The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material may be 350 to 750 words long, with a maximum of three authors (one is preferred) and no references, tables, or figures. Send material to Francine Cournos, M.D., New York State Psychiatric Institute (fc15@columbia.edu), or to Stephen M. Goldfinger, M.D., SUNY Downstate Medical Center (smgoldfingermd@aol.com).

Peer Wellness Coaches for Adults With Mental Illness

With the groundswell of attention on mental health recovery and consumer-centered care, consumer providers in mental illness (or "peers") are working in various mental health settings. However, there has been too little information regarding introduction of peers into treatment settings. Our group has developed a comprehensive program to hire, train, place, and support peers as wellness coaches.

As wellness coaches, peers support an online weight management curriculum specifically for the cognitive needs of people with serious mental illness. The curriculum is accessible to consumers via the Web and via interactive kiosks in the clinic. Kiosks are similar to those used for self-service airport check-ins and feature touch-screen interaction. The interface provides audio to read the questions aloud to the patient while the text appears on the screen and provides pictures and text for response options. The kiosk prints a color report that patients and others can use to advocate for services during the clinical encounter and to track progress.

Coaching through the curriculum is delivered by peers in person for the first session and then weekly by phone for six months. The coaching is strengths based and uses motivational interviewing principles. This clinical service—weight management education supported by peer coaching—is delivered as part of a comparative effectiveness trial in a usual care setting.

In selecting peers, we recruited adults with lived experience with mental illness and experience as a consumer provider or health navigator. It was important to assess applicants' willingness to learn and practice new skills and to receive ongoing supervision. The five peers who were hired had notable personal strengths and remarkable stories of recovery, but they lacked computer skills and recent employment.

We developed a peer coaching manual that includes information about the online weight management program, coaching session content and techniques, and procedural roles and responsibilities (available from the authors). This manual was designed to support consistent delivery of services across peers. Peers received didactic training in the manual and experiential training in coaching. Experiential training started with peers joining a master therapist for live coaching sessions and then leading these sessions. When the master therapist considered peers ready to coach independently, peers began to deliver the curriculum themselves. We found that the training period lasted, on average, five months, which was longer than expected. The skills needed to deliver high-fidelity coaching required considerable cognitive flexibility to switch effectively between the manualized coaching protocol and each consumer's weekly diet and exercise status update. There was much discussion and practice focused on balancing the educational material with variable progress by the consumers. As well, each peer's lived experience, which is highly personal, could not be part of the manual but was important to incorporate into the curriculum.

Once peers were ready to deliver services, individual supervision was provided weekly. Supervision includes time for both clinical issues and professional development. In addition, a master therapist is available on a daily basis for emergent issues. Clinical supervisors audit two coaching sessions a week to rate fidelity and emphasize benchmarks for session content. Without exception, supervision proved to be a challenge to peers at first; adjusting to considerable feedback on their coaching style and content of their calls was a process. Substantial time was spent understanding each peer's lived experience. Any facilitated reshaping of personal experiences so that they could be used effectively in the coaching relationship was, at times, emotional and difficult for the coaches but possible in all cases. Peers' skills, experience, caseload, and job responsibilities are regularly addressed in supervision.

Since the program's inception in March 2012, 74 of 81 enrolled consumers have engaged in the wellness program; many have lost considerable weight. Consumers have commented that their coach "understands me" and "sticks with me whether or not I'm losing weight." Consumers who have dropped out have typically reported financial barriers related to affording healthy foods. None of the consumers have reported that they were leaving the program due to their peer coach. Peers have reported feeling empowered by their capacity to support and motivate consumers in regard to weight issues. Various challenges have also been acknowledged by peers, including working with difficult consumers and following the coaching manual. Peers reported that it is helpful to have "a peer team that works really well together, where we can bounce ideas off each other and talk to each other if we have a hard call."

Delivering best practices while capitalizing on peers' experience is not easy but is worth the effort. Peers extend the treatment team by engaging and supporting consumers who might not have participated in a program delivered solely by clinicians. Employing peers also allows for a mutual learning environment between clinicians and consumer providers. Clinicians involved in training and supervision of peers should anticipate effort proportional to the peer's presenting skills and mental health recovery. Although approaches to peer services vary, our experiences may

inform a framework for those considering peer services.

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Reducing Jail Recidivism for Women With Co-Occurring Disorders

The number of incarcerated women is rapidly rising, increasing 6% nationally over the past ten years. Whereas men and women with mental illness are twice as likely as persons without mental illness to return to jail within six months, the prevalence of mental health problems among incarcerated women (31%) is more than twice that of men. Evidence is limited concerning approaches that reduce jail recidivism for inmates with mental illness, although there has been some success with models incorporating peer mentoring and principles of respect, empathy, and connectedness. In addition to behavioral dysfunction, confounding factors for mental health clients obtaining and maintaining jobs are inadequate housing, lack of transportation, and poor interpersonal skills.

In July 2009 the Los Angeles County Mental Health Department inaugurated Peer Employment, Education and Recovery Support (PEERS) at the Women's Community Reintegration Services and Education Center with the goal of enhancing opportunities to obtain employment, facilitate community reintegration, and reduce jail recidivism for women at risk of incarceration. The focus of the program is educational, with emphasis on the development of healthy work habits and relationships. The South Los Angeles Center is home to the county's largest number of children placed out of home, rising rates of prostitution, and school truancy of 30%. There is continued high unemployment in neighborhoods still recovering from the 1991 riots that devastated local businesses. Opportunities for women seeking services at the center have been hampered by such life experiences as domestic violence, homelessness, and trauma. Ill equipped with life skills before entering jail, women have even fewer resources upon release.

Founded on the conviction that a person is more than his or her illness, the center's approach to mental health care is holistic rather than traditional. Interacting in a manner that preserves dignity and conveys respect is the critical skill that fosters healthy relationships. Previous dysfunctional relationships often alienated women from their families and led to homelessness, continued victimization, and returns to jail.

Clients are welcomed by PEERS fellows who provide support through the assessment process. A clinician guides the individual in development of a life plan addressing needs, goals, resources, and a crisis-oriented intervention. Clients are encouraged to become an integral part of the life and community of the center and to take advantage of classes that focus on work-life balance, financial wellness, parenting, anger management, self-directedness spirituality, self-care, coping with addiction in families, job readiness, GED preparation, avoiding probation violation, and moral reconation therapy (MRT). Women apply for a PEERS fellowship as soon as they decide to pursue employment.

PEERS fellows reenter their communities while gaining an education, earning a stipend, receiving assistance to establish a home, regaining custody of their children, and developing a support network of colleagues with similar life experiences. Providing compensation aids women in rebuilding their lives and is important to enhance self-worth and dignity. Fellows work with staff to develop resumes and prepare clients for job placement interviews. On-the-job mentoring parallels PEERS fellows' becoming an integral part of the center's functioning, "giving back" through participation in MRT as leaders, and in community outreach while also working toward permanent employment. Improving life circumstances affords new challenges, such as relinquishing public assistance and being held accountable for repayment of previously incurred debt, and PEERS emphasizes the critical importance of a consistent but flexible support system.

Among the 29 PEERS enrolled in the fellowship during the first two years, 27 have not been arrested or incarcerated. Twenty (69%) completed the program, of whom 16 (80%) obtained permanent employment. The two women subsequently incarcerated completed the program but did not obtain permanent employment upon graduation.

Reflecting the South Los Angeles center's demographic characteristics, PEERS fellows during that period were predominantly from ethnic minority groups (50% African American, 16% Latina, 16% self-identified as mixed race or other, and 9% Caucasian) and had low levels of education and incomes well below poverty level. More than half were chronically homeless, and most were in the process of obtaining, or were recently granted, custody of their three (on average) children.

Successful PEERS fellows share some characteristics. For example, they are mothers with a desire to raise their children. They want a better life for themselves and their families, they would like to reduce their reliance on public financial assistance, they have a desire to make differences in the lives of others who share similar life experiences, they are enthusiastic about learning, and they have the perseverance necessary to overcome continuous and varying challenges.

Women coping with the stigma of mental illness, dire social circumstances, and incarceration histories have few options for changing the trajectory of their lives. PEERS is a model of community reintegration with the potential to reduce incarceration, facilitate employment, and give previously incarcerated women hope.

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