Innovative Transition for Individuals with Mental Health Disabilities

Presented by Jessica Hazel, Corey McKittrick, Alex Mikowski, Vesper Moore, Vicki Smith

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>> JENNY SICHEL: Well, this is a first.

>> COREY MCKITTRICK: Will they come right back?

>> JENNY SICHEL: What?

>> COREY MCKITTRICK: I said hopefully they come right back.

>> JENNY SICHEL: I might get people coming into the webinar and just type in the chat box that we are waiting for our interpreters. I don't know what happened to them.

I am going -- do you guys think it's okay to start and put it in the chat box? I am not sure what protocol here is. Any thoughts from anyone on the call?

>> I think that's best. This is Sandra.

>> JENNY SICHEL: I'm going to do that, I will start the webinar now.

[Recording in progress]

Hello everyone. We are waiting for our interpreters to hop back on, and we will get started shortly.

Hello everyone again. If you just joined we are waiting for our interpreters to hop back on, and we will get started shortly.

We will do this one more time, I am just waiting for our interpreters to hop on.

Okay. I am in contact with our interpreters, but I'm not quite sure when they will rejoin. And thank you all for holding.

If we do have any interpreters who came in through -- oh, we got one. Hi. Okay. I am going to spotlight you. Hello. Interpreter, are you able to hear me? Are you able to hear me all right?

Interpreter, are you able to hear me?

>> INTERPRETER: Yes, I can hear you.

>> JENNY SICHEL: Okay, great. Are you good if we get started? Or do you want me to wait for the second interpreter?

>> INTERPRETER: No, we can go ahead and get started.

>> JENNY SICHEL: Okay, great. Thank you so much.

Okay, hello everybody. My name is Jenny Sichel, I am the operations director at the National Council on independent living. I help coordinate logistics for these events and I wanted to welcome you all to our latest webinar, innovative transition for individuals with mental health disabilities.

Today's presentation is brought to you by the administration for community living at the department -- at the US Department of Health and Human Services in conjunction with the IL that. The IL that is operated by ILRU and in collaboration with NCIL, April, and the University of Montana.

Giving you a brief on myself, my pronouns are she/her and I'm a white female that is wearing a green shirt, short sleeve shirt, and has my hair pulled to one side in a braided.

To go over a few housekeeping details, captions are available on this webinar. You can click show subtitle in your Zoom menu bar to turn them on. We also have captions running at Ai-Media. URL is too long to read, but we will share it in the chat box. Ai-Media will allow you to lodge the font and change the color and contrast of the captioning.

ASL interpreters are present today and should always be visible as we are presenting in gallery view. Please let me know if you cannot see the interpreters.

In addition to ASL today we will have Spanish translation also available. In order to access that, you can go to the Zoom bar on your screen and choose the language you would like to hear the presentation in. You do not need to be on Zoom video to access this webinar. We will read all slide content and all questions out loud so that everything will be available to individuals calling in on the phone or who cannot see visible content.

Public chat is turned off but you will still be able to send chat messages to the host and panelists. We ask that you reserve the check for requests for technical support only.

Please do not use the panelist chat to submit content questions for the presenters.

Speaking of questions, we will be answering all questions as time permits. You are welcome to submit your questions about the webinar, but please note that they will be held until the end of the webinar during the Q&A portion.

There are a number of easy and accessible ways to submit content questions to the presenters. If you are on Zoom, you can simply type your question in the Zoom Q&A tab. You are also welcome to email your question to me at Jenny at NCIL dot oh RG. That is Jenny at NCIL dot org. I will also put my email address in the chat box.

Finally if you were on the telephone today you may press star 9 to indicate you have a question and start mute when I call and you to unmute yourself. And we ask if you were speaking your question, you limit your question to no more than 30 seconds.

We also ask that you complete our evaluation at the end of this. We take these evaluation so seriously, and they really help us to bring you these webinars and improve on the webinars that we are bringing you and make sure the content is right on track with what people want to hear. So we would be very grateful if you take a few moms to complete the evaluation.

Now I am going to go through our slides here. What you will learn today. We want you by the end of the session to describe the role of peer support in providing divergent strategies and alternatives to institutionalization for individuals in mental health distress.

We want you to be able to identify best practices for outreach and support to psychiatric survivors to receive CIL IL services when they might not identifies individuals with mental health or other disabilities.

And we want you to describe peer-run alternatives to hospitalization that include 24/7 peer run respites run by people with mental health disabilities and staffed by certified peer specialists and mental health and legal policy specialists.

And this is our link to the evaluation survey. Make sure that -- it takes all of like 30 seconds to fill this out. So we want you to do this in a pop-up when you leave the webinar. Just go ahead and fill it out, get it done, and we will be so thankful and grateful.

Onto the good stuff, everybody. We have our panelists. We have Alex Mikowski, Executive Director at access to independent Cortland County. Along with her we have Jessica Hazel, a peer advocate as well from access to independence of Cortland County. We have Vicki Smith, Executive Director at the alliance of disability advocates. And we have Vesper Moore, chief operating officer at Kiva centers and a board member at the Bazelon center for mental health.

We will start this off and Jessica I will invite you to the screen, Alex and just, and we will have you guys get started.

>> JESSICA HAZEL: Hello, my name is Jessica Hazel and I am a peer supporter. This is me, I have purple hair, glasses, and some glamorous jewelry. I use she/her, and here we go.

So the first slide is basically collaborating in a team of mental health professionals and myself. There are appropriate resources that are needed to be discharged and move on to the next level of transitioning. I will be talking from my own lived experience as a person who went through all of these transitions.

Next slide.

Options and choices. It can seem like there are no choices, but there may be some options you can choose from. It's important to try to do concurrent planning. This means to plan for multiple things at the same time. Talk with people who have gone through a particular program, or the staff of that program to help you decide.

Next slide.

One of the options is housing. For instance in my case I went to a halfway house. For some you have nowhere to go and a halfway house may be one option. There are single diagnosed and dual diagnosed facilities that will guide you to a safe path of living with others to eventually living by yourself.

Next slide.

Housing option number two. Another is going back to your original living conditions but with safety standards in place such as therapy, doctors, group sessions, and other community outreach programs that will help you plan ahead.

Next slide please.

Being by yourself. Being by yourself doesn't have to be something to worry about. There were things in the community to keep yourself busy. Find your passion. Volunteer somewhere you would enjoy giving back to the community, more importantly, feeling important. Even doing something as little as coloring or going for a stroll in the park to enjoy fresh air can be helpful.

Next slide.

Motivation. In order to get out and do things, you have to find the motivation. But motivation is very difficult. Think of the worst days and then think of the better days. Remember how you felt. The energy is quite different. Just doing something like getting fresh air boosts your energy and getting that sum on you. Doing something for someone else also helps make you feel better. It's all about getting through those few moments of a rough time so you don't have to go back to the hospital.

Next slide.

So there is a plan. Have resources in place such as getting food stamps, counseling, insurance, and income or social services to help get those insurance and income.

Get appointments made with counseling, doctors, specialists, just in case something pops up and you don't know what is going on. Social services and a safe housing plan.

Medication. Get it all set and arranged to have it picked up. Have a plan in pillbox form and make sure you follow through five days ahead of time before you run out. Have a safety plan to make sure the meds are good.

Next slide.

And then more importantly have a plan. So here is a plan. Safe housing or plan for safe housing. Make sure it is safe. Have people around you that are in a safe area. A plan of action when things get rough. Want to do, who to call, where to go. Know your resources in the community that can help you. So if you need a safe place to go, resources to hook up with you so if you have an eviction notice or where food pantries are. Safe places.

Next slide.

My experience. My experience has been different each time throughout my life. My first and second were out of my hands because I was a minor, I was living with my parents, and I returned home. So I already had a home to go to. My third, I went in and I learned I was not able to return home. Therefore I had nowhere else to go. So I had to put resources in place so I knew a safe place to go to to transition properly.

Next slide.

In the hospital. While in the hospital I applied for Social Security disability as a child due to my mental illness. I was not able to work, I was not able to go back to school because I was too sick to do anything. So the hospital helped me connect with a halfway house, and that took a month or so to get into. So patience is definitely an important thing to have because things take processing time.

I then had to go apply for Medicaid and public assistance while waiting for Social Security.

Next slide.

After 10 months in the halfway house I transitioned to supportive housing for one year and a subsidized housing grant to help pay for my rent.

Next slide.

And look at me now! Currently I am living on my own accord, working part time, involved in the community, driving my own vehicle, paying my own bills, and mentally stable and enjoying life one day at a time.

Thank you.

>> ALEX MIKOWSKI: Awesome, thanks Jessica. My name is Alex and as previously shared I am the Executive Director to access for independence. I identify as a person with a disability. I have definitely got to mental health counseling throughout my life for different stages and reasons. And I have a speech disorder so you might notice I stuttered sometimes. I also have a disability written expression. And today I have a red and black scarf on with a black and white dress and some pride things on as we are gearing up for a local pride Festival. And I have some earrings in. I am a white woman in my 40s.

I'm going to talk a little bit about trying to supervise people who experience mental health. And so the main thing that we try to do is try to have a collaborative and supportive environment. I have experienced supervisors and coworkers that have ranged from helpful with my mental health to not helpful at all, or hurtful. So I have a few tips about how to create a positive work experience.

Next slide please.

At our ILC we have many staff members who identify as people with mental health lived experience, and retreat mental health is a chronic illness, as it is, just like other chronic illnesses. It can have times when there are flare ups or times that it is harder to function.

Next slide please.

So the main thing is encouraging flexibility. Staff, when there are days that are harder, might ask for more remote days, or if they have a job that is supporting people in the community, they might want to limit the amount of public contact they have. Or try to do things that are outside of their normal job activities that excite them or uplift them. And that can help kind of give a break from the stress of their every day as mental health is struggling.

Next slide please.

The nice thing about having this creativity and working outside of people's normal job duties is we found that people have a lot of skills they don't realize they have. And so we can find those things that they are good at and that they are passionate about, and then people have been able to move into other roles that might be more aligned with what they are passionate about at the time. So it is not just a positive for the staff, it's also a really good positive for the agency and the people that we serve in the community.

Next slide please.

Boundaries. That is an important topic all of the time. But especially important when we are talking about this topic. My definition of what a boundary is is sharing what you are comfortable with and what you are not comfortable with within a roll. So I find giving people the space to vent or to work through their thoughts in the moment, I call it debriefing. Or sometimes discussing things after the fact to check in to see what people's perceptions are and work with them to have a plan to move forward.

Next slide please.

Yeah, so boundaries ensure that staff knows what can be discussed and what actions he might have to take. So for example, if the staff talks about persistent or severe thoughts of killing themselves, they have to know what actions you are going to take which might be connecting to crisis services and staying with them until a plan can be made.

Boundaries can also help prevent supervision or support from turning into a therapy session, because even though I am a therapist by trade, I am not my employees' therapist nor the community members' therapist. So the boundaries help you to think through what you are willing or not willing to do, and also what you are licensed to do.

Next slide please.

Tips for coworkers. The wonderful thing about ILCs is we have a diverse team. There are all kinds of people with disabilities and things we are really good at and things we are not. So some tips for coworkers is to try to figure out what skills and limitations that people have and our staff has found rhythms about when it is the best time to talk to a coworker about an unpleasant situation, or how to support each other when they are struggling with a consumer that had a setback or a challenge.

And some of our staff need help opening up bottles, and other people need confirmation that their anxiety is lying to them and they are really not a bother and they are doing a good job at work.

Next slide please.

A few tips about working with minors, and as my partner pointed out, I mean people under the age of 18, not people that begin the ground for things. [LAUGHTER]

I have been working with young folks for the last two decades. Within each job there was a different set of rules, but here are some of the basic principles that we have applied.

While you are not able to consent, it's really important to have their input because it is critical to engagement and to living out the independent living philosophy.

Next slide please.

Even though it is not needed for them to sign that consent form, I really encourage youths to sign consent paperwork if they are able to understand it. So that depends on what their developmental level is and how they are engaging with the process. But if they get to the age of 10 and they are still not signing paperwork, it's a really good time to have that conversation about their involvement in the support. Because it is important that the nothing about us without us also applies to kids, which is our mantra as people with disabilities.

Next slide please.

While you need consent to refer to nonemergency services, you don't need consent to give the consumer information for them to call themselves. So we do the same thing with community members that may not want to be open or may not want to sign that consent, but want support or information.

The second important point is that sometimes it is very easy to bash, quote unquote, or to put down the parents or guardians who are not playing an active role in the youth's life. But it is important not to give into that and to help the youth try to have a better understanding of how they are dealing with their parents or guardians support or lack of support.

Next slide please.

Finally, understanding your rights. It's really important that as people that use our services, we know who we should complain to or who has the oversight over this place that we are receiving help from. So hopefully you never, ever, ever have to contact a state oversight agency or a lawyer. But it's important to know where to go if you do.

We are in rural upstate New York, and in New York State there is a legal program within the state for issues that might arise. So for example, you are admitted to an inpatient hospitalization. They want you to take medications. You object. You can have that mental hygiene legal person meet with you, go to court with you, and help you through that process. So know that you have rights even if you are secluded away and forced to stay there and seek out support whenever you need it.

Next slide please.

And I am done. Thank you so much.

>> JENNY SICHEL: Thank you so much, Alex and Jessica. That was awesome.

Next up I am going to introduce to you all Vicki Smith. Vicki, do you want to pop on with your camera and voice? Give me one second, I am going to spotlight you.

Okay, you are good to go.

>> VICKI SMITH: Hello, my name is Vicki Smith. I am an older white woman with gray hair and glasses, and I'm wearing a print shirt with black and gray and other colors in a pattern that is supposed to represent flowers.

I identify as a person living with mental illness. I came to this diagnosis as a result of a breakdown that I had at a place of employment. I was not hospitalized, but I did have to receive pretty significant counseling, and I was unable to interact or go out of the house for several weeks.

I have been working in the disability arena for over 40 years as a result. This is something that becomes a vocation for many of us, and some of us are just lucky enough to get paid to do this work.

We are here today to share a tool with you. Some of you have maybe heard us talk about this before. But we call it measures of community participation. These measures are a list of things that people do in the community that include such things as going to church, getting a job, going bowling, going to a baseball game. Just lots of different things that people do.

We use this tool at intake when people come to us, and what we have found is if we can zero in on what they want to do and help them achieve those goals, that they are more likely to retain their housing. And retaining your housing is pretty important to community living. So it is a very critical thing that is being studied by Temple University. And let me say that these measures of community participation, we have talked about it on lots of different webinars over the last couple of years, and we will share them with you if you would like to have them. And all you would need to do is email either me or Corey McKittrick who runs the program, and our emails are our first name, mine is Vicki at ADANC dot org, and Corey's email is Corey at ADANC dot org. This is available at no cost. We think they make a difference. It really allows us to zero in and find out what people want to do, what is important to them, and then help them remove barriers to achieving those goals.

I can talk about this for a really long time. But I think the goal here on this webinar is to share information from many angles on how the Centers for Independent Living can really interact with and make a difference in the lives of people with mental illness. And I think there will be opportunities at the end of our formal presentations to dig more into this.

I know I was really quick, but I hope that's okay, and we leave plenty of time for questions from people watching this webinar.

>> JENNY SICHEL: I think that's great. And I think that Corey is actually going to put in the chat a link to the practice. So Corey, if you want to post -- there you go. So you guys can go visit this link and take a practice version of the measure that Vicki was just talking about.

Thank you so much, Vicki. And I am sure there will be a lot of questions for you at the end. Now I am going to introduce Vesper Moore. Vesper, would you be so kind as to hop on?

>> VESPER MOORE: I would. Hello, hello everyone, my name is Vesper Moore, I use they/them pronounce and I'm the chief operating officer of the kiva centers and I am a Board of Directors member at the [can't understand] center for mental health law. Today I am talking about the kiva centers. We are a psychiatric survivor and trauma survivor run organization, and in the mental health disability community I think it is so essential that when we look at how we can really bridge cross disability, cross generation, I think peer supporters is a part of that, mental health peer supporters a part of that.

Today and going to talk a little bit about the history of the visitors until we came to be and talk about peer run respites, and hopefully that will inspire some of the independent living centers here and initiatives to work on disability run peer respites because I think that would be a great initiative.And TCMO spaces that we can and will do this.

A little bit about our history. Our organization was born in the civil rights movement and Kiva centers was established

As a direct result of the early ex-inmate survivor experience.

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We came from a group called the empowerment sponsoring committee or M power a member run organization of people who identifies mental health consumers and current and former psychiatric patients with the mission of advocating for political change and social change within the mental health system. That's a little bit of our history, and this was in the 70s. Actually the 70s was the mental patients liberation front and in the 80s and 90s we became M power and we bridged into this work.

Next slide.

Kiva centers. The meaning of Kiva, kiva is a Hopi Zunni term which means to go deep within yourself and come out healing yourself. Fun fact about Kiva, we are in indigenous run organization and I am of [can't understand] descent which is indigenous of the Caribbean and our Executive Director has Hopi and Sunni roots and the idea of the turquoise K and the feather is symbolic of liberation, feathers mean liberation amongst many tribes. So we continue that message of liberation and self transformation, and again Kiva being ancestral chambers where people would climb in and reemerge having healed themselves whether through contemplation or meditation or many things.

When I say heal themselves I mean emotionally, finding an emotional direction towards healing because we often talk about that capacity for healing, but it is very, very important.

Next slide.

Kiva centers, we are a peer run organization that support people with social impacts like trauma, mental health, and substance use. Kiva centers fosters environments for trauma healing, advocacy, self-determination, and mutually empowering relationships. And I think that's a big part of what we do. Everything that we do as a community is designed by the community for the community, from our peer support groups to what our peer run respites look like to what our recovering community peer run droppings look like and all of our different spaces.

Next slide.

Thank you. Some of our key projects. We train and certify certified peer specialists in the state of Massachusetts. We do statewide and national technical assistance. And I think a big piece of that technical assistance has been that we have supported other states and other countries and starting peer run drop ins and peer-run respites. Right now we are supporting the state of Indiana was starting their peer run respites and we have really conversations about that that we hope to continue. We have supported the state of Maryland with an respites study and we are connected with many peer-run respite organizations throughout the country. There are 14 states and 50 in the country.

We do other additional peer support training, continuing education, some of those key pieces, and we will talk a little bit about peer-run rest put in a moment, so let's go to the next slide.

More initiatives. We have peer bridging. We are in state hospitals and mental health acute units in 100 cities and towns in Massachusetts doing informationals and some of the only nonpsychiatric peer support groups are run by psychiatric survivors, people with mental health disabilities for people on the inside and introducing them to resources on the outside, but also focusing from a places of the termination and otherwise.

We also have a Massachusetts peer workforce coalition because there are many different peer support pathways and lived experience professions. There are community health workers, peer recovery coaches, family partners, certified older adult peer specialists and it is different state to state so we like to have solidarity and join as a coalition and talk about the value of our differences and our [can't understand]

We have two peer-run respites and we are opening 1/3. One is called carina and another is called Juniper and the newest is called [can't understand]. [can't understand] is the word for moon, rest, and self reflection, and Juniper is a plant medicine for a lot of tribes.

And then from there La Paz is the word for the peace in Spanish, and that is an important piece as well. Our community was founded by Latina/Latino community members and advocates, and I think it's important to mention that a lot of Latina/Latino people have Native American ancestry and are reclaiming that indigeneity. So a lot of the names and what it is symbolic of is really to take this idea of how we approach mental health from a community focus and a holistic focus. Because when we think about what peer support is, we practice peer support at our home. At the kitchen table. We practice it in our community, at the barbershop, at the library, at the salon. So that is an important piece.

In addition we also have our Kiva recovery learning communities where we do peer support groups in libraries, coffee shops, museums, and out in the community. And we have our own drop-in centers where people can just combine. They don't need a referral or a recommendation. They can come in for support, and again it is run by people with life experience in that regard.

Next slide please.

A little bit more on peer run respites. Studies have shown that peer run respites can reduce hospitalization by 57 percent. And why is this? I think when we talk about how life experience informs our ideas of disability and health and how we understand each other and community, that context is extremely important.

I also think if there is a better guide in terms of sustainable resources that work for us in the wider community, because we know what works well for us. We in a lot of ways are experts in our own journey, you know, because we have had to navigate the systems. And we have had to face that inaccessibility, that ableism, and find ways to navigate those spaces.

So with that what we found at our peer run respites, since supporting 761 people from 2021 until now, we have found that people live more fulfilling lives in the community, and in a lot of ways I find that peer run respites is a crisis model. When we are talking about mental health, it's a fantastic way of fulfilling the promises of the disability rights movement. When we talk about Olmstead and ADA and the right to live in community with fully integrated lives.

Our Karaya and Juniper peer respites offer rest and reflection to all people experiencing emotional distress. You don't necessarily need a mental health diagnosis to stay at our peer-run respite. I think that is an important piece, because when we talk about the context of mental health it is again so fast. And when we talk about the context of inaccessibility in society to mental health, we are talking about the presence of negative messages is not as important as -- I'm sorry, the presence of positive messages are not as important as the absence of negative messages.

For example, there was a sign that says you are a flight risk and another one that says have a nice day. I am not hearing have a nice day. I am hearing that I am a flight risk. So we think about this a lot in our environments, and again our community comes together and thinks about how did I feel when I was in this inpatient space. What didn't work for me, and what environments have made me feel great. And then we build and design our peer respite homes after that model, that approach.

We support people through what is called crisis, again, to find healing. And our initiative for statewide. We also have mobile peer run respite where we meet people in the community and we support them for up to four hours at a time. Whether that is meeting them just outside of their home at a distance or meeting them virtually for support or at a favorite coffee shop or a library or a place they like to go to. We are supporting people who are struggling at that moment in time.

The great thing about mobile peer-run respite is if you tasted something like a peer respite model, when your houses are full of people and you have a lot of people who are waiting, you can go see them in the community and support them. And the beauty of this model too is that you can introduce people to resources before they come into the peer run respite. You could connect them to alternatives and you can meet with them multiple times a week. So we may do one session where we meet with someone on Monday for example, and then we will do another one maybe on Wednesday or Friday. There is not really a limitation on how often we meet with people, and we don't necessarily define the crisis for them. It is when they need it.

Next slide please.

So I think just in terms of wrapping up, something that I see in terms of mental health peer run respites and other spaces is that people leave inpatient settings and different settings with sometimes challenges trusting those institutions are trusting the resources afterwards. Some people identify psychiatric survivors, some people identify as neurodivergent, people identify in a plethora of ways because of the experiences they have had and how they view themselves in society.

And I think we don't necessarily need to conflate identity with belief system to understand that we need solidarity as a disability rights movement and as a disability community. So I think something that is so important when we talk about peer run respite models is again when we talk about the message from the South African disability rights movement -- nothing about us without us.

We are talking about designing initiatives for ourselves run by ourselves as a way of diverting people from sometimes institutions that can really harm them, and again fulfilling that promise during disability pride month that we have a right to live in community. We have a right to interdependent life and individual life and independent life.

Thank you.

>> JENNY SICHEL: Thank you so much, Vesper, for that. So we are going to enter into our Q&A portion right now. So please feel free to put your questions either in the Q&A section in the Zoom bar. You can email them to me at Jenny at NCIL dot org, or if you are calling you can hit star 9 to raise your hand and when I call on you star 6 to unmute. We do ask that you keep any forced questions to under 30 seconds of possible.

I also just wanted to mention to everybody make sure that you fill out the evaluation. A link was posted in the chat for you all, and we will post it a couple more times as well. But please go ahead and fill out that evaluation. It takes about 30 seconds or one minute maybe, but it gives us so much feedback.

The first question is I believe for Vesper. This is from Trish. Trish rights in my studies about peer-run respite home centers I see that sustained funding is a challenge for even really successful programs. Can you address this?

>> VESPER MOORE: Absolutely, absolutely. One important piece for peer-run respites is sometimes you have to propose a new piece of legislation to eventually work towards earmarked funding for something that is specifically an run respite.

What we have done very uniquely I think at Kiva centers is we have taken existing respite funding, and in our master service agreement we have written and in a way that is very aligned with peer support ideals and peer support values.

And for all clinical requirements or medical requirements, we have outsourced to other agencies entrusted folks were we have entered a memorandum of understanding and a partnership. And we have trained them in our peer support approach in what we do.

In Massachusetts it is a model A respite which is a blended capacity respite and again it is through a master service agreement. So what we have been able to do is as long as there is a continuing need and proposals or RFPs come out for peer-run respites, we have been able to put in those proposals and we have been able to say we want to expand our existing master service agreement.

And I will definitely encourage folks to email me if they need more support and technical assistance around this. My email is Vmoore at Kiva centers dot org.

>> JENNY SICHEL: And stay on because a follow-up to that, Max is asking how can we get more peer-run respites started in Michigan? There is no alternative to psychiatric hospitalization.

>> VESPER MOORE: That's a great question. It's interesting state to state, and I would say that a way to do it is partially to start with legislative action to really propose the need or really talk about and advocate for the need of an run respite. I would go to your statehouse. I would have a day, multiple occasions where you are talking to representatives about the need and the rising need of it.

I know that that is not the exact solution here, but it is one of the many things that we can do.

And I do think, to my point earlier, there are existing funds for clinical respites. And there has only been an ample expansion in behavioral health that we have seen these last three years. So if you know a peer-run organization that is willing to take on the task and you know state partners that are willing to be nimble and flexible in terms of peer-run values and what is needed in the implementation process and you want technical assistance from an entity that is already doing it, it is very tangible to take existing funds and convert it to a peer-run respite.

>> JENNY SICHEL: Great. And Trish just asked if you could put that email that you mentioned into the chat because the one on the slides is the Vesper.moore.

And just a reminder to people, if you have any questions for our panelists, please feel free to put them in the Q&A section. You can email them to me or push star 9 to raise your hand. And we will give it about another 30 seconds or so for questions.

If there aren't any more questions I will ask our panelists while we are waiting for more questions, we will say, and Trish actually just ask the question. Vicki, are you available to Zoom with a specific center or HR people or anything like that?

>> VICKI SMITH: Yes, we are.

>> JENNY SICHEL: Great. And the best email to reach out to you is the one we put in the chat, correct?

>> VICKI SMITH: Exactly.

>> JENNY SICHEL: Great. Thank you. That was just a quick question that somebody asked.

So I do want to ask well I have you want, Vicki, do you have any other things that you want people to know about mental health transitions or working with people with mental health through transitions?

>> VICKI SMITH: I will try to talk slower. This program came about because the protection and advocacy system used their investigatory power to go into homes where the state was keeping a lot of people with mental illness. They moved them out of psychiatric hospitals and into these other care facilities thinking if it wasn't a psych hospital that it was community living.

Protection and advocacy did an investigation, issued a report called trapped in a fractured system of care. That report then led to a filing with the US Department of Justice who came in and if their own investigation and then required the state of North Carolina to move people out of these institutions that weren't state run but still institutions, and into the community.

So this is a settlement agreement that the state was having difficulty achieving until they developed this model program with our center. And I think our success is one, we are a Centers for Independent Living, so we have a lot of peer support on staff and a lot of peer experience. And using that we were able to establish rapport with our folks and we are able to help people take advantage of the resources the state has to provide to people with mental illness coming out of hospitals and into the community.

One of the things that is happening is that more and more of the local management entities, that is what they call them in North Carolina, are starting to look towards Centers for Independent Living because of our peer run model as a way of achieving better success living in the community. Is that helpful?

>> JENNY SICHEL: I think that was great actually. Definitely very interesting. So thank you so much, Vicki.

And then I will just check in with Alex and Jessica, do you guys have any final departing words?

>> JESSICA HAZEL: Hi, this is Jessica. I think growing up as a minor with a mental health diagnosis and being in the hospital, I think one important thing that I did learn was to listen and be heard and believed. That was definitely the hardest part, was not being listened to and not being believed, and then having that impact growing up. And that followed you through the years and it affected me as an adult now. And I'm just about in tears because of how that does have an impact growing up and remembering how hard it was trusting the hospitalizations and trusting whether I should go back on my own or being forced to.

And I wanted to make the decision is it safe for me to go. So having those moments the last two times I went, I had to make that decision. And those decisions were very hard for me because of my past.

But I am grateful today that I did make those decisions because it was the safest for me to go. But yes, being heard as a minor, and believe them. Because what they say is so important and what they are going through. They listen to everything and they notice everything that is going on around them. So just listen and hear them, believe them.

>> JENNY SICHEL: You are going to make me cry. I also live with a mental health disability and it started when I was a minor. I 100 percent agree with that. And be open to caring for them because it's hard for anyone, including adults, to speak out about mental health. So it's really about being open as well. Sorry, Alex, you are going to say something? Go ahead.

>> ALEX MIKOWSKI: Yes, not a problem at all. Believe each other. If you take nothing else away, that's a good thing to take away.

I would just encourage that one thing that was helpful for me is the theory of the rubber band. As stress and life kind of pulls tension on that rubber band, figuring out what are the self-care things or the support you can do that lessens the tension on the rubber band. So I have days when my mental health is not as great or when stress or drama is high. So I have a plan for whom I going to talk to, even when I leave this webinar. This is great but it's just a little more stress, so how am I going to take care of myself?

So that is the last thing I would leave you with. What is your plan to take care of yourself in an average day and when you are having an average day.

>> JENNY SICHEL: Great, thank you so much. Thank you two both for joining. Vesper, any final words? If not we will do a quick wrap up. Go ahead.

>> VESPER MOORE: I think I would just want to say thank you all for taking the time today. The mental health disability community and all disability communities are expensive, and it's really great to see this continued dedication to cross disability and crossgenerational work. I'm excited to see moving forward.

A little bit about myself. I was institutionalized as a young adult and that is why I do this work, but I have also found over time being more and more involved in the disability community, it's an important piece that we are together as much as possible and collaborating on these initiatives. Thank you.

>> JENNY SICHEL: Great. Well, thank you to all of our presenters. This was amazing. And to all of our attendees, we have our evaluation link on the screen right now. And you can also take a screenshot with your phone of the QR code. Go fill it out, 30 seconds, and we would be so appreciative.

Thank you again to everybody, and we will see you on our next webinar.

Thanks all.