not spoken about at all or told in half-truths. It became, therefore, a family history of secrets buried with the person about whom we knew nothing or little. Since we lived primarily in agrarian societies and large urban areas there was little chance that necessary social structures would be in place in order for the truth to be told, recorded, and preserved.

We dedicate this section to all who came before who had lost HOPE before the world recognized their unique differences. We applaud their pure strength, determination, and faith to endure and persevere! We are beginning to learn a lot from many and that information will become helpful to future generations so the suffering which was tolerated will never be repeated.

We usually talk about stigma being the single most important barrier as identified in our WRAP classes for “Things That Held us Back.” So, if it is an identifiable barrier, we wish to do something to reduce/remove stigma as a priority. What better way than to investigate the history of Mental Health which we have come to understand is very well buried under many layers of social, medical, legal and bureaucratic strata. Come join us on this early expedition as we dig through those layers of fears, tears, and heartache. Come prepared with an open and inquiring mind, a shovel, and a box of tissues!

15.Answer in writing these 4 questions.

**CONSIDER THESE QUESTIONS:**

❧ Why is Mental Health History Important?

❧ Why do YOU think it has been a “hidden” history?

❧ Why is it important to unearth the history?

❧ What is the connection between this archeological dig and “stigma”?

**EARLY HISTORY OF MENTAL HEALTH**

*Note: None of the ancient languages developed a word for "history"...because “history" as we understand it today was known as "memory.” Now, that is something worth thinking about for the particular history about which we are reading!*

From the beginning, HOPE *(WRAP Key Concept 1)* and SUPPORT *(WRAP Key Concept 5)* were recognized as being essential for survival. That’s why our ancestors lived in villages where tribal customs included offering up hope in the face of loss and danger. (Some people today still do.) People in our villages

were culturally similar. Individuals were not nearly as judgmental as individuals in our society today because we were all “peer.” We had not yet found the necessity of excluding others and labeling them as “different” because our cultures were “flat.” Who did not have a challenge? It rarely occurred to us to set somebody apart because s/he had different ways of approaching life. If

s/he were excluded for any reason, the community welcomed the individual

into the circle of trust which existed for survival. Universal good was the goal.

Enter commerce, travel, dispersion, power struggles, and greed and we may go somewhere with the early villagers looking something like those having to prove their goodness by being the same. . . same appearance, same mannerisms, same styles of communication, even same dreams and aspirations. Even Job, after his many traumatic experiences, was affected and his faith tested, but he was given continuous support by family and community.

In promising to describe the history, we were implicitly promising to demonstrate the need for change. . .for measuring how far we have come and how far we have to go. Part of the research involved in preparing this segment was difficult to uncover. This is a hidden history in many aspects because the topic has been somewhat hidden since the inception of intentionally applied stigma. When and why did we find it necessary as a society to exclude, rather than to include, based on the premise of a perceived “invisible” difference?

**THE LIVES THEY LEFT BEHIND: SUITCASES FROM A STATE HOSPITAL ATTIC**

Project Willard, New York: A beautiful scenic summer destination point for

well-heeled Northeasterners for over a century, situated on one of the historic “Finger Lakes” in Upstate New York. Hidden in the obscurity of the town’s history was the greatest local revenue producer and employer, Willard Insane Asylum. An architecturally significant and prominently situated local landmark, the actual internal mechanism was a secret, hidden or not discussed….until recently.

This exhibit has “come out of the attic” for one and all to view and attempt to make sense of the findings. The patients were generally referred to by their assigned numbers only so their numbers became their identities. In our exercise, we have included the numbers as well to make that obvious, albeit painful point, although the names (at least first or last) have now been learned by the archivists.

**WHO**

#22040 - Mademoiselle Madeline

She was a French American intellectual committed by her husband because he did not like her behavior and beliefs. She died at the age of 90 in a nearby facility after spending most of her life at Willard and advocating for her discharge--sometimes “we know too much and speak too well.”

#27967 - Mr. Frank

A WWII veteran, shortly after returning from the war, was served on a cracked plate at a restaurant in New York. When asked for a replacement plate, he was denied; he had a temper tantrum and spent the rest of life at Willard. This was long before we knew the struggles which returning veterans experience.

#14956 - Mr. Lawrence

Immigrated to this country from Galicia--what is now known as Austria--and was a window washer at the famous (infamous) Bellevue Hospital. One day, he was rather boisterous while doing his work: his records indicated he was “loud, boisterous, singing, shouting, praying, and claiming to hear the voice of God.” *(USA TODAY 12/5/07, Craig Wilson, reporter)*. He was taken inside and committed, later being transferred to Willard. He worked well alone, so he was the official grave digger for the institution. Yes, he was buried at the Willard Cemetery, in the ground he once nurtured and sowed. His grave was marked only by his number, as was the case with all those who died and were buried there.

Numerous of the Willard patients had immigrated alone to this country, many from around the turn of the last century and mostly from Europe. They wished to escape cruelties and atrocities there with the full intention of sending for their family members back in the “old country,” once they became settled and economically able to do so. Sometimes, this never happened for reasons we have alluded to earlier. In several recently documented cases, there were concentration camp survivors committed to Willard. Can you imagine having survived that horror only to find forced and free labor here in the land of the free?

We are learning more fully on a daily basis the need for being **Trauma- Informed**! In fact, the state of New York has created a special unit within the Department of Health to screen at every opportunity for the possibility of trauma, particularly from within psychiatric, both in-patient and community based, settings. It recognizes that many people may be experiencing a natural human response to a catastrophic life event which would require a unique approach of support. These iatrogenic responses may sometimes become more difficult to move away from than the original/presenting issue. Frequently, the consequences are longer lasting because people may become stuck, both literally and figuratively.

Many reasons for commitment to Willard and languishing there were simply natural human responses to life’s adversities….such as the young husband who “inappropriately” grieved his young wife’s death during childbirth, or like the woman who dared to have the courage to leave her philandering and abusive husband. Many others were unemployed and lived in poverty from which they could not escape. Others were lonely and isolated. Their lives were coming apart and no amount of advocacy, good behavior, good works, or faith--one woman was a Dominican nun--seemed to matter.

**WHAT**

Almost total annihilations, professional atrocities, invisible scars, visible scars from lobotomies, friends dying in their arms, freedom and trust violated, stigma expanded, little information about patients, including next of kin contact information, if families were known; families were not always not notified of significant events, including death.

**WHEN**

Opened as Willard Asylum in 1869 and became Willard State Hospital in 1890. Willard closed in 1995 with 4,000 patients in residence and after some 50,000 people passed through its halls during a 126 year history. According to Dr. Peter Stastny, one of the authors of the book profiling the finding in the attic, “People did not leave there unless it was in a box.” In other facilities spanning the 18th, 19th, and 20th centuries, we found similar, but well concealed, potential situations during our research.

**WHERE**

Willard, New York, as well as institutions across this nation, including Dorothea

Dix in North Carolina.

**WHY**

In a civilized society, is there an explanation? A discussion of Social Justice does little to explain the attitude associated with the atrocities. At the time, the rationalization may have been: “These patients were deemed incurable, locked in and locked up forever.” This reflects the universal thought of the day as related in the book, “The Lives They Left Behind: Suitcases from a State Hospital” by the author, Dr. Peter Stastny.

This incredible body of work, both visual and verbal, is visionary. The burden which was so great has become a gift from those at the helm: Peter Stastny was a psychiatrist with the New York Department of Health when he was

called in 1995 by the curator of the New York State Museum, Craig Williams, to assist him with the project of documenting the 427 found suitcases in the attic as Willard was closing.

Dr. Stastny consulted with cinema photographer Lisa Rinzler for her expertise of visual archiving. Additionally, Darby Penney became involved in this 10-year project of documenting contents of the suitcases and attempting to put the pieces of the lives in the puzzle together, giving meaning finally to those who had existed there.

It is interesting to note that more was known about the building itself than was known about the occupants. The Second Empire designed building was

proudly registered on The National Register of Historic Places in 1975. It

currently houses a prison for drug-abusing parolees. Peter Stastny is currently Associate Professor at Albert Einstein College of Medicine. As of this research and writing, no family member has retrieved their loved one’s possessions.

The people mentioned above deserve a round of thanks for bringing this story from the shadows. It is currently a traveling exhibit. For its debut in Albany, New York, over 60,000 people attended. The time is here and now for those of us interested in Real Reform and Real Recovery to carry the banner of possibility. This is one time which we hope will be a harbinger of the future that, “When people have problems, biographies usually disappear.” As those noted above said about Willard, “They have managed to move from being hidden in the crevices of an institution to being in a room of their own. Now they can talk to us and share who they are.”

**DOROTHEA DIX**

Dorothea Dix (1802-1887) was a distinguished social reformer. She was a pioneer in mental health and prison reform, as well as taking the lead for women during the Civil War as the Union Army’s Superintendent of Female Nurses. She recognized early on that many individuals were being held in prison instead of being treated for emotional and medical conditions in a hospice-type arrangement with an attendant wellness atmosphere. She campaigned, lobbied, and advocated for the right of this service to exist for over twenty years. She was lovingly, and sometimes apprehensively, known as “Dragon Dix.” She may have created one of the early cracks in the proverbial glass ceiling.

By the year 1848, North Carolina and Delaware were the only two of the original Thirteen Colonies without “Asylums for the Mentally -----------.” (Fill in the blank with any one of many disturbing and archaic terms.) Off Dix went to many different locations in North Carolina to explore the possibilities for such a place of retreat and refinement for those who most needed a healing place.

Dix completed an exhaustive study, presented her findings and choice of location to the North Carolina Legislature. After failure, negotiation, re- negotiation, (and while nursing a prominent Senator’s wife,) the bill passed the North Carolina House and Senate on December 30, 1848. The fiscal appropriation was for only $7000.

Citizens of means who were able to donate land, food, equipment, and additional dollars did just that after yielding to her convincing and selfless arguments. Many people were convinced that her good works were a genuine effort to actually serve those among us in a humane manner without regard to a bottom line, as we would say today. “Dragon Dix” boasted that donating to her cause really was donating to  *her* cause. . .and with her, “what you saw and what you heard was what you got!”

She insisted that the organization NOT be named for her as was the desire of most of those in support of her efforts. She relented to allowing the area to be named “Dix Hill” but not “Dorothea Dix” anything! Dix Hill admitted the first

person on February 22, 1856.

**DEINSTITUTIONALIZATION**

Another factor to consider in our mental health history timeline is **deinstitutionalization**, which began in the US in 1955 and catalyzed by The Community Mental Health Bill of 1963. This is the concept of replacing long- term psychiatric hospital stays with less isolated community-based

alternatives, such as supported housing, assertive community treatment teams (ACT) and other local, state and federal initiatives. Some say this was a means of reducing costs; however; according to people and organizations on the other side of the issue, there seems to be to The Olmstead Act, issued in 1999, reinforced the right of individuals to live in the least restrictive environment in their own communities rather than in institutional placements.

Deinstitutionalization had sound concepts at its heart. However, population growth has far outpaced the availability of adequate beds in psychiatric hospitals over decades. In 1970, there were 413,066 mental health beds in the US; by 1998, there were only 63,526. *(Source: Wikipedia)* According to data cited in *The Shortage of Hospital Beds for Mentally Ill Persons* (March 2008,) there were 340 public psychiatric beds available per 100,000 U.S. citizens in

1955. By 2005, the number plummeted to a staggering 17 beds per 100,000 persons.

While hospitals have been emptying--even closing--most communities still lack comprehensive and appropriately coordinated discharge planning services, as well as limited community alternative options. Many people have nowhere to go but the streets, homeless shelters, and often to jails or prisons. As unacceptable as long term hospitalization may be, these outcomes are even less so. Today in North Carolina, about one third of all people who are homeless, and up to one fifth of those incarcerated, have mental health struggles. *(Our Journey Home: 10-Year Plan to End Chronic Homelessness in*

*Pitt County.)*

As reported in The *Olympian* (Washington) on October 9, 2003, “40 mental health hospitals have closed in the last decade, according to US Justice Department and, during the same period of time, 400 new prisons have opened.” Rykers Island Prison in New York, Cook County Jail in Chicago, and the Los Angeles County Jail are currently the three largest *de facto* psychiatric facilities in the US.

**COMMUNITY–BASED CRISIS INTERVENTION**

Human voice, human touch, and having a heart—being human--is especially important when supporting someone in crisis. In this electronic-driven world, we sometimes need to hear a real voice connected to a real person. For that very reason, many communities have implemented hotlines for emergency or crisis situations, and warm-lines for making that connection and keeping a person safe. These resources usually have a toll free number to streamline access from any location. In talking with the caller, a hotline operator may activate a mobile crisis team to wherever the person is located.

The purpose of mobile crisis is to intervene in situations where an individual's mental or emotional condition may result in behavior that poses an imminent danger to self or others. Mobile crisis teams (MCT) visit people in their homes or community sites, and others meet individuals in clinics or hospital emergency rooms. The team often includes a number of different types of mental health workers, including a psychiatrist, RN, MSW, psychologist, and Peer Support Specialist. In North Carolina, the MCT was one of the first paid positions that called for a PSS. Please refer to your notes at end of manual for services available in your area.

**Examples with Appropriate Quotes—Activity Fish Bowl**

How might PSS principles and activities be applied to achieve the best possible community alternative outcomes?

The One Minute Paper or fish bowl with appropriate quotes:

❧ “People don’t care how much you know until they know how much you care”! -- Mike McKnight

❧ “We must not only educate the mind, but also the heart”. – Kobi Yamada

17.Define stigma and write 2 ways you as a PSS can reduce stigma in your community.

**STIGMA**

*If we cannot now end our differences, at least we can help make the world safe for diversity.*

- President John F. Kennedy

No history of Mental Health would be complete without discussing stigma and its effects. Stigma is the expression of discrimination, disapproval, judgmental attitude, or rejection toward an individual regarding personal or cultural differences, including but not limited to physical attributes or characteristics, beliefs, practices, disability, or diagnosis. Stigma is a form of ignorance that gives permission to the school yard bully, to the street gang member, and to the neighborhood gossip. Whether we are a recipient of it or a witness to it, stigma hurts us all.

As recently as August 4, 1988, a US Presidential candidate had to address rumors about his mental health. When asked whether the nominee should make his mental health records public, the opposing candidate replied, “I’m not going to pick on an invalid.”

For us as Peer Support Specialists (PSSs), stigma is not just the use of the

wrong word or action. Stigma is about not respecting individual differences. It is the use of negative labels to identify a person living with issues around the topic of mental health. Stigma is a barrier and discourages individuals and

their families from getting the help they need due to the fear of being discriminated against.

18.What would be an appropriate approach for a Peer Support Specialist to take with a person served who talks about suicide. Pg 32-33.

**SUICIDE**- As stated earlier, stigma in our lives is pervasive. Until only a few years ago, many people avoided interactions with patients who had cancer. They talked about this condition in hushed tones and termed it the “C” word. Similarly, even today, people avoid talking about individuals who may experience challenges and may have experienced trauma, leading to even greater struggles. Speaking of suicide today is analogous to decades ago and the usage of the “C” word for describing cancer. This gives hope to the advantages of research and education. It is impossible to have brought you here and stopped the conversation as it led to one of the most important and painful situations facing us in this field.

**Note**: This may difficult for some to review, but it is absolutely necessary! As Peer Support Specialists, we will hear stories of suicide from those who have attempted it, those who think about it, and those who have experienced it from the other side (the loved ones left behind). Perhaps we will be able to move the topic of suicide from whispers behind closed doors to thoughtful, “heartful”, meaningful discussions in our living rooms and classrooms and board rooms.

We must try to initiate that conversation about suicide and the stigma around it because the following facts are too alarming:

❧ Suicide is the 8th leading cause of death in the United States, claiming about 30,000 lives a year.

❧ Ninety percent of persons who commit suicide have depression or another diagnosable mental or substance abuse disorder.

❧ Every day, 14 young people between the ages of 15 and 24 commit suicide;

that's approximately 1 every 100 minutes.

❧ Suicide attempts are among the leading causes of hospital admissions in

 persons under 35.

❧ Men are more than four times as likely as women to commit suicide.

 However, women attempt suicide about twice as often as men do.

❧ The highest suicide rates in the U.S. are found in white men over the age of

 85.

❧ Suicide can be prevented.

There will be practical approaches to prevention discussed in appropriate

sections of this curriculum.

19 Make a brief timeline sighting the main Legislative events beginning in 2001-2013. Pgs. 34-40.

**PARADIGM CHANGE: THE PEER MOVEMENT WITH REFLECTIONS ON SOCIAL JUSTICE** *We envision a future when everyone with a mental illness will recover.-* New Freedom Commission on Mental Health, 2003

So how did we come to “know what we know?” How did we learn that there might be a better way to become inclusive and embracing? When did we realize that we could benefit from discovering the beauty and newness of another’s story? Did others endure the same pain, struggles, and invisibility, but ultimately make meaning of it?

The historical answers are plentiful and may surprise you. The origins of the “Peer Principle” are found in the early Native American community as “Peer Guides.” From the 1840’s to 1900’s in this country, temperance missionaries appeared after self-disclosure. Groups of physicians came together for addiction removal and “healing of the head” from 1850 to 1920. AA and other

12-step groups from the 1930’s had active networks in place. Surprisingly, European countries like Switzerland started the peer/mentoring/sponsor process consistently on a maintenance basis by 1877. Everybody seemed to understand Reisman’s Recovery slogan from 1965, “To get it, you have to give it away.”

At about the same time there was thought, not necessarily movement in the US on all fronts in terms of pairing up “peers”, there were other smaller and equally effective movements designed to bring attention to and reform the idea of somebody being different and being held without promise of appeal, against his will, forever. In 1908, there was a resulting outcry to the autobiography published by Clifford Beers, “A Mind that Found Itself”, describing his experiences in mental “asylums”. This provided the impetus needed for those who were outraged to think this sort of thing would/could happen in America…better yet, in Connecticut! Soon was formed The Connecticut Mental Hygiene League, the first of the support groups as we know support groups today.

We have learned that differences and cultural beliefs are possibly divisive. We know that it is necessary to question “how we know what we know” as well as asking, “Do we know as much as possible?” Is something possibly hidden here? If so, “what and why?”

Are we ready to embrace the concept of inherent worth which each individual

brings to the table? Are we applying universal principles and our own an

agencies’ values and ethics? How would we feel if somebody said, “Who would want to be you?” Do we fully grasp the impression of “for the greater good” and how one person’s not questioning is able to lead to “group think” or “herd mentality” to expand the concept to include an enormous number of individuals.

The road to recovery reform in North Carolina has been quite extensive, with twists and turns and ups and downs over the last couple of decades. We would like to start this section with some brief explanations before summarizing some of the legislation that regulates mental health care services in our State.

In North Carolina mental health, substance use disorders and people with intellectual distinctions are managed under the same agency. The Department of Medical Assistance (DMA), a division of NC Department of Health and Human Services (DHHS), serves as the State Medicaid Agency. DMA provides oversight of Medicaid and waiver issues.

The term, 1915 (b)/(c) Medicaid Waiver, refers to two sections of the Social Security Act that allow states to apply for waivers from federal Medicaid policy. These waivers that are in effect in North Carolina are lengthy, but we will attempt to highlight what we feel are the portions that are likely to affect those working as peer support specialists.

It may be important to note here two portions of the waiver that deal with “statewideness” and “freedom of choice”.

Chapter 122C (Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985) is the North Carolina Statute that “regulates” mental health care services in this State. This law outlines the management, funding and governing aspects of those services.

As mentioned earlier in this text, The Olmstead Decision passed in **1999** required states to place people with mental health disabilities in to more community based programs and fewer institutions.

**2001**: North Carolina's General Assembly passed the "Mental Health System Reform Act," which required local jurisdictions to separate the management of mental health services from the delivery of those services.

Previously, county programs and area authorities delivered mental health services by directly employing the care providers.  This law required the governmental local management entities (LMEs) to contract with private providers for the mental health services needed by residents and to change their focus to system management and oversight.

**April 1, 2005:** The State of North Carolina, in collaboration with Piedmont Behavioral Healthcare (now Cardinal Innovations Healthcare Solution, created a pilot program using 1915(b)/(c) waiver authorities (see note below). The pilot program allowed the LME to operate as a Prepaid Inpatient Health Plan (**PIHP**) for Medicaid. In essence they were acting in the role of an insurance provider.

Services were provided based on a capitated model, in which a set amount of money each month is paid per person rather than per service. Capitation is used as a means of controlling the growth of health care costs by allowing management providers flexibility to budget money by designating services based on the needs of those served.

According to the State:

 “The goals of this capitated health plan initiative are to:

* Better tailor services to the local consumer by adopting a consumer-directed care model and focusing on community-based rather than facility-based care.
* Enhance consumer involvement in planning and providing services through the proliferation of MH recovery model concepts.
* Demonstrate that care can be provided more efficiently with increased local control. “

**December 2006** During its first year of operation, it was determined that the waiver program had generated savings through care and utilization management strategies. The State received approval from CMS in December of 2006 to invest those savings into additional 1915 (b)(3) services. The purpose of the new services was to provide cost-effective, supplemental services and supports aimed

at decreasing hospitalizations and helping individuals remain in or return to their homes and communities when preferred and appropriate.

**2010** - Due to the success of the capitated service delivery model, the State requested and obtained approval from CMS to expand the model to other LMEs across the State over time. NC General Statute 122C was amended to require the expansion of the waiver program statewide by July 1, 2013.

**2011** - Legislation was passed requiring the N. C. Department of Health and Human Services

(DHHS) to, once again, restructure the management responsibilities for the delivery of services to individuals through the 1915 (b)/(c) Medicaid Waiver.

The Managed Care Organizations (MCOs), formerly called local management entities (LMEs), are the regionally based agencies that receive a set monthly payment from the state to provide both state- and Medicaid-funded mental health, intellectual and developmental disability and substance abuse services around the state. With that money, the MCOs must allot services for everyone under their care.

The statute requires each MCO, in order to participate in the waivers, to have a catchment area with a population of at least 300,000 by July 1, 2012 and 500,000 by July 1, 2013.

Part of the responsibilities of the MCO’s is to ensure that the providers are qualified and certified. They also monitor the services provided by having a coordinator meet with the providers and the people being served to determine if the services are appropriate and beneficial.

A large network of private providers was built up to increase service capacity in local communities across the state. Concerns were raised by advocacy groups about the quality of care because of so many changes so quickly in the system without proper infrastructure to deliver that care.

**January, 2012** - Western Highlands Network (WHN) was the first of the state’s mental health local management entities to convert to the new managed care model, piloted by Piedmont Behavioral Health (Now Cardinal Innovations). By July of the same year WHN board of directors fired the CEO because he had failed to inform them that the agency had fallen $3 million in debt. The agency tried to gain stability but their contract with the state was terminated in July, 2013. Efforts were made for a smooth transition of services as the agency was absorbed into Smokey Mountain Center.

**DOJ Settlement - Transition to Community Living Initiative**

**2012** -The State of North Carolina entered into a settlement [agreement](http://www.ncdhhs.gov/mhddsas/providers/dojsettlement/nc-settlement-olmstead.pdf) with the United States Department of Justice. The purpose of this agreement was to make sure that persons with mental illness are able to live in their communities in the least restrictive settings of their choice, in accordance with the requirements of the American With Disabilities Act, The Rehab Act and the Olmstead decision. The NC Department of Health and Human Services is implementing the agreement through the Transition to Community Living Initiative.

“The Transition to Community Living Initiative has six primary components:

* In-Reach and Transition - Providing or arranging for frequent education efforts and discharge planning targeted to individuals in adult care homes and state psychiatric hospitals. (*This portion is specifically important because MCO’s are required to have an in reach person who is a peer support specialists*.)
* Diversion – Diverting individuals from being admitted to adult care homes.
* Housing – Providing community-based supportive housing with tenancy supports.
* Supported Employment – An evidence-based service to assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment.
* Assertive Community Treatment – An evidence-based treatment and support model of services offering intensive customized, community-based services for people with mental illness.
* Quality Management – using data to evaluate progress and outcomes.

Each component has settlement milestones. Implementation plans are completed during collaborative work group sessions that are open to the public.”

**2013** - The governing unit of the area authority is the area board. The section of Statue 122C that outlines the makeup of the area boards has been revised several times over the years. However, we just want to note here that the most recent legislation in effect requires no fewer than 11 and no more than 21 voting members. Those members must represent various areas of expertise, including health care management, insurance, finance etc. and most importantly for our purposes, at least 6 members representing consumers of mental health care services.

Oversight of the waivers is performed by Intra-Departmental Monitoring Teams (IMT) with representation from all divisions within the Department of Health and Human Services (DHHS) involved in the operation of the 1915(b)/(c) waivers. They meet monthly or quarterly with The Division of Medical Assistance (DMA) leading the teams. The Division of Medical Assistance (DMA) retains final decision-making authority on all waiver policies and requirements.

Information in this section was taken from the following resources:

**Section 1915(b) Waiver (to the Social Security Act)**

**STATE OF NORTH CAROLINA**

**NC MH/IDD/SAS Health Plan**

**Renewal**

**April 1, 2013 (115 pages)**

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/NC_Cardinal-Innovations_NC-02.pdf>

**Demonstrations and waivers …select North Carolina, 1915 (b) (c)** <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html>

**NC Department of Health and Human Services website (DOJ Settlement)**

<http://www.ncdhhs.gov/mhddsas/providers/dojsettlement/index.htm>

**Chapter 122C.**

**Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985.**

<http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_122C.html>

**NC Department of Health and Human Services website (Medicaid History)**

<http://www.ncdhhs.gov/dma/pub/historyofmedicaid.pdf>

**The Affordable Care Act** expands affordable Medicaid coverage for millions of low-income Americans and makes numerous improvements to [Medicaid and the Children's Health Insurance Program](http://www.medicaid.gov/medicaid-chip-program-information/medicaid-and-chip-program-information.html) (CHIP).

<http://www.medicaid.gov/affordablecareact/provisions/provisions.html>