Mental Health America's It's My Life: Peer Partners

A Peer Driven Answer to Isolation and Social Exclusion

It's My Life was conceived as a peer intervention for the scores of people living with serious mental health conditions and the social exclusion that so often comes with them.

In order to make It's My Life accessible to more people we have adapted the program to run on a support group model. This provides a number of benefits to the individuals participating in the program and to the agencies providing it. One of the most significant benefits is the automatic increase in the availability of peer support through the dynamics of a support group structure.

Unlike the original model where the primary (and sometimes sole) source of peer support is the Peer Life Coach, participants in IML Peer Partners will be connected, and supported by other program participants.

IML combines the techniques of two evidence based practices, peer support and psychiatric rehabilitation, and the techniques and principles of the emerging practice of self-direction.

As each participant is introduced into the program a Peer Coach gathers baseline information from them. New members participate in an interview using the Personal Outcome Measure© (POM) tool, developed by The Council on Quality and Leadership. This survey is designed to measure how each individual rates their own quality of life. It is a qualitative tool that is scored quantitatively. This tool looks at 21 quality of life indicators, such as:

- Do people use their environments
- Are people connected to natural support networks
- Do people have friends
- Do people interact with other members of the community

The Coach also gathers a brief history about hospitalizations and emergency services usage over the prior two years. The results of the POM and service usage are confidential and maintained securely by the Coach and their supervisor.

It's My Life: Peer Partners is a variation on MHA's original social inclusion program, It's My Life: Social Self Directed Care.

Mental Health America piloted the original program for 18 months in Northern Virginia. The program was designed to assist people living with serious mental health conditions and experiencing isolation and social exclusion.

The participants in the pilot were chosen from people receiving treatment through the Assertive Community Treatment model and living on SSI benefits. The other distinguishing characteristic was that all of the original participants had a diagnosis of schizophrenia or schizoaffective disorder.

These parameters were designed to work with individuals who have the most difficulties in developing social connections and personal relationships, and who were living below the poverty line on subsistence benefits. The other factor was that these individuals were receiving the most intensive model of outpatient treatment and had substantial histories of hospitalizations and ER visits.

The Coach serves a double role as the group facilitator and as a "teacher" as group members explore a variety of social skills that will better equip them for participating in community activities. The Coach also assists participants in locating activities that interest them that are available in the community at low or no cost.

Each person develops (with the assistance of the Coach and the group) their own assessment of their social life. They then develop a series of primary and secondary social goals. These goals may be modified as the program evolves.

After setting their social goals they develop a social action plan consisting of specific activities they can put into practice that will help them in the attainment of their goals. The most common identified goal has historically been "The person wants friends or even a single friend). As they develop their action plan they identify activities they enjoy pursuing. By carrying through with these activities they put themselves into environments where they can meet other people with similar likes.

Each participant is provided with a small social budget by the program. The suggested amount is $35-$60 per month. While it does not seem like very much, for people living below the poverty line on SSI, it is a significant amount. These funds can only be spent on social activities. The individual is tasked with developing a "social budget" that identifies specifically how the money will be utilized to assist them in achieving their social goals.

Each week that the group meets the participants develop new action plans for the following week. The group (with a recommended size of 10-12 people) breaks into smaller groups of two or three people who support each other during the implementation of their plans. The program provided each person with tools and assistance to develop goals and to measure confidence and achievement.

Each support group meets weekly or every two weeks for 90 minutes. Each person has an opportunity to discuss their progress in implementing their action plans and achieving their goals. Sixty minutes of the group time is for discussing the details and supporting each other. Thirty minutes of the group is used for the Coach to work with the group on skill building activities with the agreement of the group.

The two programs, It's My Life: Social Explorations and It's My Life: Peer Partners have detailed manuals for Peer Coaches to use. All forms and lesson plans are provided (although coaches are welcome to add to the materials), and MHA is available to provide Technical Support by telephone or video conferencing, and by email. **For More Information Contact:**

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In this version, two full time peer specialists provided each participant with one on one, face to face support and social skill building coaching.

In the first phase of the pilot the coaches would often accompany the participants on their excursions into community activities.

Participants identified activities that they enjoy. Using a small self-directed "social budget" they participated in the activities which provided them with opportunities to meet other people with similar interests.

Success in the program was gauged using several designated outcomes: 1) Quality of Life using the Personal Outcome Measure survey; 2)Guided journaling,; 3) Program satisfaction using anonymous satisfactions surveys; and 4) Re-hospitalization and emergency services usage rates compared to the 2 years prior to entering the program.

Our outcomes surprised even us. Quality of life, as determined by the individual, increased dramatically. As an example, in the baseline survey 0% of participants said they had as many friends as they would like. In the final survey 75% answered affirmatively.

Re-hospitalization and emergency services rates went down over 70%, and 95% of the participants rated their satisfaction with the program at the highest possible score.