Parachute NYC: Tracing the Origins, Development, and Implementation of an Innovative Alternative to Psychiatric Crisis

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Note to Reader

This white paper is a product of extended collaboration among multiple partners involved in designing and implementing Parachute NYC: the New York City Department of Health and Mental Hygiene, the Nathan S. Kline Institute (NKI) for Psychiatric Research, and experienced trainers in the Need Adapted Treatment Model (NATM: Volkmar Aderhold, Petra Hohn, and Edward Altwies) and Intentional Peer Support (IPS: Chris Hansen and colleagues). The working group held multiple calls between December 2014 and June 2015 to shape the direction and content of the paper. Researchers at NKI, with Leah Pope taking the helm, took primary responsibility for drafting initial text and integrating feedback from partners. That said, we want to acknowledge the project leadership's unusual commitment to transparency—a commitment that is both firmly aligned with the two therapeutic approaches that have informed Parachute and often conspicuously absent from official accounts of demonstration programs. In line with that, you'll quickly see that the text in front of you is a polyphonic document. In response to instances where there was extended discussion of a particular point, lack of consensus, or remaining questions, we have included sidebar text boxes to add additional thoughts or articulate points of dissent. Again, it is our hope that such a strategy reflects the working group's commitment to the approaches that ground Parachute NYC—in particular, the commitment to listening carefully to and allowing space for multiple voices. We encourage new readers to add comments of their own as they work their way through the paper and reflect on their own experiences with Parachute NYC.

Parachute NYC's footprint can perhaps best be limned along three coordinates:

- *Ambition*: Among select company in public mental health authorities in the U.S., City DOHMH has fully embraced peer integration into the provision of everyday care and support. In the oft-derided public sector, and at odds with the reigning premium on efficiency, Parachute NYC set out to deliver a gentler, more inclusive, slower-paced, *peer-integrated dialogic care* without regard to the direct costs of doing so (banking on offsetting savings in institutional care foregone) and untroubled by the dearth of hard (RCT) evidence of its effectiveness. Moreover, it chose to do so – not through the flexibly innovative efforts of a passionate few housed in some NGO but through the notoriously balky bureaucracy of the public sector, using the resources, personnel, venues and incentive mechanisms ready at hand. Inevitably, too, recruits to Parachute's vision of recovery-oriented, peer-integrated, dialogically-based "transformational" care were at various states of readiness, knowledge and commitment.

- *Achievement*: Parachute NYC was the first large-scale urban implementation of dialogical practice in the U.S., and only the second (joining Germany) internationally. It is the single largest effort to date *anywhere* to integrate peers into the public mental health system and was virtually contemporaneous with Berlin and Hamburg in introducing dually-trained peers to dialogic teams – but did so on much larger scale than either of the latter. Its four crisis respites figure

in the still fledgling industry of peer-staffed crisis respites but each has its own sponsoring agency and distinctive character. Lastly, at the instigation of trainers and City architects, it has pioneered the "train-the-trainers" method in ensuring continuity of dialogically-prepared teams.[1]

- *Legacy*: The U.S. mental health landscape is littered with "demonstration projects" as notable for the faintness of their impact and they had been for their originality when launched. Inevitably hostage to the market realities of managed behavioral health care, Parachute NYC's long-term sustainability rests upon four crucial achievements: (1) the promised better care, improved outcomes and lower costs of the innovation itself (still pending); (2) the regulatory and billing apparatus needed to transpose Parachute-proven practices and personnel into the new mental health market place (now in place);[2] (3) a mutually-productive partnership negotiated with the state (dedicating some dialogically-trained, peer-integrated team effort to work with people recently discharged from state psychiatric facilities); and (4) VNSNY's decision to double down on its support of Parachute's integrated mobile teams, solidify its sponsorship of teams in three boroughs, and commit to working with the State to adapt dialogic practice to the needs of returning inpatients.

If, as we attempt to spell out and account for, the end result is something short of what serious reconfiguring of the crisis response in public mental health should *look like*, the effort recounted here will serve as a useful index of *what it would take*.

Overview

In 2012, the Fund for Public Health in New York, Inc., in partnership with the New York City Department of Health and Mental Hygiene's (DOHMH) Division of Mental Hygiene, launched Parachute NYC, a citywide approach to providing a "soft landing" for people experiencing a psychiatric crisis.[3] Funded by a $17.6M Health Care Innovation grant from the Federal Centers for Medicare and Medicaid Services (CMS),[4] Parachute NYC has worked over the last three years to shift the locus of care from hospitals to community settings and the modality of treatment from crisis intervention to longer-term, community-integrated care. Parachute NYC's continuum of services includes:

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[1] See the separate research report describing the work undertaken "toward an integrated curriculum." To clarify: although "peer-staffed" the respite directors are clinicians, not peers; technically, this makes them neither "peer-run" nor "peer-operated" (Ostrow and Croft 2014:4).

[2] In that respect, Parachute's home office in City DOHMH proved prescient, actively shaping the terms and conditions of the new Home- and Community-Based Services, and participating in the workgroup developing the new state certification protocol for "peer specialist" (a position that will be able to bill under HCBS, making New York the first state to make that possible). See: http://www.nypeerspecialist.org

[3] A full list of project partners can be found in Appendix A.

[4] Parachute NYC is funded by Funding Opportunity # CMS 1C1-12-0001 from Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation to NYC Department of Health and Mental Hygiene.

- Four specially-trained mobile crisis teams that are staffed by behavioral health professionals and peer specialists (individuals with their own experience of being diagnosed with a mental illness who have been trained to support others) who provide long-term engagement (at least one year) for individuals and their families in their home environment;
- Four community-based crisis respite centers led by professionals but staffed by peer specialists that offer short-term stays (up to two weeks) for people experiencing a psychiatric crisis; and
- A "warm line" operated by peer specialists to provide counseling and referral services to people in emotional distress.

It is by providing these services that Parachute NYC aims to deliver better care and better health at lower costs for New York City residents in crisis. Such an approach to psychiatric crisis work is pioneering in its scale and reach, aiming to transform the healthcare workforce and reshape the delivery of psychiatric care in a city of over eight million people.

This White Paper traces the origins, development, and implementation of Parachute NYC from 2012-2015. For the last three years, as DOHMH and its six provider partners[5] have implemented Parachute NYC across the city, the Nathan S. Kline Institute for Psychiatric Research (NKI) has undertaken mixed methods research to perform both a process and outcome evaluation of the project. The process evaluation uses an ethnographically-based track-and-report-back protocol to flag implementation issues as they arise and keep the City abreast of programmatic progress and difficulties; the outcome evaluation measures CMS mandated domains of health, care quality, and utilization. It is through this work that NKI has developed a detailed portrait of the structural and practice changes Parachute NYC has introduced, tracked key milestones in the project as it has launched in succession across four boroughs, and documented important areas of disconnect where what was anticipated or imagined for the project did not match on-the-ground realities. This white paper thus provides a forum for describing the original vision of Parachute NYC, reviewing its actual implementation to date, and identifying the values resources, system linkages, attitudes, policies, and practices that might make future iterations of Parachute feasible.

Context for Launching Parachute NYC

Individuals experiencing a psychosis-related mental health crisis currently have few community-based treatment options. Despite several decades of efforts to treat people diagnosed with serious mental illness in the community, the standard model of care for people in crisis in the United States continues to emphasize hospitalization and immediate treatment with antipsychotic medications. Thus, even several decades after the advent of deinstitutionalization, significant challenges remain in providing accessible, adequate, and appropriate care to people determined to be in psychiatric crisis.

There is a substantial literature documenting how people diagnosed with mental disorders experience considerable distress and are at increased risk for particularly poor

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[5] Visiting Nurse Services of New York, New York Health and Hospitals Corporation, Community Access, Riverdale Mental Health Association, Services for the Underserved, and Transitional Services for New York, Inc.

outcomes. People diagnosed with mental illness are less likely to be working and more likely to be unemployed (Cook 2006), experience deeper poverty (Ware and Goldfinger 1997; Vick et al. 2012), are overrepresented in public disability programs (SSA, 2012), as well as in the criminal justice system (Fazel and Danesh 2002; Lamb and Weinberger 1998), and are 10 to 20 times more likely to be homeless than the general population (Susser et al. 1997). They also have physical health comorbidities that create additional complexities in treatment; 68% of adults with a mental disorder have at least one general medical disorder (Druss and Walker 2011). Diagnoses of mental disorders are also associated with a twofold to fourfold elevated risk of premature mortality, with studies finding that clients diagnosed with mental illness die an average of 10-25 years earlier when compared to the general population without mental illness (Colton and Manderscheid 2006; Druss and Walker 2011; Walker et al. 2015).

Association with poor outcomes intensified by social disadvantage (Draine et al. 2002)

Even with such demonstrated need, treatment options for this population are of limited benefit and often costly. There continues to be an overreliance on emergency departments and acute inpatient hospitalization for crisis-related mental health care. Between 1992 and 2001, emergency department (ED) mental health visits increased in number and constituted a growing proportion of all ED visits in the United States (Larkin et al. 2005). During this time, the number of psychosis-related ED visits also increased in metropolitan areas per capita and was higher for Black, non-Hispanic individuals (Pandya et al. 2009). Acute inpatient hospitalizations are also rising. Data from the National Hospital Discharge Survey demonstrate that U.S. inpatient psychiatric admissions rose between 1996 and 2007, most dramatically for youth but also for adults (Blader 2011). Thus, although reducing behavioral health hospitalizations has been a policy goal for many years, such data suggest that alternative treatments have not yet led to a decrease in the type of psychiatric emergencies that eventuate in inpatient care.

The overreliance on hospital-based care has had negative consequences on both structural and individual levels. First, hospital-based care is enormously costly. In New York State, an estimated 10,000 people use psychiatric hospital care per year, costing $1.3 billion in federal and state funding. In contrast, $5.3 billion is devoted to the 700,000 people in the community. This is the historical residue of an outmoded state hospital system and such disproportionate resource distribution is “no longer sustainable” (NYS Office of Mental Health 2014:2). Second, hospitalization itself—and often the events that lead to hospitalization—can subject people to traumatic, humiliating, and distressing experiences. Recent data on “sanctuary trauma” and “sanctuary harm” (Frueh et al. 2000; Cusack et al. 2003) have brought this issue to the forefront of policy discussions. Third, the tendency to hospitalize people in crisis helps account for many lives on the “institutional circuit”—lives that are dominated by institutional stays and largely haphazard transfers across institutional domains (Hopper et al. 1997; Luhrmann 2008). Such durable patterns of hospitalization not only suggest discontinuous and fragmented care, but also largely exclude family and social networks from treatment decisions and limit the possibilities for community re-integration over time.

Indeed, alongside the overreliance on hospitalization, existing treatment options for people experiencing a mental health crisis offer few possibilities for involving people’s family networks and limited access to recovery-informed practices that integrate peer support. Too often, this has meant that people diagnosed with mental illnesses develop

identities based on lifelong service use and patienthood, unable to reimagine themselves as productive contributors rather than "sick" people (Corrigan and Watson 2002).

Conceptualizations of "recovery" and peer support were introduced in the 1990s as part of the mental health service user's movement (Davidson et al. 1999, 2012) and there is growing evidence that people who have been diagnosed with mental illness offer embodied evidence of recovery to those in crisis (Austin et al. 2014; Hopper 2007). Nonetheless, substantial challenges remain with integrating peers into treatment teams (Gates and Akabas 2007).

> There are multiple, contested definitions of "recovery." For some, it is defined as "living well"—whatever that means to you. For others, "recovery lies in undoing the cultural process of developing careers as 'mental patients'" (Mead et al. 2001:135-136). Still others question the term as implying that there is some illness to recover from, or something from the past that needs to be "recovered." Its use here signals an overarching commitment to the notion that people diagnosed with mental illnesses can lead meaningful and productive lives (Davidson et al. 1999, 2012). Broadly speaking, the term "recovery" has come to represent hope-based changes in the mental health system.

An Alternative Vision of Care for People in Crisis

It is against this backdrop of costly and repeated cycles of hospitalization, limited community treatment options, and lack of peer participation in treatment—in short, a mental health system that continues to limit possibilities for people to reconfigure their lives after crisis and prematurely diminishes their capacity to aspire (Appadurai 2004)—that "alternatives" to psychiatric crises and to *early* psychiatric crises in particular have been launched. An accumulating body of research offers evidence for a more promising long-term course for those diagnosed with serious mental illness and suggests that early engagement and treatment can facilitate 'in phase' developmental tasks such as connecting to school, work, and social relationships (Harding et al. 1987; Harrison et al. 2001; Harrow and Jobe 2007; Heinssen et al. 2014). In turn, coordinated specialty care programs like RAISE and, more recently, OnTrackNY, are working to provide evidence-based and recovery-oriented treatment to young people who have recently started experiencing what have been deemed psychotic symptoms (Dixon et al. 2015; Heinssen et al. 2014). Furthermore, mental health consumer/peer groups and other stakeholders have built convincing arguments for community-based care and alternatives over routine hospitalization, including using crisis respite services and integrated community crisis services to help reduce the costs and harms associated with emergency hospitalization for psychiatric crises (O'Callaghan et al. 2011; Croft and Isvan 2014; Ostrow and Croft 2015). Reviews of both U.S. and international residential alternatives to hospitalization indicate that with appropriate response, crises need not escalate, nor herald a lifetime of revolving door care and poor community adjustment (Alvarez-Jimenez et al. 2011; Cullberg et al. 2006; Johnson et al. 2010; Warner 2003, 2010).

In New York City, government took the lead. The anticipatory ground for the public mental health bureaucracy's embrace of Parachute NYC was prepared by two parallel developments within DOHMH: a deepening commitment to recovery and the integration imperative with respect to peers. Critically positioned staff, including Adam Karpati, Trish Marsik, Meggan Schilke, Pablo Sadler, Jody Silver, Vindya Pinnaduwa, Richard Delaney, David Gross, and Seana O'Callaghan (on loan from NKI) were instrumental in setting up working groups to re-examine standard mental health practice from a recovery-oriented perspective, tapping invited speakers for out-of-government expertise, and drawing upon its own advocacy-staffed Office for Consumer Affairs to knit peers seamlessly into whatever

recovery-promoting practices it might propose. Anchoring all these activities was a solid foundation of bureaucratic proficiency, including budgetary, administrative, contracting and accountability practices—all of which would prove critical in assembling the necessary elements to what would become Parachute NYC in remarkably short order.

Conceptually, the rationale for an alternative *clinical* approach to psychiatric crises was provided by a working paper prepared for the joint International Network Toward Alternatives and Recovery (INTAR)/Center to Study Recovery in Social Contexts conference in November 2009. Coordinated by Peter Stastny, that paper explored actually existing alternatives to conventional American responses to early psychiatric crises. Prominent among them was the Finnish experience, spanning nearly four decades of work from the Need Adapted Treatment Model through the Open Dialogue approach. A separate working paper for the same conference noted that the dialogical alternative promised to "disrupt the disablement process itself," in part by reworking what is too often the traumatizing quality of the clinical response (Hopper 2009). But this was sheer hypothesizing until a working group[6] convened in the wake of the conference and began to put together proposals for a pilot program. The initial design for "Early Access to Recovery" (EA2R) drew explicitly on the Swedish "Parachute Project,"[7] employing a "need-adapted treatment model" (NATM) to offer "a comprehensive, non-coercive, home- and community-based set of services that will likely avert admissions to psychiatric emergency rooms and inpatient services and result in greater satisfaction with services, enhanced continuity of care and stronger community supports" (Early Access to Recovery: Executive Summary, November 2012). Notably, too, provision was made for a short-term, peer-staffed "crisis residence"—something the NYC peer community had long lobbied for, in the wake of Jeanne Dumont's original "crisis hostel" in Ithaca.

Conspicuous by its absence in this early work, however, was the integration of peers in the crisis intervention and family engagement work of NATM. Nor, for that matter, was there discussion of their role in any of the Scandinavian publications on NATM or Open Dialogue. But the City DOHMH participants in the working group insisted: as part of Medicaid Redesign, the integration of trained persons with "lived experience" into routine public mental health services would be fundamental to any package claiming to be "recovery-oriented." Provision for their inclusion would *not* be missing from the next round of funding sought.

Although the working group's efforts to secure foundation funding for an EA2R proposal proved unavailing, the working group in effect laid much of the groundwork[8] for a much more ambitious proposal forged by DOHMH in response to a Notice of Funding Availability (NFA) issued by the Centers for Medicare and Medicaid Services Innovation Center in the winter of 2011-2012. Respondents were expected to submit full-scale

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[6] This group included researchers, peers, and clinicians from both within and outside government: Jeanne Dumont, Kim Hopper, Seana O'Callaghan, Pablo Sadler, Jody Silver, and Peter Stastny.

[7] The six principles of the Swedish Parachute project included: (1) Early and fast intervention; (2) A therapeutic approach and crisis intervention; (3) Family and network involvement; (4) Easy access to care; (5) Lowest possible dose of neuroleptics; and (6) A homelike milieu for impatient care. See Cullberg et al. 2006.

[8] Especially useful in that regard was the invited presentation prepared in November 2011 for the Foundation for Excellence in Mental Health Care.

proposals—not demonstration projects, but models of care that were already "operational," "capable of rapid expansion" and with a "clear pathway to ongoing sustainability"—10 weeks from the date of issue (with letters of intent due in only 5 weeks).[9] The city assembled a working group to craft a hybrid proposal to test the local viability of an alternative home-based treatment approach, crisis respite centers, and a peer-staffed "warmline." This first meant securing official sign off at the Commissioner level and then orchestrating the staggered launch of nine distinct innovative projects (four mobile teams, four respites, one support line) that would eventually enlist five not for profit agencies and a City hospital, each with its own human resource policies and only one or two of which represented itself as schooled in hiring, deploying, and supporting peers. In the interest of furthering "integrated care," a contract would be needed with a network of Federally Qualified Health Centers to place nurse practitioners at the respites. A separate contract would be negotiated with a state research institute (NKI) to do implementation analysis. To introduce the innovative approaches, outside trainers would need to be hired, and three separate training regimens would have to be scheduled: one avowedly foreign (NATM/OD) and two that were developed locally in the U.S. as outgrowths of the rights-based, peer support movement: IPS and Peer Health Navigation (the latter developed specifically for Parachute NYC by Peggy Swarbrick). This would in turn require the importation/coordination of non-local trainers (NATM trainers were based in Germany and Sweden, and IPS trainers in Vermont and other states). Four buildings would need renovation before the promised respites could be opened; vans and cars would have to be procured to facilitate the work of repurposed mobile crisis teams.

That all of this would take place in New York City—a city covering over 300 square miles and home to over eight million residents, almost half of whom speak a language other than English at home (U.S. Census Bureau 2013)—made the undertaking all the more ambitious. That it was proposed at a time when New York State was embarking on a major redesign of its Medicaid program—ending the state's fee-for-service system and replacing it with care management for virtually all of New York's nearly six million Medicaid beneficiaries—made its explicit promise to improve care and reduce costs crucial to securing official support. Importantly, from the outset, DOHMH and collaborators kept a restorative and transformative vision up front: the ground was paved for Parachute NYC by a commitment from the city to reduce (or at least contain) the traumatic impact of the ordeal of diagnosis and treatment, and to expand the range of self-determination for those people officially designated as patients.

Parachute NYC: Program Model and Goals

As implemented on the ground, Parachute NYC represents the first attempt, nationally or internationally to create a comprehensive, community-based treatment model for individuals who may be deemed to be experiencing psychosis that addresses

[9] For the full announcement from the CMS Innovation Center, see http://innovation.cms.gov/Files/x/Health-Care-Innovation-Challenge-Funding-Opportunity-Announcement.pdf. Congress created the Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures… while preserving or enhancing the quality of care" (innovation.cms.gov/about/index.html)

both physical and mental health needs and integrates peers into service provision.[10] By targeting individuals aged 16-65[11] who are experiencing a psychiatric crisis, the program directs services both to young people who are "system-naïve" (and can hopefully avoid a future of repeated cycles of hospitalization through early intervention), and to older people who have long histories in the mental health system (and are thus in need of an alternative approach to care). Following CMS' triple aims of better care, better health, and lower costs, DOHMH set out six goals in its initial proposal for Parachute NYC as shown in Table 1 below.

Table 1. Parachute NYC's Triple Aims

Better Care	Better Health	Lower Cost
Reduce ED/inpatient use by 50% or more	Produce better mental and physical health status and quality of life for participants compared with norms in the literature	Reduce health care expenditures by $50 million over three years
Increase by 25% participants' receipt of annual physicals, annual colonoscopies (For 50+ pop), and annual mammograms (for females 40+)		Reduce health care costs for average participant during the year of participation in Parachute by 20%
80% of participants will maintain a high level of satisfaction/engagement with the program		

Providers transmitted demographic and contact information (age, gender, ethnicity, insurance coverage, and zip code) to NYC DOHMH for all Parachute NYC program entrants via the Parachute Portal. By April 30, 2015, Parachute NYC had served 1242 unique individuals through Mobile Teams and Respite Services (see Table 2 below). The majority of those served were female (56%) and of Non-White race/ethnicity (77%). About one quarter identified as Hispanic or Latino, about 40% as Black or African American and about a quarter as White. Two thirds of Parachute participants were between 26 and 64 years old. Approximately one third were under age 25. Half had public insurance, but due to routine delays in verifying insurance, the insurer was unknown for 42% of Parachute NYC enrollees.

[10] See Appendix B for a chart comparing the core functions of several community care models.

[11] All teams served individuals 18-65 with the exception of the Brooklyn Mobile Crisis Team, which initially focused on younger individuals and thus accepted clients starting at age 16.

Table 2. Demographic Characteristics of Parachute Participants

Demographic Characteristics of Parachute Participants[12] Total, Any Mobile Team Services, Respite Only						
	Total (n=1242)		Any Mobile Team (n=614)		Respite Only (n=628)	
Gender	N	%	N	%	N	%
Male	692	56	393	64	229	48
Female	546	44	221	36	325	52
Unknown	4	<1	0	<1	4	<1
Age						
>65 years	32	2	16	3	16	3
26-64 years	832	67	325	53	507	81
19-25 years	305	25	208	34	97	15
12-18 years	73[13]	6	65	10	8	1
Race/Ethnicity						
Black/African American	481	39	229	37	252	40
Hispanic/Latino	295	24	153	25	142	23
White	291	23	99	16	192	31
Asian	58	5	38	6	20	3
American Indian	3	<1	0	0	3	<1
Native Hawaiian or Pacific Islander	2	<1	0	0	2	<1
> 1 race/ethnicity	15	1	3	<1	12	2
Unknown	97	8	92	15	5	<1
Insurer						
Medicaid	554	45	170	28	384	61
Medicare, Dual Eligible, CHIP, VA	89	7	22	4	67	11
Private Commercial Insurance	36	3	15	2	21	3
Other	45	4	28	5	17	3
Unknown	518	42	379	62	139	22

[12] Data obtained from the Parachute Portal, April 30, 2015.

[13] The process and outcome evaluation conducted by NKI did not look at Parachute program participants under the age of 18. Thus, this white paper does not necessarily reflect their experiences. Parachute participants under age 18 were served by the Brooklyn Mobile Crisis Team and had access to the New York City Children's Center Community Respite Program until the age of 17.5 years old.

History of Approaches Used in Parachute NYC: Need-Adapted Treatment Model, Intentional Peer Support & Peer Health Navigation

Need Adapted Treatment Model (NATM) and Intentional Peer Support (IPS) figured prominently in the program proposed by DOHMH. Each of these approaches was selected as a promising mode of community-based care that could extend beyond the life of the intervention. The intent in using both NATM and IPS was to enlist non-professional members of the community—family and social networks, and a network of mental health peers—in supporting individuals in crisis. The models seemed not only compatible with each other, but also particularly promising for limiting both current and future crises and ED visits.

It is useful to note here an unresolved tension in this project (and public mental health at large): resort to psychiatric shorthand or everyday phrasing ("mental illness") to designate people in crisis is a convention that Parachute NYC calls into question even as workaday realities keep it alive. Parachute's two formative approaches each find such usage to be unequal to the existential reality of extreme states or their resolution. But they do so for different reasons. For NATM, the difficulty lies in its epistemological inadequacy: diagnostic labels artificially freeze a social process, arrogate the power to define it in some privileged authority, and silence the generative voices (and ignore the interests) that are vital to its sustenance. It may serve other purposes, but as a stand-alone diagnosis denies the dialogic groundwork—the call-and-response of everyday life—of the suffering it names and classifies. As a rights-based social justice movement built on the grievances of service users (and refusers), IPS objects on political grounds: resort to medicalizing language objectifies as pathology what should be seen as the gnarled social products of history and circumstance. As part of the overall ordeal of diagnosis and treatment, psychiatric labels divest sufferers of their own agency and alienate them from their own experience and what may hold self-transforming potential. In reinforcing convention, habitual use also conspires in masking the social determinants of widespread distress and disability.

Public mental health, as readers are well aware, is undecided on this question. In practice, however, Parachute NYC has staked out a position even if it is not yet one articulated as canon. Fidelity to this developmental ethnographic reality will take some adroit footwork (and the fledgling state of our [self-auditing] efforts in that regard will be only too plain here). But we should be clear: This is not just a matter of policing language or proclaiming tribal loyalties. We recognize that words matter because they wound and because of their world-making power. But the argument here is ongoing. This document will neither erase nor adjudicate the contending positions. Instead, it will register and mark them for what they are: stubborn reminders of the troubled state of our own naming and framing efforts. The occasional awkward phrasings we let stand should be read in this light. That they all *belong* in the same document—whether as bitter contestants, clueless habit, or live-and-let-live neighboring camps—is indirect testament to the dialogic worldview to which NATM and IPS bear witness.

Need Adapted Treatment Model and Open Dialogue

Psychotherapeutically-based, comprehensive and integrated treatment for schizophrenia spectrum psychoses has a long tradition in Finland and other Scandinavian

countries, where the Need-Adapted Treatment Model (NATM) and the Open Dialogue (OD) approach were developed. Both models were introduced in Finland amid large scale policy changes that focused on creating alternatives to psychiatric hospitalization, scaling up community-based treatment options, and requiring intensive, cross-sector coordination. Although there are distinctions between the approaches that will be described below, OD grew out of NATM and Parachute NYC draws on both of these traditions. NATM and OD are linked theoretically and operationally by several emphases, including:

- Rapid response and immediate intervention;
- Integration of the client's social network throughout the entire treatment process;
- Commitment by a consistently configured treatment team to assume responsibility for treatment for as long as necessary; and
- Minimal use of neuroleptic medications.

Implementation of these models has led to a qualitative transformation in the type of psychiatric care offered in Finland. In Western Lapland, evidence suggests that by intervening with young people with psychosis there has been a substantial decline in incidence rates of frank schizophrenia over a period of 20 years (Aaltonen et al. 2011; Seikkula et al. 2011; Seikkula and Arnkil 2014:173). Studies to date also indicate outcomes that are equivalent to or better than outcomes of standard, medically focused treatment for people diagnosed with psychotic disorders (Gromer 2012). Taken together with optimistic results for innovative, early intervention approaches to psychosis in the last decade (e.g., Iyer et al. 2015; Marino et al. 2015), these findings are key in surmounting pessimism about outcomes and associated stigma for people with psychosis.

Need Adapted Treatment: Development & Key Principles

Need-adapted treatment of schizophrenia spectrum psychoses was initially developed during the 1960s-1970s by Yrjö Alanen and his colleagues in Turku, Finland. Founded on the principle that schizophrenic disorders are heterogeneous and thus require case-specific treatment, his hospital-based team first introduced psychodynamic treatment on the inpatient unit and then crafted a project that transformed traditional psychosis wards into psychotherapeutic communities, enlisting the entire staff as part of treatment and addressing the therapeutic needs of patients as well as those closest to them; pharmacotherapy was regarded as a treatment adjunct to support psychosocial activities (Alanen et al. 1991, Alanen 2009). Klaus Lehtinen instituted systemic treatment and, with the assistance of Helm Stierlin (2009), a three-year family-therapy training program was implemented for staff in Turku beginning in 1979. These newly formed teams focused on patients entering treatment for schizophrenic psychoses for the first time. Teams were required to meet jointly with a patient and his or her family members as soon as possible after admission. Regular "therapy meetings" then continued to be held with the patient and his or her support network to acquire a shared understanding of what had happened and to help participants recognize their current situation as a consequence of difficulties experienced by them and their network rather than a mysterious, individual illness. In this way, treatment was connected to the flow of everyday life and activities.

Over the course of developing the model, the Turku team came to define the central elements of the NATM approach as follows (Alanen 2009):

1. Therapeutic activities are carried out flexibly and on a case specific basis to meet the changing needs of both patients and their personal networks (usually the family and significant others).
2. The prevailing orientation is psychotherapeutic, characterized by empathetic attitudes toward patients and open communication.
3. Different therapeutic activities complement each other rather than emphasizing an either/or approach (i.e., patients often undergo several treatments at the same time—attending family sessions *and* individual therapy, for example).
4. Treatment is seen as continuous, with progress and outcomes monitored constantly over time (especially during early years of engagement).
5. Follow-up evaluation is important both for individuals and for the development of the treatment system.

Alanen's capsule summary, it bears noting, was part of an address entitled, "Towards a more humanistic psychiatry." From the start, we think it fair to say—and long before the user-inflected vocabulary of "empowerment" was available to articulate it—NATM was a practice deeply committed to participatory treatment planning and a collaborative search for meaning and moving forward as critical elements in the social response to psychosis.

Beginning in the 1980s additional refinements were made to the NATM approach in particular regions of Finland, including in the province of Western Lapland, where Jaakko Seikkula and his colleagues developed the Open Dialogue (OD) approach. In many ways, the OD approach extends need-adapted treatment and review of the literature here is thus useful in understanding the orientation taken by Parachute NYC. Seikkula et al. (2006:214) describe the OD approach as an "innovation operating within the need-adapted approach" since it similarly focuses on "the provision of psychotherapeutic treatment for all patients within their own personal support systems." Indeed, founders of OD were already following the need-adapted tradition when they started efforts to alter the way inpatient admissions were being handled and began to integrate individual and family therapy into open treatment meetings for patients in the hospital (Seikkula 2011). Similarities between the two models can be seen in the seven main treatment principles of OD[14]:

1. The provision of immediate help: Clinics arrange the first meeting within 24 hours of the first contact and 24-hour crisis service exists.
2. A social network perspective: Patients, their families and other key members of their social network are always invited to meetings.
3. Flexibility and mobility: The therapeutic response is adapted to the changing needs and location of each case.
4. Responsibility: The team takes charge of the entire treatment process, from engagement to discharge, with network meetings acting as a "hub."
5. Psychological continuity: The team assumes responsibility for treatment for as long as it takes, members of the patient's network are invited to participate throughout, and various methods of treatment are integrated.

Kindred developments in narrative therapy and family therapy include Speck and Attneave (1973) on family networks, Anderson and Goolishian's (1988, 1992) work on human systems as linguistic systems, White and Epston's (1992) narrative therapy, and Beels' (2001) personalized survey of narrative in psychotherapy.

[14] Seikkula and his colleagues have written extensively on the seven treatment principles of the OD Approach. See Seikkula et al. 2001; Seikkula et al. 2003; Seikkula et al. 2003; Seikkula et al. 2006; Seikkula 2008; Seikkula and Arnkil 2014.

6. Tolerance of uncertainty: Meetings are held frequently to build relationships and a sense of security (may be daily during the first 10 to 12 days) but usually no detailed therapeutic contract is made in the crisis phase in order to avoid premature conclusions or decisions about treatment.
7. Dialogism: The focus is primarily on promoting dialogue and secondarily on promoting change in the patient or family.[15]

Despite such similarities, Seikkula's extensive writing on the underlying frameworks of the OD approach[16] suggest that it is distinguishable from NATM in part by its practice of cultivating dialogue—a "mutual act" where meaning develops in the interpersonal space between people—as the engine of therapeutic change (Seikkula and Trimble 2005:465). Seikkula roots the OD approach in the dialogic traditions of Bakhtin, Vygotsky and Voloshinov, where language is seen as a meaning system that is jointly constructed in the space between interlocutors, as well as in social constructionist and postmodern theories that privilege polyphony and promote the integration of different psychotherapeutic traditions. He was especially taken with Bakhtin's interpretation of Dostoevsky's understanding of narrative—and the primal integrity of contending points of view ("polyphony") that no authorial privilege could displace. From this perspective, psychosis has its own integrity and "can be seen as one way to deal with experiences so terrifying that they cannot be expressed other than through the language of hallucinations or delusions" (Seikkula et al. 2003:191). The therapeutic aim in OD now becomes to facilitate a distinctive kind of reflective dialogue that enables participants to develop a new common language over the course of many meetings.

Or, as Seikkula describes it:

> In the meaning-networks of social relations, the polyphony of life serves as the engine of psychotherapy. At the same time, this new reality is *both* experienced jointly, in a way not possible previously, *and* new words are created for those difficult experiences that as yet have none. In this way, new meanings and new understandings are constructed. The shared emotional experience opens up the monological impasse to dialogical reflection, which in turn obtains its meanings from the inner dialogue of the patient. The inner and outer dialogues are part of the same language; no sharp boundary divides them. [2003:87]

This emphasis on creating a new, jointly constructed reality presupposes that all participants in the treatment meeting have the chance—and take up the invitation—to be heard and understood. Such an approach suspends "treatment planning" as an outside activity of professionals, committing them instead to transparency and radical contingency.

Because meaning depends on response—and response, in turn, anticipates and depends upon further response, in an unending chain—Bakhtin often referred to the "unfinalizability" (or essential incompleteness) of dialogue.[17] Meaning is constantly

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[15] As William Isaacs (1999:10,19) writes, "Dialogue is a conversation in which people think together in relationship. Thinking together implies that you no longer take your position as final. You relax your grip on certainty and listen to the possibilities that result simply from being in a relationship with others—possibilities that might not otherwise have occurred… from shared meaning, shared action arises."

[16] Seikkula 2003, 2008; Seikkula and Olson 2003; Seikkula et al. 2003; Seikkula and Trimble 2005; Seikkula and Arnkil 2014.

[17] Bakhtin 1984; Holquist 2002

generated and transformed by the intrinsically unpredictable process of linked, co-animating response. The chain may be interrupted but, in principle, never ends. And the more voices that can be incorporated in this process—the more "polyphonic" the exchange—the richer the possibilities for fresh, "emergent" understandings to be generated by the dialogue.[18]

Need-adapted, dialogue-oriented practice thus takes a rather distinctive form. Rather than as experts called upon to repair dysfunctional families and identified patients, therapists work chiefly as skilled generators of productive dialogue. Their role in facilitating such a dialogue is essentially to listen attentively and respond—not with interpretations or explanations or suggestions—but in ways that demonstrate careful notice of what has been said. Where possible, the response may open up a new perspective on what was said. Working in this way requires present-oriented intensity of attention and skillful timing, so that answering words fit within and fuel the natural rhythm of the conversation. Dialogic team members respond as fully embodied participants in an evolving conversation, with genuine interest in what each person has to say and avoiding any suggestion that something said was somehow "wrong." They practice "omnipartiality," enlisting every voice in the process. In this way, *productive* dialogue can create what had not existed before.[19]

In this way, OD recasts the role of the professional within the treatment process. Therapists are no longer considered experts whose job it is to work upon the patient and his or her family. Rather, therapeutic expertise consists primarily in skill at generating productive dialogue. This requires therapists to listen attentively so they can ask questions that follow directly from what has just been said (rather than planning all questions in advance) and that help link the different voices in conversation (Seikkula 2003; Seikkula et al. 2003).

Finally, OD often includes "reflective conversation" among team members in front of the patient and his or her network. The team members reflect on what they have heard from the patient and the network, as well as what they have heard from each other, with the dual goal of facilitating dialogue and constructing the next steps of a treatment plan. Treatment planning is thus entirely transparent; "discussions are aimed at opening up a variety of alternatives for decisions" (Seikkula et al. 2003:193). The patient and his or her network members then have the opportunity to give feedback to the treatment team about what they have heard in the reflective conversation.

Repeated reference to dialogue should not be taken for an exclusive concern with the content of *talk*. In the OD approach, silence can also function as a kind of "therapeutic attunement," making room for the surfacing of "untold stories" and new voices. Similarly, tying answers to "present moments" in the conversation extends the dialogic space of both utterance and response and allows for emotions to emerge, sometimes with great and productive intensity. And sometimes, too, the trace of a conversation—and the potential for continuing it—is captured not in words but in embodied memory, the somatic not-yet-told record of what transpired.[20] The dialogic focus is not so much on the content of jointly-

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[18] Seikkula and Trimble 2005

[19] Seikkula 2003; Seikkula et al. 2003.

[20] Olson et al. 2014; Seikkula 2008.

produced narratives as it is on the sequential unfolding of "present-moments" in which feelings register before words do. In these inter-subjective spaces, the knowing-of-myself-through-the-eyes-of-others occurs.[21]

Seen in reference to these themes, the OD approach can be understood not so much as a departure from the original need-adapted treatment model, but more accurately as a series of refinements upon that model. If the need-adapted approach transformed treatment to include the family of the patient in crisis, the OD approach extends this to the whole social network of the patient and makes the language practices of these treatment meetings paramount. This involves a willingness to keep treatment options open, a commitment to ongoing constructive dialogue, the introduction of transparent reflecting, and an openness to hearing multiple voices. What is created in turn is a "dialogical borderland" where "a [unique] language for suffering may be born that can give the suffering a voice" (Seikkula and Olson 2003:409).

Key Outcome Data

Research on NATM and OD has been ongoing since the 1980s and shows promising results when compared with more standard mental health treatments. Although existing studies have been criticized for naturalistic designs and the use of historical comparison groups that may not fully account for differences across time in diagnostic criteria, care policies, available resources, and social conditions, the existing data indicate that NATM and OD are both viable alternatives to treatment as usual. Gromer's (2012) comprehensive review analyzes results of several projects that ran from the early 1980s to the late 1990s; she examines results of the Turku project at 2 years (Alanen et al. 1991) and 5 years (Lehtinen 1993); the API project (Integrated Treatment for Acute Psychosis) (Lehtinen et al. 2000); the Western Lapland project (Aaltonen et al. 2011); the ODAP project (Open Dialogue in Acute Psychosis) at 2 years (Seikkula et al. 2003) and 5 years (Seikkula et al. 2006); and a study which focuses on longer-term stability of outcomes by comparing cohorts in three different time periods (Seikkula et al. 2011). Her findings demonstrate that NATM and OD are associated with fewer participants living on disability pensions, fewer symptoms, and fewer hospital days than treatment as usual. Furthermore, OD is also associated with better social functioning and more employment, and newer versions of OD are associated with fewer days spent in the hospital, lending some evidence to the notion that the practice is evolving and showing more positive outcomes as it is refined (Gromer 2012:175).

Current Iterations and Trends

Local variations on NATM and OD are currently being practiced and developed in Finland, Norway, Sweden, and Germany, as well as in the United States in Massachusetts (at Advocates, Inc. and the Institute for Dialogue Practice), Vermont (at the Counseling Service of Addison County) and New York City. As in Parachute NYC, some of these sites integrate short-term crisis respite care into the treatment model, providing a home-like setting outside of the hospital for individuals to weather a psychiatric crisis. Further detail on crisis respites will be provided below.

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[21] Bakhtin 1990; Seikkula 2011; Stern 2004; Shotter and Katz 1998.

A recent shift in dialogic practice has been to specify fidelity criteria—or those "key elements" of dialogic practice that characterize the therapeutic style of Open Dialogue (Olson et al. 2014). Mary Olson and Douglas Ziedonis at the University of Massachusetts Medical School are leading this effort. The elements they have identified so far are focused on the actual practice of dialogic psychotherapy and include criteria such as having two or more therapists in a meeting, using open ended questions, and emphasizing the clients' own words rather than symptoms; additional work is underway to identify those organizational and system features which are necessary for implementation. Together, these efforts can be seen as an attempt to operationalize dialogic practice and to prepare it for broader scale implementation in the United States.

Intentional Peer Support

Developed by Shery Mead in the mid-1990s, Intentional Peer Support (IPS) evolved as a relational alternative to mental health assessment, diagnosis, and treatment that is designed to think about and capitalize on transformative relationships between people. IPS is one of the evolving outgrowths of the consumer/survivor/ex-patient movement that blossomed in the counterculture of the 1960s and 1970s alongside the advent of deinstitutionalization and in reaction to histories of negative treatment in the mental health system (treatment characterized by coercion, over-medication, and rights violations) (Chamberlin 1979). It also emerges directly from Mead's own experience as a "mental patient," a traumatic experience that influenced her to see disconnected and non-mutual (i.e., coercive) relationships as the most salient problem for people diagnosed with mental illnesses. This experience, along with her work with survivors of domestic violence and her academic work in both MSW and doctoral programs, inspired Mead to transform the meaning she saw perpetuated by an often dysfunctional mental health system by helping to build a social movement that could offer an alternative. She sought to personally establish hopeful and health-promoting relationships with others like her. They would, in turn, build similar relationships with others like them, relationships where people could learn and grow together (Mead 2010). Below, we contextualize IPS within the cultural and historical trends from which it emerges, detail the three principles and four tasks that constitute core IPS theory and practice, and link IPS to the everyday work of crisis respites.

Historical Roots of Peer Support

IPS emerges parallel to and is influenced by the largely grassroots political and advocacy movements of mental health consumers, psychiatric survivors, and ex-patients. Beginning in the 1970s in the U.S. and other Western countries, persons carrying diagnoses of mental illness effectively "rose up," sharing their "lived experience" with each other and advocating for themselves publicly and politically. This was no conventional interest group; it was a rambunctious, grassroots, rights-based, "embodied health movement"—a civil rights movement—that urged wholesale reform of psychiatric ideology and practice.[22] Coercion was and remains a signature concern. Of special relevance to Parachute NYC were "user-controlled alternatives" that rejected hierarchical relationships and drew on the hard-won expertise of personal experience in reconstructing the close work of personalized care. Together with the federal Community Support Program beginning in

[22] Brown et al. 2004. See also discussion in Davidson et al. 1999; Jacobson 2004; McLean 1995.

1975 and variable state commitments to involve clients in the creation of programming and policy in the early 1990s, this produced a wealth of client-driven programs, peer support initiatives, and attempts to integrate peers within traditional programs.[23]

On a theoretical level, IPS has links to the social construction perspective promulgated by the antipsychiatry movement (although IPS does not see its core approach as being "anti" anything, but rather as being *for* creating the kind of mutually respectful, growth producing relationships that human beings tend to welcome, regardless of the underlying philosophical and organizational contexts, mental health or otherwise). It is linked, in turn, to the consumer/survivor/ex-patient (c/s/x) movement. Beginning in the 1960s, as psychiatry's methods and outcomes were facing unprecedented scrutiny, the antipsychiatry movement—spearheaded by works from Ronald Laing (1960) and Thomas Szasz (1961)—argued that psychiatric diagnoses are stigmatizing labels applied to individuals whose behavior deviates from conventional expectations. Questioning the assumption that people who fall outside the range of "normal" are "sick" or "unstable," these critics suggested that much of what is called "mental illness" is shaped by societal reactions to behavior rather than anything internal to the individual and effectively serves to marginalize and "other" its recipients.

The c/s/x movement builds on these theoretical foundations to "talk back" to psychiatry and the mental health system. In particular, the movement challenges the primacy of the dominant paradigm of biomedical psychiatry, arguing that defining problems solely as diseases to be treated by professionals not only has had dissatisfying results for patients, but also dehumanizes suffering and underestimates or dismisses the role of other factors that contribute to distress (e.g., trauma, abuse, poverty, loss, and violence) (Mead et al. 2001). In this sense, the c/s/x movement takes a broader view of health and wellbeing that highlights the social determinants of health (Braveman et al. 2011; Wilkinson and Marmot 2003). In turn, it seeks to understand what has come to be known as mental illness and/or its treatment in terms of social justice and has worked to create alternative and complementary, relationship-based modes of supporting people. Firmly believing that recovery—the widely circulating, but far from orthodox, notion that persons diagnosed with psychiatric disorders can reclaim a life of their own authorship whatever persisting adversities they may be dealing with[24]—members of this movement link what is often defined as 'illness' to a social context which encompasses an awareness of trauma, culture, social inclusion, and connectedness.

As even its champions will admit, the notion of "recovery" suffers from an essential ambiguity—promising, fraught, multivalent, and reminiscent of similar critiques of NATM/OD—that allows for varied interpretations and working misunderstandings of "recovery-informed practice." For some, what is popularly known as 'recovery' is defined as 'living well'—whatever that means to you. For others, "recovery lies in undoing the cultural process of developing careers as 'mental patients'" (Mead et al. 2001:135-136). Still others question the term "recovery" as implying that there is some illness to recover from, or something from the past that needs to be "recovered." The word has also come to broadly represent the hope-based changes in the system but with the benefit of hindsight,

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[23] See Mclean 1995; Jacobson 2004; Goldstrom et al. 2006; Tanenbaum 2012, Chamberlin 1978.

[24] See Jacobson, 2004; Davidson et al. 2011; Slade, 2009.

it's apparent that both the intensely individual nature of recovery and various strategic deployments of the term work against any uniform definition of it.[25]

In New York City mental health circles, one cannot talk seriously about recovery without recognizing the formative role of peers in initiating, fueling, and repeatedly redefining that conversation. For peers, the contest is inescapably political, capping decades of discriminatory treatment and abuse, marginalization, poverty and ignored grievances. The *promise* held out by the recovery movement may have been transformative, even revolutionary. But public mental health authorities continue to wrestle with the pragmatics of integrating a commitment to recovery into common practice and doing so in the face of limited resources and ingrained resistance from clinicians, and others still hewing to an outmoded biomedical paradigm.[26]

Three themes in a recent ethnographic study of peer support at Baltic St. A.E.H. (Austin et al. 2014) are of particular relevance to peer support as seen in Parachute NYC and IPS: transforming (reflected upon) experience into expertise; becoming credible embodied evidence of recovery; and shrugging off the weight of the (mental health) system. Together they make for a powerful counterpoint to conventional "patienthood." This helps explain why Shery Mead's own personal experience, work, and extensive study have been central to the development of IPS. Having been hospitalized repeatedly from the time she was a teenager, Mead (2010) suggests that she learned to live the life of a "mental patient" over time, believing that she was sick. It was only after a psychiatric nurse confronted her one day with the choice between being a mental patient for the rest of her life or being a social worker (what she was studying to do), that Mead began to appreciate that there were other ways to understand her life than through the lens of mental illness. Thinking back to that time, Mead recalls, "I decide[d] to find some way to work with the idea that stories can be redefined," betting on the fact that "there [were] others, like me, who [had] been stuck in a mental illness story that is not of their own choice or making." Thus, out of the belief that there are opportunities—seized or created anew if need be—to re-define ourselves and our experiences, early versions of IPS were born.

Defining and Practicing Intentional Peer Support

IPS defines peer support as "a system of giving and receiving – founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful." Rather than focusing on diagnostic criteria or psychiatric models, peer support emphasizes "understanding another's situation empathetically through the shared experience of emotional and psychological pain" (Mead et al. 2001:135). The central idea is that mutual relationships are powerful tools in enabling people to reconstruct and rename their experiences as well as finding new ways to move forward in their lives (Mead and Hilton 2003:88). Importantly, the application of IPS principles is not limited to interactions with

[25] See Jacobson 2004, Bellack 2006 and Hopper 2007 for further discussion.

[26] The struggle continues. Practitioners issue correctives locating recovery within a set of measurable social criteria (e.g., living independently, no longer behaving oddly, resuming expected social roles). Peer partisans up the ante, presenting recovery as a process that constantly re-shapes treatment through claimed autonomy, rewritten rules of engagement with the community, and an identity as a whole person not a rehabilitated psychiatric patient.

troubled or previously hospitalized people, but extends to all professional and personal relationships. A cultural shift—not treatment adjunct—is the ultimate goal.

Over time, the theoretical underpinnings of IPS have been crystallized into three principles and four tasks that give people a way to practice those principles. IPS' three principles include: (1) Moving from Helping to Learning; (2) Focusing on the Relationship rather than on the Individual; and (3) Stressing Hope and Possibility rather than Fear. The first principle shifts the power dynamic in a relationship from the power differentiated "expert-helpee" to one where both parties are expected to learn and contribute (Mead 2010a). This reinstates the natural respect and mutuality of freely chosen community relationships (e.g., friendships), where people see each other as true "peers" who both have something to offer and something to learn. It also challenges the clinical assumption that helping is necessarily helpful, in part because "our assumptions about what others need [are] not always/if ever accurate" (Mead 2010a). The second principle of IPS reminds people to focus on the quality of the relationship between themselves and others rather than getting bogged down by individual needs and trying to meet them. The idea is to build the relationship and make it sustainable by prioritizing the needs of both people to have a good experience of the relationship. Focusing on the relationship allows for reciprocity and role shifting and emphasizes the space between two or more people; this, in turn, opens up fresh lines of communication. Finally, the third principle encourages people to think about crisis or challenge as an opportunity for growth and connection and to react not out of fear (characterized by power imbalances and prescriptive behavior) but out of hope, in the possibility for creating something new. Admittedly, this can mean sitting with a good deal of discomfort and fear in order to move to a place of hope (IPS Facilitator Manual 2014). However, the idea is to create a context where the risk of change is shared and borne by the relationship in a way that supports everyone involved to grow toward what they want.

IPS has also specified four tasks that are described as ways to practice the core IPS principles. These include:

1) Connection: IPS holds that the most important part of establishing a transformative relationship is cultivating connection—finding a place where people can "get" each other despite the space between them. Connecting, awareness of disconnection, and reconnecting—whether with individuals, family, community, and/or culture—is the primary task.
2) Worldview: How we come to know what we know. Worldview acknowledges that the way each of us sees and understands the world and our place in it is shaped by our own life circumstances and experiences. Practicing this task entails helping one another explore and understand how we've come to make sense of the world, including through the lens of trauma that has impacted many of our lives. Worldview also involves listening to each other from a position of not knowing (i.e., recognizing, exploring and being prepared to confront and change one's own assumptions, including and especially the way we've been shaped by pathologies, diagnoses and dominant cultural perspectives).
3) Mutuality: Instead of a service type arrangement, rather a relationship that is about the worldviews of both of the people in a relationship. Mutuality acknowledges and encourages both people to share their experiences, views and needs. "If it's not working for both of us, it's not working."

4) Moving towards: Heading in the direction of we want instead of away from what we do not want. The premise is that "mental health is not the opposite of mental illness." Rather, wellbeing is created when people focus on and move toward what they want, rather than spending all of their effort and energy on what they do not want (e.g., managing symptoms and diagnosis). This also involves thinking about crisis as an opportunity for growth and connection and supporting each other to use our relationships to co-create new and sometimes unexpected or surprising possibilities.

Taken together, the principles and practices of IPS are centrally about creating transformative relationships between two or more people through connection and dialogue. Like NATM, then, IPS privileges the idea of holding multiple truths, tolerating uncertainty, sitting with discomfort, and listening differently. Positioning itself to challenge the still lingering beliefs and practices of an overbearing mental health system, it is firmly committed to recovery, to hope and, ultimately, to social change.

IPS in Crisis Respites

In addition to training people in the core principles and tasks of the IPS framework, IPS facilitators offer crisis training that is designed primarily for peer support workers in residential settings such as crisis respites. In contrast to the traditional view of crisis in the mental health system as something that often calls for rapid intervention, medication, restraint, containment and control, IPS posits that crisis is an opportunity for growth and change. The approach offers proactive crisis planning but also suggests specific forms of engagement for people already in crisis, when it becomes paramount to interact with them in a way that respects their relational needs (e.g., connection, shared interest, manageable levels of discomfort) of all concerned (Mead and Hilton 2003:89). In creating this sort of virtual space, crisis response in IPS is thus driven by the desire to create and maintain mutual relationships and to make it possible for new meanings to be drawn from the crisis experience in the person's own context (Mead 2007). Rather than being worried about risk and liability, IPS encourages people to focus on the relationship and how they can use the relationship together to stay connected through challenging times. Service providers and recipients alike are asked to "sit with discomfort" and to work to connect, explore possibilities, move beyond old patterns, and co-create new, shared stories together.

People report that when in crisis they prefer "someone to talk to but not in a hospital" (Lyons et al. 2009:429). Crisis respites are one form of these important short-term residential (or community-based) supports for weathering crisis as an alternative to voluntary hospitalization. Similar approaches are crisis hostels, acute residential alternatives, and both residential and non-residential (community-based) crisis programs. Admission criteria for guests vary locally (and controversially), especially with respect to stable housing and perceived suicidality; some programs exclude people who are not housed, while others work with them to find housing. Some exclude people who are thinking or talking about suicide whereas many actively welcome these conversations (Ostrow and Croft 2015). Organizational structures range from informal support in people's homes (Chamberlin 1978) to independent, generally peer run agencies, to programs offered by mainstream providers. Their staffing models may consist of peer staff only or may rely on a mix of clinicians and peer staff. But consistently, this

> The intent of the peer movement was to create alternatives that are entirely peer-run, led, and staffed. As this movement has grown, a range of staffing configurations has developed—with much controversy.

approach offers people in crisis non-hospital based, non-medical model environments with flexible supports that enhance personal growth and autonomy through relationships that support guests in identifying their own aspirations, hopes, and plans to overcome crisis and connect with communities. They focus on moving beyond crisis, and creating opportunities for growth, relationships, and finding ways to "live well"—more than on symptom resolution through medication (Mead and Copeland 2000; Ostrow and Croft 2015). Peer communities, especially those available in peer-operated respites, provide an added dimension of self-determined identity for guests (Dumont and Jones 2001; Mead and Copeland 2000). Currently, many peer-operated respites provide access to Wellness Recovery Action Plans, peer support groups for hearing voices or conversations about suicide, individual time with a peer specialist, and recreational and educational activities (Croft and Ostrow 2015).

For over three decades these short term residential alternatives to hospitalization have been launched as successful, innovative demonstrations (Sledge et al. 1996; Fenton et al. 1998; Dumont and Jones, 2001; Greenfield et al. 2008), but funding streams have not been reliable (Stroul 1988), so in 2015 they remain relatively rare. As states create ways to fund what are deemed to be person-centered and recovery oriented health care systems through Medicaid waivers that support peer services, they will become increasingly available.

Peer Health Navigation

Peer Health Navigation is a training developed and led by Peggy Swarbrick that focuses on leveraging the knowledge and resources of peer specialists to help individual's bridge physical and behavioral healthcare gaps. Swarbrick defines wellness as "a conscious deliberate process whereby a person makes choices for a self-defined lifestyle that is both healthier and more satisfying" (Swarbrick 1997, 2006). Wellness encompasses eight dimensions (emotional, environmental, financial, intellectual, social, physical, spiritual, and occupational) and achieving wellness means finding a balance of health habits, ranging from sleep and rest to involvement in meaningful activity (Swarbrick 1997, 2006).

Swarbrick and her colleagues have developed a wellness model that allows for multiple roles of peers that can help promote wellness, particularly in the physical dimension. These include the roles of peer wellness coach (Swarbrick et al. 2011; Brice et al. 2014, Swarbrick 2013), wellness support provider, and peer health navigator. Recognizing how powerfully the physical dimension of wellness interfaces with the other seven dimensions, peers in these various roles are trained in effective communication skills to assist others in choosing and achieving wellness-related goals, to provide structure and support to promote progress and accountability, to assist individuals in strengthening their readiness to actively pursue wellness related goals, and to compile and share healthy lifestyle resources and strategies (Swarbrick et al. 2011). The Peer Health Navigation training builds on the foundation of the wellness model and focuses on physical wellness, including accessing routine health screenings, and adapts it to the New York City environment. Additional information on how Peer Health Navigation was integrated into Parachute NYC will be provided in the implementation section.

Implementing Parachute NYC

Since first launching operations in January 2013, Parachute NYC has made enormous headway in transforming approaches to crisis in New York City. On a structural level, the changes have been impressive: four need adapted mobile crisis teams, four crisis respite centers, and one peer-operated warmline were fully operational across the city by March 2014; 198 staff have been trained in the Need Adapted Treatment Model, Intentional Peer Support, and Peer Health Navigation (constituting 20,934 hours of total training offered by DOHMH—an average of 3 weeks of training per person); and 64 full time equivalent new staff positions have been created exclusively for peers. These structural changes have, in turn, enabled Parachute NYC to serve thousands of New Yorkers. As of April 2015, the mobile crisis and respite teams had served 1242 unique individuals and the warmline has fielded 23,501 calls[27]. Together, these complementary approaches to care are helping change the way that people in crisis and their support networks experience the mental health system and are expanding local opportunities to engage in care that are relationship centered and recovery oriented.

The fact that Parachute NYC was launched successively across four boroughs over time[28] meant that there was sufficient time for taking stock of what Parachute achieved and what challenges teams faced. In the following section, we first describe the process and outcome evaluation undertaken for this project by the Nathan S. Kline Institute for Psychiatric Research as a way of orienting the reader to why and how the data included in this report were collected. We then take up a series of implementation issues faced by teams in the course of launching and implementing their work. Tracking such issues provides space to both highlight the important milestones of Parachute NYC and to acknowledge places where disconnects occurred that leave room for improvement.

Positioning NKI's Research

DOHMH contracted the Nathan Kline Institute (NKI) to conduct a process and outcome evaluation of Parachute NYC. Although CMS funded an independent evaluation to assess Parachute's impact on diversion from emergency departments and inpatient stays, receipt of annual physicals/preventative health screens, and Medicaid costs, they did not evaluate the actual implementation of this novel and complex innovation, nor did they interview Parachute NYC participants directly to measure outcomes related to care quality, health and functional status, and service utilization.[29] By contracting with NKI, DOHMH also built in an ethnographically based track and report back mechanism that allowed them to document the launch of this pilot innovation and conduct mid-course corrections of implementation issues. Such an arrangement was put in place to support continuous quality improvement throughout the life of the project and to be proactive about changes that might be suitable for replication efforts in the future. Quarterly interviews with participants receiving Parachute NYC services also ensured that DOHMH could capture

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[27] Represents warmline calls from April 2014-April 2015 since individual calls were not tracked before the implementation of the telephone system.

[28] Manhattan operations launched in January 2013, followed by Brooklyn (April 2013), the Bronx (September 2013), and Queens (March 2014).

[29] The external evaluator hired by the Center for Medicare and Medicaid, Mathematica, did interview Parachute staff as part of its evaluation and also plans to interview Parachute participants.

outcomes related to better health, improved care quality, and lower utilization of costly services.

Process Evaluation

NKI's process evaluation was conducted primarily through ethnographic observation in the field and key informant interviewing of people at various levels in the project. Throughout the project, NKI research staff engaged in the activities shown in the box to the right.

Field notes were taken during all of these observational activities and positioned NKI to submit 24 "dispatches" to DOHMH—memos that summarized critical observations and provided informed feedback so the city could detect operational difficulties early and make appropriate mid-course adjustments. They also led to the writing of two longer memos regarding training and implementation challenges and a report on the challenges posed to Parachute by NYC's exceedingly diverse cultural mix (Cubellis 2014).

Shadowing Process Evaluation Activities

- Observed 112 days of NATM and IPS training
- Attended over 300 staff meetings and clinical supervision sessions with mobile crisis teams
- Attended 55 staff meetings with crisis respite center staff
- Conducted at least 75 days of informal observation of mobile and respite teams
- Completed 60 key informant interviews with Parachute leadership and staff
- Shadowed mobile crisis team staff during 5 network meetings
- Conduct 7 interviews with four young men experiencing a first episode of psychosis
- Conducted 9 focus groups with mobile crisis and crisis respite teams
- Helped facilitate 28 meetings for the development of a training curriculum for Parachute NYC that can support future replication efforts

Outcome Evaluation

In addition to this ethnographic work, NKI conducted an outcome evaluation for Parachute NYC participants. NKI staff recruited 170 adult volunteers who used Parachute NYC services (volunteers were either clients of the mobile treatment team and/or had stayed in a crisis respite center) through the help of clinical teams and crisis respite staff. By January 31, 2015 when enrollment closed, NKI evaluation staff had enrolled and completed Baseline Interviews with 170 Parachute NYC enrollees: 77 who received any services from the Mobile Team and 93 who used Respite services only. Volunteers were surveyed at Baseline and quarterly for 1 year and were given an incentive for each completed interview. Eighty per cent of baseline surveys were conducted within 60 days of enrollment in services for a psychosis related mental health crisis. The distribution of quarterly follow-up surveys for the cohort used in this data analysis (May 15, 2015) was: Baseline = 170; Month 3 = 124; Month 6 = 101; Month 9 = 78; Month 12 = 52. The purpose of the interview was to evaluate participants' health, mental health, and quality of life outcomes, their engagement in the Parachute NYC model and their use of non-Medicaid services. Since the evaluation was not funded to include a comparison group, we used standard measures with published norms or data for comparable groups to anchor findings. Appendix C includes a detailed description of the survey domains and validated measures.

Concurrent with the NKI surveys, NYC DOHMH collected demographic information (age, gender, ethnicity, insurance coverage, and zip code) on all Parachute program entrants in the Parachute Portal. Parachute NYC service contacts, reported by providers, were entered into the Portal.

Sample Characteristics (baseline): Survey participants using Any Mobile Team Services were predominately young (Median age 25) and male (69%) with minority racial and ethnic backgrounds (91% Non White-Non Hispanic). In the five years prior to enrolling in Parachute NYC, half had used MH services: 57% had been hospitalized for emotional reasons, 53% had used ER services for emotional reasons, with a median of 2 ER visits and 10% had used substance use services.

Those using Respite Services only also had predominantly minority racial and ethnic backgrounds (83% Non White-Non Hispanic), but men and women were roughly equally represented (47% men; 52% women), and one third had children. Those using Respite only were older (Median Age = 39 years), and had histories of extensive mental health service use in the prior five year: 70% had been hospitalized with a median of 3 ER visits for emotional reasons, 77% had used ER services for emotional reasons, and 27% had used substance use services.

Compared to both the general population and to people with schizophrenia diagnoses,[30] survey participants at Baseline rated their general mental health significantly worse, had significantly more symptoms, and significantly worse overall social functioning. They rated their general physical health significantly worse than the general population but better than people with schizophrenia diagnoses.

Interim Outcomes Analysis: NKI conducted an interim analysis of selected outcomes using data from 525 interviews conducted through May 15, 2015 when we had an average of 3.1 interviews per survey participant. We used linear mixed effects models with random intercepts and random slopes (continuous measures) or generalized linear mixed effects models (categorical measures) to estimate the change over time for survey participants. Logistic models were used to examine the probability of hospitalization. Linear and non linear models were examined to see which model best fit our data. We report results for piecewise linear models using 0-10 months and >10 months when this fit our understanding of the data and a two piece model improved fit.

We performed mixed effects 2-piece linear regression models that included age, gender, time in Parachute NYC and Parachute service use as covariates on selected outcomes(see table in Appendix D). These analyses showed that overall, participants' psychosis-related crises resolved without hospitalization. Compared to Baseline, participants' ratings of overall mental health, their confidence in their ability to cope and their experience of mental health symptoms improved significantly up to 10 months, and then declined for the duration of the follow up.[31] Participants' experience that Parachute NYC services supported shared decisions declined significantly during the first 10 months of follow up, and then significantly increased during the remaining 2 months. Ratings of overall physical health were significantly better for those who received higher amounts of Parachute NYC services, for males, and for younger survey respondents.

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[30] Addington and Addington 1999; Barnes et al. 2012; Dickerson et al. 1997; Fiscella et al. 2007; Kreyenbuhl et al. 2009; O'Brien et al. 2009; Salyers et al. 2000; Silva et al. 2010; Smith et al. 2013.

[31] Final analyses will include the effect of discharge from Parachute on participants' health, mental health and quality of life in order to clarify whether extension of treatment beyond one year might be warranted in order to solidify improvements made during Parachute enrollment.

During the first 3 months of study participation, the probability of being hospitalized for mental health problems was significantly lower than in the 90 days prior to enrollment. A linear regression that included as covariates age, gender, time in Parachute NYC and Parachute service use showed that older participants were significantly more likely to be hospitalized during the entire follow up period. The risk of being hospitalized within the follow up year is 38%, which is comparable to rates in follow up studies of first episode programs (range 12% -56%) (Alvarez-Jimenez et al. 2012).

NYC DOHMH assessed Medicaid savings by comparing Medicaid costs for Parachute NYC participants with those of a sample of Medicaid eligible individuals who met Parachute NYC eligibility criteria, with baseline and pre-enrollment characteristics matched by propensity score matching. This analysis has been updated every quarter but results are incomplete to date.

Because NKI research staff surveyed participants up to five times in the course of a single year, survey appointments also provided a forum for Parachute NYC participants to talk freely about their experiences and to reflect on how their physical and emotional health and daily activities had changed over time; in some cases, the survey also enabled participants to reconnect with mobile treatment teams after a period of disengagement (e.g., a participant would request that the NKI staff member tell the mobile treatment team that they were interested in being contacted again and NKI would pass on this information to the appropriate team). Follow up surveys that took place at the mobile team offices also allowed for additional contact and reconnection between clients and teams.

Analysis of Process Data

It is through NKI's extensive contact with both staff members working on Parachute NYC and clients served by the intervention that the research team has come to develop a deep understanding of how Parachute NYC works on the ground and how participants experience mobile crisis teams and crisis respite centers. The NKI research team met weekly to review implementation progress and issues across all sites and share feedback from team members and clients. Periodic data analysis sessions were also held to take stock of recurring themes, milestones, and disconnects and memos were written to expand thinking on particular issues. Prior to writing this paper, the research team re-reviewed all written field notes, dispatches, memos, and interview notes to confirm the most pressing concerns; specific quotes from participants were drawn out that are representative of regularly occurring themes and concerns. What follows below is a distillation of the most important implementation issues that have surfaced in the last three years; we recount both milestones achieved and challenges faced for these issues as a way of taking stock of what has been accomplished and priming discussion for what might come next in future iterations of Parachute.

Key Implementation Issues

By nearly every account,[32] Parachute NYC constitutes (in Pat Deegan's apt phrasing) a "disruptive innovation," and both the newness and its upheaval are still being reckoned with. In hindsight, it's easy to say that at least some of the latter might have been better

[32] A possible exception being people wholly new to the public mental health system and its ministrations.

anticipated and planned for. But public mental health's record is full of fresh and failed demonstration programs, most of which surface quietly and recede without raising much dust or interest. Dedicated labor over many years may produce the coveted protocol of a recognized "evidence-based practice," but these are rare, researched-spawned, and tightly prescribed. Parachute's ambition was more targeted: to train mixed cadres of clinicians and peers in (what were thought to be) kindred versions of dialogic work with people in crisis as the first step ("proof of concept") in what could slowly take shape as an alternative community of practice. Put simply: could peer-integrated dialogic practice work here?
The approaches chosen did not make for tidy replication. As noted earlier, although experienced practitioners and capable bureaucrats, Parachute's architects were to some extent flying blind: a highly selective Open Dialogue training institute and a small clinical program in Massachusetts notwithstanding, there is no "prototype" of NATM- and IPS-informed practice on the U.S. public mental health scene. The detailed workbooks of IPS and impressive store of peer-reviewed tributes to NATM/OD may have sufficed to establish their legitimacy as promising, practice-based approaches. But neither training manual nor publishing record deals with the demanding pragmatics of implementing so radical a departure from mental health business as usual. Recruited agencies were no better informed; nor, for that matter, did they all see themselves as committed to what was sometimes described as a "transformational" endeavor. (That said, at least one veteran mobile crisis service provider (VNSNY) welcomed Parachute as an opportunity to recall its designated mobile teams to the original hybrid remit of that work, which could include engagement, crisis resolution and more extended psychotherapy.[33]) The core competencies, requisite participants, staging areas and organizational homes may have been provided for; but aside from these essentials, Parachute NYC had few sureties on board. Saddled with having to field and resolve a myriad of operational glitches, City officials had little time for institutional outreach or cross-sector overtures to players in complex, multicultural system already girding themselves for big changes on the reimbursement horizon.[34]

The City itself was only too aware of the limited playbook they were able to offer as part of the contracting process. Accordingly, instead of the usual monitor-by-deliverables approach to contract management, its oversight was active, engaged and interventionist: answering sometimes frantic calls from participants needing reassurance that whatever approximation of an imagined ideal they had going was "good enough" for now; fielding and responding to research team dispatches and memos; doing extensive outreach to sister

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[33] See Lindy, D. C., Laitman, L.B., Moynihan, P.J., Pessin, N. Mobile crisis settings, in *Emergency Psychiatry: Principles and Practice*. Glick, R.L., Berlin, J.S., Fishkind, A.B., Zeller, S.L. eds. Philadelphia: Lippincott, Williams and Wilkins, 2008, pp. 413-424. It was not unusual, apparently, for "a client being treated in a clinic [to be] also seen by an outreach worker who conducts family therapy in the home" (p. 416).

[34] To push the point, with an eye toward what recovery-oriented practice entails: few linkages were made to entities, agencies or venues more broadly thought to constitute the "de facto mental health system" (Regier et al. 1978). Criminal justice is the system uppermost in mind, with employment and/or education a close second.

agencies, institutions and clinics in NYC to inform them of what Parachute had to offer; meeting regularly with the mobile teams to field complaints; revising eligibility criteria; troubleshooting the inevitable disagreements and misunderstanding that arose between trainers and trainees, and trainees and their agencies; negotiating entrée into the State's Medicaid redesign effort and, once there, ensuring provision for "Parachute-like" services and (certified) peer-provided assistance; in the last year of the project, making especially timely presentations to managed-care organizations detailing what Parachute-like services had to offer; and, as the promised deadline for issuing new rates and regulations for HCBS kept receding in that final year, providentially securing 2 years of bridging funding from the State to keep 3 mobile teams and 4 respites operating.

"With the introduction of NATM's dialogic approach, I felt permission to be more open, and vulnerable with my team members, especially during supervision and network meetings. I felt less pressure to make an authoritative assessment about my families. This came as a relief – that I could share my genuine responses, my feelings, in a useful way and get support from colleagues. With this, a sense of ease and teamwork developed among the front-line staff that I have not experienced in other mental health settings."

Against the backdrop of hectic preparation, wholesale embrace of learning-by-doing, and adaptation of welfare-state therapeutics to the rough-and-tumble of Big Apple innovation staging, the achievements of Parachute NYC may be better appreciated. Plainly put: the hoped-for carryovers from training and further development through practice and supervision both occurred. Integration of peers into crisis respite centers and mobile treatment teams—for all the difficulties soon to be rehearsed—looks to be an irreversible change, ratified in newly issued state regulations.[35] Striking—and, for the time being, sustained—changes have been made in each team's modus operandi over the course of the project. Mindful of all the caveats with respect to uneven and/or inconsistent practice to be discussed below, it's still worth noting that both observed behavior and informal commentary suggest real progress. For the substantial majority of staff who remain with the project, Parachute NYC has meant improvising previously unexampled ways for peers and professionals to work together. In the process, images of "the other" have also undergone overhaul, with both groups considerably more alive to the possibilities of collaborative work and aware of the distinctive expertise of the other. Still, however provisional, this represents real movement in a labor force not known for innovation.

More specifically, and even if present to different degrees of depth and proficiency, striking developments can be identified across the mobile teams and crisis respites. They capture what might be called a reworked culture of practice still in formation: disrupted practice, buffered transitions, integrating peers, and work-related subjectivities being remade.

[35] In this instance, as noted earlier, the structural complement has been aggressively attended to, with Parachute-affiliated DOHMH staff extensively involved in drafting the new regulations specifying Home- and Community-Based Services (referred to at a September 15, 2014 project meeting as "Parachute-like")

- *Disrupted practice*: Treatment options have broadened, coercive actions are much more suspect, hospitalization problematic, and referrals to other services may be buffered and/or mediated by team members (with peers sometimes the de facto go-to personnel (see below)). The pace of treatment planning has become more deliberate. With peers on board, both assessment and decision-making have slowed down. Language is reflexively policed, with clinicians reporting being more self-conscious about resorting to diagnostic or objectifying language (though, surely, context and audience continue to influence habit). But at least as a standing option, the therapeutic focus can be pulled back to the here-and-now, ferreting out untold stories, taking the broader view, and easing up on pathology. Self-disclosure has even crept into the therapeutic toolkit and shown its (sometimes confident, sometimes tentative) face in network meetings as well as respite encounters.[36]

- *New routines: buffered transitions and reworked relationships with the broader system*: New relationships and novel ways of interacting with hospitals have emerged. Some of this involves creative negotiating and establishing trust—convincing hospitals, for example, that peer-run respites have the necessary expertise and resources to handle certain crises. One unexpected benefit of the teams' commitment to "continuity of care" is that follow-through and "smoothing" of transitions to non-Parachute parts of public mental health have become common practice. This is especially obvious in several instances of potentially traumatic hospitalization, where mobile teams have effectively taken charge of a fraught situation and allowed the police to stand-by as security instead of intervening as coercive force.

- *Integrating peers*: Parachute NYC has created 64 FTE's positions for peers; pending training for "certification" as peer specialists, their service will be "billable" in respites and mobile teams under Home and Community Based Service categories in the NYS 1915i Medicaid waiver, ensuring their employability. But beyond secured employment, Parachute's peers have provided *embodied* evidence of recovery and articulated accounts on how it might be achieved. They not only present but also *represent* hope and the prospect of post-psychosis solidarity. The recovery message, so easily reduced to sloganeering, is here made real and personified—as when a peer member of a crisis team self-identifies as once-in-terrible-trouble herself. Our experience is that this is of huge value to both the person in crisis *and* the family (itself also in uncharted waters). In some venues, the connection has been extended to a network of peers, as with "alumni days" at respites, learning about other peer-run organizations and training programs beyond Parachute NYC, and introductions to groups like the "Hearing Voices" collective. Put simply, for peers, Parachute NYC

[36] Further note: Nor is disclosure simply the signature deployment of peers, though navigating the clash of professional cultures is still problematic. Disclosure is not a one-time declaration. Once revealed, it's subject to further question and/or clarification, rumor, backstage conversations, protective cover, and other forms of impression management. All of which complicates the discloser's interactions with others: some wise to the fact, others still in the dark; some co-workers, others clients or their families.

has meant employment, recognition, and the stunning (if not unproblematic) transformation of what was once stigmatized into marketable asset.

- *Remaking subjectivities:*[37] The presence of peers on teams has had other spillover effects as well, notably at the level of professional roles and identities. While peers struggle to navigate the unfamiliar work-world of a system that now embraces as deployable skill what it once saw only as treatable condition, clinicians have wrestled with a related but doubled challenge. On one front, they have had to "unlearn" much that prior training and conditioning had taught them. Before, legal liability and professional privilege had made theirs the decisive voice in clinical matters. Parachute's polyphonic premise—the active cultivation of many voices in treatment planning—asks them reframe the decision-making process as collaborative teamwork. Also difficult for some is Parachute's recovery-informed stance toward peers as deliberative agents in their own right, enjoying full "participatory parity" in negotiations with families and persons in crisis.

With these common developments across mobile teams and crisis respites in mind, the sections below review key implementation issues that stakeholders across the board—City administrators, trainers, practitioners, agency staff and researchers—had to contend with in the roll out of Parachute NYC. Our aim is to offer a more finely-grained and contextualized account of the various components that went into building and sustaining this ambitious undertaking over the last three years—from the rapid turn-around of the initial proposal, to the coordination of trainings, to the task of hiring staff and supporting peer integration, to the milestones and practice difficulties encountered by mobile crisis teams and crisis respite centers. Each of the nine areas outlined should also alert the reader to areas that deserve additional consideration and planning in future Parachute-like projects.

> *"It's very heartwarming to see changes in the people [team members] you least expected it from. I think sometimes it is exactly that phenomenon that makes it all worth it, when these changes occur. That's what's so powerful."*
>
> ~ NATM trainer

As noted above, a great deal of bureaucratic toil and trouble-shooting took place behind the scenes throughout Parachute's implementation; the same was true, to varying decrees, at the agency level. By its very nature, such "invisible work" escapes the ethnographic gaze, and some of the events and impressions recounted here are necessarily second-hand. For the most part, this work involved the problem-solving efforts glossed above—from the mundane (arranging visas, travel and lodging), to the intercessory (running interference between Parachute staff and agencies, insisting on staff release time for trainings, to the dramatic (persuading one or another of the frustrated principals, early in the game, NOT to quit)—that harry any attempt to graft

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[37] Anthropologists use the term subjectivities as a noun of process. Like its intimate partner *culture*, subjectivity is "both an empirical reality and an analytic category: the agonistic and practical activity of engaging identity and fate, patterned and felt in historically contingent settings and mediated by institutional processes and cultural forms… [it] constitutes the material and the means of contemporary value systems…" (Biehl et al. 2007:5). Here, it should be clear, we're talking about such in-flux, potentially transformative activities as embedded in the therapeutic work of Parachute.

the different and difficult onto the familiar and routine, and to do so with a cast of not entirely enthusiastic players. The City's work went far beyond the expected due diligence of governmental oversight embodied in the much-contested (and occasionally modified) "deliverables." There was real, substantial commitment here, an investment of self and reputation. As a final flourish, in the waning months of a no-longer grant-funded and not-yet-reimbursable promising practice, the City secured bridge funding to extend the demonstration while more sustainable funding options are designed.

1. Initial Design

The rapid turn-around to the NFA issued by CMS in the winter of 2010-2011 made for hectic circumstances under which to design a complex program with many moving parts. There was no time for piloting, no trial run with potential partners; past experience and future prospects would have to do. The usual drawn-out courtship of contracting and consulting with trainers and/or MH provider agencies (a total of 10)—whether through collaborative process or competitive requests for proposals—was severely truncated. The central signature practices (NATM and IPS) had strong pedigrees in their sites of origin and promising records of replication elsewhere. But neither had a recognized "evidence base," nor had they been mounted on the scale proposed here or in a city as large and diverse as New York (see earlier discussion of NATM and IPS for history and evidence). In consequence, parties to the contract *on both sides* found themselves negotiating terms and conditions of implementing therapeutic initiatives of which they themselves had limited understanding and less experience. (As discussed below, the seismic shift in clinical approach required of "repurposed" mobile crisis teams, and the under-appreciated complexities of integrating peers into both mobile teams and crisis respites, would prove especially challenging.) Nor would Parachute NYC be a stand-alone program: frontline workers at an established omnibus crisis-referral mechanism (Lifenet) would have to be briefed on Parachute NYC protocol and taught a new regimen of rapid assessment and triaging.

In the best of cases, prospective partners would be making open-ended commitments to programmatic or training regimens the details of which would have to be worked out—*improvised* is not too strong a term—during actual implementation. (A staggered start-up schedule for crisis teams and respites ensured that subsequent launches could learn from the mistakes of earlier ones.) It also left room for agency engagements that may have been more opportunistic than one might have hoped for. In that event, late-breaking requests for additional effort, flexibility or accommodation on the agency's part—e.g., additional space to accommodate the team's changing needs; providing time and resources for the team to handle "case management" responsibilities, instead of handing them off to Health Homes; ensuring staff availability for ongoing training and/or supervision—might well be met with something short of enthusiasm.

Last, although a research-based, implementation tracking-and-feedback mechanism would be built into the Parachute NYC roll-out, the fine-tuning of operational adjustments was to be leveraged by the less-than-subtle mechanism of contract-specified "deliverables." Reckoning them in advance of actual practice in a complex service environment with little advance warning of Parachute's launch would prove an exercise in educated guesswork.

2. Training

Parachute NYC was hugely ambitious on the basis of training alone, promising to train staff in three different, yet complementary approaches: Need Adapted Treatment, Intentional Peer Support, and Peer Health Navigation. The full complement of training is approximately 5 weeks and includes NATM (112 hours); Basic IPS (35 hours), IPS Co-Reflection (7 hours), IPS Crisis Training (14 hours), and IPS Advanced Practice (14 hours); PHN (14 hours); and multiple other individual trainings (e.g., Recovery 101, Overdose prevention and response). The enormity of this undertaking cannot be overestimated. For NATM trainers, Parachute NYC is only the second large-scale implementation of the model to date (Berlin being the first city where it has been taking shape for nearly a decade). For IPS trainers, Parachute NYC offered an opportunity to bring their approach to new scale and make an imprint on a complex, urban public mental health system.

Coordinating the logistics of training alone was impressive since it involved hosting non-local trainers for each of these days, managing both mobile crisis team and respite team schedules, and ensuring that there was appropriate coverage in the field for clients as training activities were underway. More impressive still, was the adaptability of the trainers to frequently changing circumstances, personnel, and training requirements. Training in NATM and IPS is an intensive process, requiring sustained participation from people in the room and asking participants to engage in deep and self-reflective practice. On the one hand, this can be an equalizing and empowering experience, with peers and professionals in various positions training together. On the other hand, it can be emotionally exhausting and conflict provoking, requiring thoughtful management from trainers. NATM trainers (Volkmar Aderhold and Petra Hohn) and IPS trainers (led by Chris Hansen) were incredibly adaptive throughout the course of training, responding to the needs of the particular group being trained at any one time and willing to pivot and refocus if necessary. This attitude was particularly important for a project where people were being asked to learn very new approaches to care—and in some cases, to unlearn other foundational approaches.

Prior to taking up each of the trainings individually, it is helpful to identify four challenges that were common to all trainings: (1) the inability for all team members on a specific mobile crisis or respite team to train together; (2) the lack of agency leadership participation at most trainings; (3) the minimal familiarity of trainers of the different approaches—NATM, IPS, and PHN—with each other's approaches and the lack of opportunities to collaborate or learn each other's approach during the life of the project; and (4) the fact that at the outset, there was little consensus at the training or operational level about who would be practicing NATM and who would be practicing IPS, and how this would be supported within Parachute NYC.

First, because of staggered hiring and staff turnover, not all staff on teams were able to train at the same time. Thus, someone who was hired later in the project may have trained with people primarily from another borough or, more problematically, jumped into trainings mid-sequence. One mobile crisis team was a notable exception to this, with most team members hired at the start of the project and consistent throughout. The team benefitted from this joint training, particularly because they were able to draw on real-life situations in role plays, to trouble-shoot difficult situations, and to work with the same team members they collaborate with daily in testing out new techniques. Although staff

turnover and new hires are inevitable on any project, to the extent that teams can be in place when training begins and then go through training together, the more likely they will to be able to build team cohesion and to link the theory and skills they learn in training to their everyday work on the ground.

Second, people in leadership positions at provider agencies rarely attended any of the trainings. The result was that staff were trained extensively in approaches that their supervisors and/or agency leadership were largely unfamiliar with and that, at times, did not line up directly with agency policies. This may not be entirely surprising since, as one member of the Parachute NYC Community Advisory Board shared, it takes 5 to 10 years for an agency to shift to a culture of recovery. One person in a leadership position who did attend all the trainings recognized how "radically different" these models were and what a long process it was—a "long process of unlearning" in many cases—to become familiar with a new and "very sophisticated way of working with people." The fact that she had participated in trainings not only gave her a deep sense of the material but also meant that she was available for supervision and support in the following months as her staff grappled with the challenges of working in a new kind of way. This was not the case on other teams, however, and staff were thus left without access to regular and direct support from the people to whom they report.[38] This shortcoming also meant that systemic changes and adjustments necessary to adequately implement the paradigm and practices did not happen, leading to conflict, confusion, and in many instances, reverting back to traditional modes of treatment (see footnote on Model Fidelity, p.60)

Third, trainers of NATM, IPS, and PHN were not entirely familiar with the other approaches being used in Parachute NYC, or about expectations of who in the project would be practicing what, and/or the intersection of the approaches. Although trainers did have some opportunities throughout the project to talk together about the overlaps and differences in their work, trainings themselves were stand-alone events and the work of integration was left to team members themselves (e.g., to think about how the approaches were complementary and could be used in tandem). As this issue has played out, there has been ongoing discussion about how to alter both the trainings and the system for any future iteration of Parachute and to think more seriously about the possibility of a truly integrated training curriculum (*see more on Train the Trainer below)*.

Fourth, and in part a function of the lack of integration of the two trainings, it was not clear to what extent NATM and IPS were each intended to be put into Parachute NYC practice regardless of one's status (clinician or peer) or venue of operation (mobile team or respite center). Apart from fortuitous reckonings during supervision, staff were largely left to their own devices in cobbling together combinations or adaptations in daily practice.

NATM Training

Bringing NATM to New York City was not simply a matter of ushering the transmission of a well-formulated practice from one setting (Northern Europe) to another. Although NATM draws upon a well-documented tradition of psychotherapeutic approaches

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[38] Staff did have access to periodic supervisory sessions with NATM and IPS trainers (an issue addressed further below), but this cannot replace the value of working on a team where leadership (whether direct or higher up) demonstrates investment in the model and takes time to learn the approach.

to psychosis[39] and boasts significant overlap with some forms of family therapy,[40] NATM (and such later developments as Open Dialogue) are rightly seen as reworking the foundations of social responses to psychosis. Training in NATM is thus much more than simply adding an assortment of techniques to one's existing toolkit of treatment; it really involves a reorientation process and, for some, a good deal of *un*learning, especially of the assessment role orientation that is characteristic of traditional mobile crisis work. Equally important, training is not just a matter of lecturing, sharing ideas, or talking in a more distant fashion about the topics at hand. Trainees participate in lengthy role plays (sometimes lasting 90 minutes) in which persons in crisis work with their families, invited friends, and mobile crisis teams in mock network meetings. The exercises ask people to put themselves in everyone else's shoes as much as possible, to maintain an open mind, to adjust to the given language of the family and network setting, and to facilitate in a way that all voices can be heard and, hopefully, understood. These scenarios often draw on real life cases, but they are still extended acting exercises that ask people to take on roles that differ from their everyday professional roles—a dynamic that destabilizes recognized identities and often tests conventional conceptions of professional norms; the psychiatrist is asked to feel the way an identified client might feel, the social worker asked to imagine how a peer specialist might respond. Trainees may ridicule or reject these moves at first but they appreciate them later on and it is through sharing and processing these experiences together that teaching and learning takes place.

The newness of this approach to therapeutic work, as well as the newness of this approach to training for therapeutic work, became especially apparent when local trainers took over the charge to facilitate the training (Parachute NYC team members volunteered to become local trainers as part of the "Train the Trainer" initiative described in more detail below). As local trainers witnessed new trainees struggle as they once had, they connected more deeply to their own experience. In intervening with one particularly resistant trainee, a local trainer reflected:

> I struggled with [training]. I'd say I was resistant to it, and in thinking back, I don't know if I was resistant to it in its entirety, or just certain components. And because I felt so strongly…I know I came off as a pain in the butt. But it's really something that, for a lot of people, it's gonna be part of the process, going through that internal battle and just really fighting yourself, like, "What are we doing?" …You start to feel that way because [the training] is making you re-think your ideas, and your values, and the way that you see things. It's forcing you to have that, well, "Is there really something else out there?" And that's disturbing, it's disruptive, you know, it sets you off balance.

In turn, these moments offered space for the European trainers to reconnect to their own process, as clinicians and trainers. One of the lead trainers offered:

> It also made me revisit some of the training experience that I had in your shoes, now, standing in my shoes. It's hard, right, when you try to get people to pick up on something, and you feel that they have to fight you and they have difficulties, not because they want to fight you, per se, but this energy

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[39] See Alanen et al. 2009

[40] For a review, see Beels 2002 and Stierlin 2009

> needs to go [some place], and you have to stand for it, you have to be able to contain it, and take it, and continue your teaching process.

Ultimately, the struggle experienced by both trainee and trainer reaffirms the vitality of the process of the network meeting as a therapeutic container. As one of the new, local trainers said:

> It truly is the experience…and I really feel like that kind of dawned on me in that moment, [that] what you experience, taking this training as a trainee, is really what the family is feeling. We really are asking them to conform to this new way of doing things; and it's uncomfortable, and it's weird, and it doesn't feel right. And it's unsettling for them; we're asking them to look at themselves in a new way, look at the issues in their home in a new way. We're asking them to look at whomever they're identifying as the problem in the family, and what's going on with that individual, in a new way.

At the level of implementation, a primary challenge for NATM trainers was that they were asked to rework their entire curriculum and training rhythm to meet the demands of New York City. Although the training brought to New York City has been in development in Germany since 2008 (drawing on elements from the Swedish and Finnish curricula) and includes a highly structured and refined curriculum (based on a 16-day course with 2-day segments of training split up by 6-8 weeks of practical experience), the trainers had to completely change the structure and pace of their training to meet the needs of four boroughs with staggered launch dates. Trainers found this difficult, not only because of how hard they had to work to adapt their existing materials, but also because the way it was organized in New York City meant that people were joining trainings at different times and different levels; this disrupted the integrity of the group learning process.

An additional tension raised by NATM training was the fact that the approach does not rely on a manual. NATM trainers were insistent there is no "cookbook" for learning NATM—that much of it involves experiential learning, testing out new techniques, and seeing what feels natural to say in a particular moment (within a general framework of fidelity to the model). The entire method of the training is to get people to learn by doing the exercises and reflecting together about them. Furthermore, a roadmap or syllabus of what is to be expected in each training is generally not feasible from the trainers' perspective because they are constantly making adjustments to accommodate who is attending training and how a particular group is progressing. The trainers thus work developmentally, fine tuning what they teach to the needs of the group; in this sense, the training, too, is "need-adapted"—like a giant network meeting that has its own developing structure and rhythm. This can be frustrating for established practitioners who rely on checklists and protocols when delivering care, as well as for people with no clinical training who may be less confident of their therapeutic grounding and/or skills.

Over time, through collaboration between NATM trainers and NKI researchers, some accommodations have been made to streamline and clarify materials for the audience in New York City. The subsequent Train the Trainer effort (described below) further adapts NATM training materials to a style that is more consistent with some of the hallmarks of American trainings, while keeping the integrity of the training—and its reliance on experiential learning—intact.

Intentional Peer Support Training

Just as bringing NATM to New York City meant ushering in a model of care that seeks to dramatically rework the response to psychosis, so too did bringing IPS to the city involve signing on to a radically different way of structuring service relationships. As described earlier, IPS' roots in social justice movements promote a trauma-informed way of relating that is premised upon mutually accountable relationships. In turn, IPS training is highly interactive and asks participants to challenge themselves and take personal risks.

The training itself is well structured and well resourced. Trainers rely on a rich manual that details IPS principles; exercises and handouts are provided of the slides used during training. Such materials provide anchoring texts and activities for the duration of the training and reference material for future use. Trainers also model IPS techniques for trainees throughout, giving those who are learning the approach a chance to watch it in action and begin to understand how to draw on personal experience effectively. The peer experience is clearly (re)valorized in IPS but the unifying theme is one of careful attention to relational dynamics and the training makes clear that drawing upon one's personal experience takes reflective work and practice.

One difficulty encountered in the IPS training for Parachute NYC—and one that speaks to the larger challenge of peer and professional integration on this project—was tailoring the training to address a population of trainees that included peer, non-peer, and supervisory staff. Here, preparation may have been wanting and corrective measures bit slow to take shape. IPS training is suitable for anyone interested in mutual support and has been used to train people who work in both traditional and alternative mental health settings. Even so, early feedback on the IPS training suggested that many clinicians felt alienated by an approach that seemed to question the utility of clinical perspectives.

The challenge, of course, is to fashion some sort of respectful working understanding that can accommodate the awkward fact that the same system that hosts Parachute NYC, has invited IPS to train its cadres, and is opening itself to substantial peer involvement *also* has a history of having hurt and humiliated many in the room. Questioning the conventional notion of "mental illness" and expressing skepticism toward standard diagnostic and treatment practice are understandable coming from trainers and participants who have repeatedly suffered the damaging, even traumatic consequences (intended or not) of "treatment."[41] Many have seen their own diagnoses and treatment regimens change radically over time, often with little apparent linkage to new science. Understandably, this proved difficult and demoralizing for some clinicians to hear. A few reported feeling "othered" by such dynamics—"Why were we even bothering to try if we were the bad guys to start with?" But resistance to IPS trainers speaking of the harm and perceived evils of "the system" on the part of clinicians was neither uniform nor

> IPS trainers were not alone in overestimating the extent to which NYC clinicians—not all of whom were eager conscripts to Parachute—were already well-versed in recovery-oriented practice. For some, then, confronting the open disbelief of peers with respect to diagnostic "labeling," therapeutic prognosis, and treatment effectiveness was something of a shock. Cobbling together some common ground with respect to "what is known as mental illness" from which the training could proceed proved an unexpected opening challenge.

[41] *From IPS training field notes:* When one is hospitalized because they are "at risk" and deemed incompetent, they *become* incompetent—their living and self-determination muscles atrophy. In many cases, it takes years to reclaim that stolen competence and to rectify the damage done its wake.

unyielding. Much of it probably reflected mutual unfamiliarity—on clinicians' part, with respect to recovery's broader implications; on the part of IPS trainers, with respect to Parachute's mixed cadre of trainees. Some clinicians found the alternative perspective bracing, challenging them to rethink gestures and assumptions long taken for granted. And, as we were to learn, there were a number of Parachute NYC clinicians, researchers, and managers who themselves had lived experience of mental health diagnosis/treatment but had not previously disclosed it; for them, IPS was a welcome validation.

As noted earlier, the design/planning/start-up schedule for Parachute NYC was hectic at best. The vision was bold and far-reaching – to introduce *both* large-scale peer integration *and* a novel clinical approach to public mental health's response to psychiatric crisis, and to do so in equal measures of commitment. But it did not fully appreciate what adopting the two core approaches—*alternatives*, not adjuncts, to conventional ways of working—would mean for everyday aptitude and practice, let alone how difficult it might be for some (clinicians especially) to make the shift. For their part, IPS trainers had little notice of who was to be trained, what trainees understood themselves to have signed up for, or what they were expected to get out of the trainings. A good deal of mid-course correction was thus inevitable, especially in the early sessions.

As a result of training experience, interventions by City managers, and feedback from NKI researchers and participants, IPS trainers worked hard to develop a language, stance, and tone that could be heard by all. One instance is especially telling:after one such tense exchange early in the third sequence of training, the lead IPS trainer responded by highlighting her own clinical background when training resumed the next day. This was complemented, however, with a moving account of how, in a moment of crisis, when being committed as a patient in the system in which she worked, one of her own clinicians took the time to connect and talk of his own personal suicide attempt. This overnight improvisation served to usher in a more inclusive feel to the training, one that recognized that any project working *within* the existing mental health system would need to make peace and find common cause with agents it intends to enlist in the new effort.

Peer Health Navigation Training

Peer Health Navigation training was included in the design of Parachute NYC to be responsive to ongoing national efforts to promote integrated physical and behavioral healthcare services. The rising human and economic costs of fragmented healthcare have been the subject of a considerable amount of research, since much of the excess mortality in people with serious mental illnesses can be explained by disproportionately high rates of mortality from preventable or treatable cardiovascular and pulmonary diseases (Druss & Walker 2011; Nardone et al. 2014). Peer health navigation is one such approach to bridging physical and behavioral healthcare gaps, with peers taking on a range of responsibilities in this arena, from collaborating with individuals using their services to create personalized wellness habits, to developing a resource listing of community resources and providers, and to coordinating linkages and appointments to providers. The overarching concept is that peer support can be a central ingredient to create, enhance, and implement a coordinated and patient-centered healthcare system (Griswold et al., 2010).

Respites are supposed to have a home-like feel. Adding standardized clinical care could achieve a laudable goal, and yet undermine the primary goal of the respites – to provide safe, homelike environments that promote comfort and personal growth. Also, unlike clinical settings, they also enable residents to maintain both routines and ties to the community while staying there.

In New York City, Peer Health Navigation training was reduced to two days (from six, as originally planned). Feedback from trainees suggested that, although they found the concepts behind the training convincing and useful, they did not receive enough institutional support to identify the available health resources that the program's clients might want or need to access. Nonetheless, peer specialists were certainly activated around physical health issues as a result of the training and these issues thus became part of their advocacy work.

The City also connected mobile teams and respites to a liaison from a federally qualified health center that served as an entry point for clients with physical health needs. Although Parachute NYC had anticipated being able to provide on-site primary care services at the crisis respites, they were never able to achieve this goal because the federally qualified health center said they could not deliver care at a site that was not approved by the Joint Commission on Accreditation of Healthcare Organizations. As of December 2014, one LPN from the Community Healthcare Network (CHN) has been spending time at the crisis respite centers in order to provide health education that is responsive to the interests of respite guests and to link guests to necessary primary care services at CHN's network of 11 federally qualified health centers. Although there has not been sufficient time to date to evaluate how this relationship between CHN and the respites is working, or to get feedback from respite guests on the utility of having an LPN on site, the goal of integrating physical and behavioral healthcare remains an important one, as crisis respite centers can offer a critical point of access for linking people to primary care services.

Creating a Community of Practice

An essential and outstanding question for people involved in Parachute NYC is how to create a community of practice for people who have been trained in both NATM and IPS. Parachute NYC involves a huge paradigm shift in clinical practice, particularly because the project converts existing mobile crisis teams (a time-limited and quite traditional intervention) and integrates peer staff into the work in a much broader and more sustained way than seen before in New York (each of these issues will be described in further depth in subsequent sections). The viability of this shift depends crucially on the commitment of individuals who are interested in it and motivated to adopt it. But it also requires sustained rehearsal; to learn how to do something very different is not only a matter of attending trainings but also of being exposed to and then practicing a different way of working in the world. In short, it requires a community of practice that offers both the extended possibility of learning and the moral support to continue the hard work—work often at odds with the de facto protocols of public mental health.

Mobile crisis and respite teams have had ongoing supervision from trainers throughout the duration of the Parachute NYC project. This is clearly a valuable element of the project design that has enabled teams to troubleshoot especially difficult situations and network crises. Even so, the larger question of how to build and sustain a different culture of crisis response is an essential one. Team members voiced anxiety in trainings about not having the ongoing support needed to develop and refine their skills, but most proposals hatched in response (e.g., creating an online forum for people to continue training discussions) wound up stalled in the planning phase. What is clear in any event is that

creating a sustainable community of practice takes persistent effort and resource-infusion and should be integrated into program design from the start. The "Train the Trainer" effort currently underway and described below is one such effort to build out the Parachute NYC community of practice over the long term.

Early on, Parachute NYC leadership, trainers and practitioners identified a need for connective tissue—a forum where members of mobile and respite teams across boroughs, across disciplines, and across professional/peer identities could share additional learning resources as well as discuss practice challenges and successes. A Learning Community was launched by DOHMH in February 2014 to create connections, share ideas, offer mutual support and provide information about Parachute NYC activities. Seven monthly teleconferences addressed community-selected topics, including self-care strategies; Mobile Team and Respite collaboration; Integration of peers on Mobile Teams; Hearing Voices; Moving toward connections; and Peer Certification. A Parachute NYC Learning Community web-based resource was developed so Parachute staff could find support for practice challenges, but this was rarely used. Participants expressed concern about voicing practice challenges on a site open to supervisors.

Later, a de facto Community of Practice emerged organically in the Train the Trainer effort described below as Parachute NYC developed local resources for NATM and IPS training beyond the limits of the initial project.

NATM Train the Trainer

In the final year of the NATM training process, with strong encouragement and institutional support from DOHMH, several trainees from each borough took part in a parallel process called "Train the Trainer." By participating in an intensified learning process themselves, this self-selected group of trainees was preparing to follow in the footsteps of Parachute's international trainers, teaching the "core curriculum" of NATM to the final cohorts of peers and clinicians hired for the Parachute NYC project. The original NATM trainers were part of this process and helped shepherd local trainers through all of the training sessions.

This effort to formulate a local group of trainers began two weeks after the international-led training program came to an end in July 2014. Because of competing commitments related to time and resources, some of the new recruits had to withdraw from the process. Even so, the "Train the Trainer" effort moved forward with a core group of eight local trainers that represented respite and mobile teams – peers and clinicians – across the four boroughs served by Parachute NYC. That peers thus have become integral to the training of clinicians on a new mental health intervention is a signal achievement of Parachute NYC.

Preparing for their role as trainers entailed an extensive preparation and planning process that preceded each of the four scheduled training series. Fidelity to the principles of NATM meant cultivating a flexibility and responsiveness to the needs of trainees. Consequently, there was a constant tension between the need to prepare and the readiness to improvise, as one might do during a network meeting. The understanding that over-preparation would facilitate any needed departures from what had been planned for became essential to the group's work.

During regular three-hour meetings, the neophyte trainers re-evaluated, re-worked, re-framed—and, at times, added their own original material to—the training materials. Some of their novel training materials were picked up by the international trainers when they returned to shepherd the local trainings. To date, the local trainers have led four series of NATM training, Days 1-3 (October 2014), Days 4-7 (January 2015), Days 8-12 (March 2015), and Days 13-16 (May 2015).

IPS Facilitator Training

Parachute NYC practitioners who had been working for at least six months and met qualifying requirements were invited to complete an application for consideration to take part in IPS Facilitator Training. During the five-day training, peer specialists and clinical staff worked in progressively smaller groups to practice guiding each other through portions, or "modules," of the IPS Core Curriculum. Each participant facilitated a piece of the training each day, with the expectation being that the responsibility would grow as the week advanced. Eventually, each person individually facilitated a lesson-plan module on his or her own. A key component of the training included daily discussion of the multiple layers inherent in any teaching effort, from "technical mishaps," to "maintaining neutrality." In addition, each day opened with two or three facilitators introducing themselves and telling a version of their own stories. While these stories anchored the training, the material in the IPS curriculum drove the practice, and the invitation to step into the facilitator's role was made in tandem with a choice about which modules to teach. New trainers worked from the IPS Facilitator's Guide, a version of the IPS Core Curriculum that builds in space to make notes and cultivate ideas around how to facilitate connections to the material.

In this way, rather than making changes to the content, facilitators-in-training focused on thinking creatively about how to foster learning. For example, a peer specialist and a clinical staff member from one respite worked together to facilitate "The House," a module designed to bring out a person's worldview through a discussion of a "house" as a metaphor for that person's emotional life. As they facilitated, each offered details of his own "house" and encouraged the other facilitators-in-training, to think about their "house" and reflect on their emotional lives. They then elicited reflections on each person's individual process, drawing attention to similarities and differences within the group, thereby fostering an awareness of the possible diversity of worldviews. As a group, everyone provided feedback, discussing what went well and what could have gone differently, with particular emphasis on pedagogical choices.

The facilitators-in-training repeated this process, moving methodically through the IPS Core Curriculum, linking content and learning outcomes by trying out different facilitation techniques. New facilitators were also encouraged to take a birds-eye-view of the curriculum, and direct links to broader concepts, such as trauma, empathy, and boundaries, were made explicit. To date, the Parachute NYC project includes a community of twelve local IPS Facilitators who are equipped to offer on-going training to individuals across Parachute. Two of these facilitators are also NATM trainers, and all the facilitators are part of the local effort to continue and deepen the practices that inform the Parachute model.

3. Staffing Parachute NYC

Parachute NYC had to tackle the formidable task of staffing four mobile crisis teams, four crisis respite centers, and a warmline in quick succession. In numbers alone, this was an impressive accomplishment: Parachute NYC's nine different teams account for 84.3 full time staff positions, 64 FTE of which are for peers with lived experience of a mental health diagnosis and treatment. This represents one of the largest efforts nationally to date to integrate peers into the delivery of mental health services (more information on peer integration is detailed in (4) below).

In addition to hiring and integrating peers, Parachute NYC expanded the functions of existing mobile crisis teams to become combined mobile crisis and need-adapted treatment teams. Teams were required to keep up their traditional mobile crisis work in addition to serving new clients with need-adapted treatment, although the City did make accommodations to reduce the number of traditional mobile crisis referrals. Along with provision for new FTEs. this expanded charge came with a more diversified staffing model. Although traditional mobile crisis teams are generally multidisciplinary, Parachute NYC called for family therapists to be hired onto each team because of the approach's significant focus on including a client's support network in treatment. Each Parachute NYC mobile team thus had a variety of clinical staff (e.g., psychiatrists, social workers, family therapists, and psychologists (on the Brooklyn team)) as well as peer staff to engage clients and their families.

Despite these obvious successes, a number of challenges beset agencies in staffing fully operational teams. First, many mobile team members initially had difficulty transitioning to a mixed caseload of traditional mobile crisis clients and Parachute clients. Some staff voiced that they had "not signed up for Parachute" and, in fact, had chosen to work in mobile crisis specifically because of its short-term nature. As one team member reflected, "You don't apply to and become a member of a mobile crisis team to then do long term treatment." Using a model that focused on longer term engagement of clients and their families thus felt like being asked to do a radically different job that they were not necessarily interested in doing. Meanwhile, others voiced that they were not opposed to this new type of work but that it was especially difficult to work in both models—to be asked to respond in a traditional mode one minute ("which is very defined and really is very much focusing on risk… and mitigating risk") and then pull back and operate under a different paradigm the next minute. Some staff complained that people should have been given a choice between the two modes of working and that it was essential to recruit people for Parachute NYC who were "fresh and young" and/or "excited" about a new way of working with people.

There was significant variation across mobile teams and respites as they worked to hire new staff and deal with staff turnover. Some mobile crisis teams, for example, had difficulty hiring a psychiatrist while others had difficulty hiring peers. The impact on the affected teams was considerable. In the case of one team, a psychiatrist did not join the team until over a year into the project, leaving the team scrambling to provide medication consults through other means. On another team, a peer who took two months off to attend to personal issues found it hard to rejoin the team and ultimately decided it was not a good fit, which left the team without a full complement of peers for some time; this complicated the fundamental challenge of fully integrating peers into teams.

Staff turnover was a more frequent issue. Much has been written on the lack of stability in the behavioral health workforce, with turnover rates in mental health agencies ranging from 25%-50% per year (Woltmann et al. 2008). While turnover can be valuable in the implementation of new projects, giving agencies flexibility to hire staff whose goals and skills are aligned with those of the project, so too can it be a barrier to effective practice implementation, particularly because it disrupts team consistency for both the team members themselves and the families they serve. Staff turnover seems especially important for a model like Parachute NYC, since such significant investment is made in training staff and since offering team consistency to people and their networks is a key element of the NATM model. The illustrations provided in Appendix E show staffing patterns for two separate mobile crisis teams, each showing how difficult it was to recruit and retain a full complement of staff. Overall, NKI staff calculated a 37% turnover rate for Parachute NYC staff across all boroughs; of the staff who left, 48% left within the first year of implementation for their team.

Further investigation into the reasons for such turnover is important. Apart from what might be thought of a general lack of fit in some cases, however, staff who left the project highlighted the following concerns:

- *Salary:* Staff noted that different agencies involved in the project had different salary ranges for the same position, leading some agencies to appear more desirable than others. Others reflected that salaries for some positions were lower than other comparable jobs outside of Parachute NYC (e.g., a psychiatrist with years on an ACT team would take a pay cut to join a newly formed Parachute NYC mobile crisis team). Many peers did not feel that their salary range (easily at or near the top for such positions nationally) adequately reflected the level of responsibility they were required to take on.

- *Lack of organizational/agency support*: Some staff felt that the agency they worked for did not support Parachute NYC and/or did not understand project aims and needs. In turn, everyday logistical and administrative barriers were not always addressed.

- *Ineffective leadership:* Staff did not always feel supported by leadership and complained of inadequate opportunities for supervision. They looked for supervision that not only advised them on their clients but also inquired about and promoted self-care.

- *Job stress:* As is commonly cited in the literature on burnout (Maslach et al. 2001; Morse et al. 2011), staff noted that working in the field of crisis intervention is enormously stressful and can lead to burnout.

- *Lack of opportunities for professional advancement:* As is true across employment in the human services field, Parachute staff reported that they perceived (or had been told) there was limited room for professional advancement in their role. In

any number of cases, however, it was clear that this was felt more acutely because Parachute NYC was grant funded and its future unclear.

Again, none these issues is singular to Parachute NYC; indeed, they are commonly encountered in community mental health programs. We take note of them here because of the novelty of the models, distinctive demands of the work, and still fluid state of peer integration. All of which suggest that future iterations of dialogic practice will have to take up and grapple with these issues both on the front end of project design (in terms of staff recruitment) and throughout implementation (in terms of staff retention). At least with respect to the mobile teams, substantial progress on these issues may be anticipated owing to the decision of VNSNY to carry forward as the sole agency sponsor with expanded hiring, support, supervision and training responsibilities. In the following section, the issue of hiring and integrating peers into mobile crisis and crisis respite teams is taken up in further detail.

4. Peer Integration

A defining feature of Parachute NYC—and one that will be consulted as a possible model for efforts mounted elsewhere—is the large scale integration of peers into the behavioral health workforce. As noted earlier, this was a constitutive part of Parachute-related planning even before a formal project had been contemplated. With recovery embraced as the guiding premise behind treatment options for people diagnosed with mental health conditions, the use of peer supports has gained force, is increasingly seen as a best practice approach (Davidson et al. 2012; Davidson, et al. 1999; Felton et al. 1995; Mead and MacNeil 2006), and is one of the ten fundamental components of recovery developed by SAMHSA (SAMHSA 2006). As we have noted, peers offer timely, credible, embodied evidence of recovery for individuals in crises and their networks; they have biographically-rooted ways of connecting with people diagnosed with mental illness (and their families) unavailable to people without lived experience.

As noted earlier, the record to date strongly suggests that integration of peers into the Parachute NYC workforce has had a meaningful, positive impact on peers themselves, on the clinical staff who work with peers, and on the clients and families served in Parachute NYC. We can be more specific. To begin with, many peers have noted the affirmation they've experienced in being hired as part of an innovative project that aspires to transform crisis work in New York City. In addition to bringing peers formally into the public mental health workforce and providing jobs with a living wage and benefits, multiple peers have reflected on how satisfying they have found their work—whether as part of mobile teams or as respite specialists. Two aspects in particular stand out: connecting with people in crisis and finding their distinctive perspective valued on a team that has traditionally had a clinical focus. One respite-based peer described his role as "supporting people where they're at, walking with them in their journey," and being able to say, "I've been there… I've experienced a part of that… That's a powerful thing." It was not simply that "telling one's story" had expressive value; when deployed as a way of "being with" someone in crisis, taking the edge off the utter strangeness of that experience, it could have real therapeutic utility.

Interviews with clinical staff on mobile crisis teams and at crisis respite centers confirm how much they value what peers have brought to their teams. We heard from multiple staff members that peers establish unique connections—that they "connect with people in ways I cannot;" that they "have been able to ask questions or bring things out of a client or guest or relate in sometimes a way you just can't;" or that the personal experience they share "has gone so much further than anything I could say." A mobile team clinician remembered first introducing a client to a peer after several sessions and having the client turn to look directly at the peer. "I had never seen him make eye contact before." Others note how much they've learned from peers that their clinical training did not teach them. In particular, they have found ways to share personal experiences with clients and to open themselves up in ways that were not possible (or maybe not allowed) before.

Most importantly, the presence of peers has had a positive impact on the work done with clients and families served by Parachute NYC. In feedback gathered during surveys with both mobile crisis team clients and crisis respite guests, there were multiple testimonials about the unique value of a peer. As one former respite guest remarked, "Peers make a big difference. They get it. They get me." Others shared reflections with a similar tone, noting peers were "particularly empathetic" and "relatable" during a difficult period in their lives; still others noted how useful peers had been in helping their families understand that there was life after a psychiatric crisis. Finally, several made a point of sharing that peers have been instrumental in connecting them with the concrete services they need—from employment and educational opportunities, to housing resources, to benefits counselors, to recovery groups like Hearing Voices.[42]

Precisely because of its ambition, Parachute NYC also affords multiple opportunities to revisit the challenges that have been well documented in prior attempts to do this kind of transformative work. Gates and Akabas' (2007) study of strategies that promote integration of peers into the staff of social service agencies provides a useful framework for thinking about peer integration in Parachute NYC. Through in-depth interviews with 93 non-peer staff at 27 social service agencies and a focus group with 15 peer staff, the study identified four major themes that impact peer integration: (1) attitudes toward peer providers; (2) role conflict and confusion (including issues about poorly defined jobs, inadequate training and lack of communication, peer recruitment, and policies related to staff/client relationships); (3) lack of policies and practices around confidentiality (including disclosure of peer status, peer access to client records, and peers not sharing information about clients with non-peer staff); and (4) lack of support. Gates and Akabas suggest that there are specific workplace strategies to respond to these issues and promote the effective integration of peers. Using their framework, this section identifies five specific problems that have interfered with peer integration in Parachute NYC to date and offers some suggestions on how such problems might best be addressed.

> *"I feel like I influenced her, encouraged her to be open… because I disclosed. It wouldn't have happened in the same way [with a non-peer]. It's different."*
>
> ~Peer specialist

[42] It might also be noted that peers – on the team or in the respite –send a unique message of possibility re future employment to concerned families, and put policy makers on notice that their presence will be essential to productive system change.

Attitudes toward Peer Providers

As described earlier, attitudes toward the inclusion of peers on mobile crisis and respite teams have been largely positive, with reflections from multiple non-peer staff about the enormous value of having someone with lived experience available to connect with clients in crisis and make the concept of recovery real. As the research just summarized shows, the task of integrating peers into a traditional workforce is never easy; it involves navigating the fear and uncertainty of staff who have been trained to treat people with mental health diagnoses as fragile, weak, and needing their "expertise." Some of those concerns include how to "manage" peers experiencing their own mental health challenges in the workplace, and whether they will have difficulty with some of the harsher realities of the job—such as seeing people in a very distressed state, or, in such an extreme unsafe state that they need hospitalization. An ongoing challenge to those working with peers in mixed settings is to create an environment that supports people hired for their "lived experience" as they seek to connect with others in kindred crises, while at the same time holding them to professional workplace standards.

A good deal of effort was put into preparing agencies for integrating peers. Guidance was varied and intense especially at the outset of the project: drawing on one group with extensive expertise, importing the director of a peer-run respite from upstate, deploying the City's own peer employment specialist. Throughout these opening rounds, there was a sense that even as peers played an inimitable role in helping clients and families open up and share their experiences, they were still learning the ropes with respect to technique, craft, or clinical judgment as part of functioning teams. In most cases, we think it fair to say, problems in managing misgivings, coming to terms with what crisis work demands, and gaining competency in dialogically-geared clinical work eventually resolved themselves.[43] (In some cases, clinicians and peers alike decided the work was not a good fit and left the project.). But it's instructive to note how steep the learning curve (for everyone) could be.

Hiring Challenges/Benefits Counseling

Each mobile crisis and respite center provider that was contracted by DOHMH for Parachute NYC was responsible for hiring its own staff to fill positions. Few guidelines were given at the outset for hiring peers, though advice was offered through consultations with providers (NYC and upstate) who had significant experience doing so. In practice, the hiring process for peer staff was very different depending on which agency the person was applying to and what its human resources protocol looked like. While this is to be expected in a project with so many unique providers, several challenges arose with respect to the formal process of hiring peer staff.

First, the agencies contracted for Parachute NYC had radically different levels of experience employing peers. They were not equally knowledgeable about what peer employment meant, what peers would be doing or what qualities would make them a good fit for the job. Some agencies assumed that prior clinical training was necessary or that lived experience alone was sufficient, thus failing to adequately assess for other important

[43] On some teams, an approximation of full integration was achieved in practice and celebrated in supervision, even as team leaders wrestled with logistical constraints that made consistently integrated home-visits difficult. See fuller discussion under the next section below on role conflict.

qualities (described more below). Agencies also were not always attuned the specific HR concerns peers might have. As a result, peer applicants were not well counseled about the application process. One example of where this made a difference: peers often received no advice on how to fill out applications with respect to past criminal justice involvement. While such a history is not automatically grounds for not being considered for the job, misrepresenting it was. Thus, only peers who knew that it was better to be completely open on the application, and suffer the hassle of having to explain legal troubles in the past, could move forward in the process. Additional, project-informed means of assessing agency readiness to employ peers seems advisable; so might providing agencies with consultants on peer employment (in a section below, we float the possibility of non-agency-based employee assistance.).

Second, agencies hiring peers saw vastly different characteristics as desirable qualifications for a role as a peer specialist. In one, peers were hired almost exclusively on their past clinical education and experience in the mental health system; others hired peers with limited education and work experience. While necessary, "lived experience" alone is by no means sufficient for employment as a peer worker. In future replication efforts, providers might be advised to look for strong empathetic and communication skills, some personal strength and resilience that can be tapped in dealing with people in crisis, an understanding of the loss and marginalization many experience in the wake of treatment and diagnosis, and the human rights issues inherent—along with a certain level of literacy, education and proven work experience—are generally desirable.

Third, not all agencies provided job descriptions for peer workers that clearly described job requirements and duties. Some appeared to hire with most of the above qualities in mind; others seemed to be at loose ends about what peers might be doing in their Parachute NYC roles. Lacking an appreciation of the need for empathy, teamwork, hospitality, and personal resilience, these latter did not seek out or emphasize these qualities as job requirements.

Finally, despite being given flexibility in the composition of peer staff (e.g., hiring for full-time or part-time positions, or some combination), agencies resorted almost exclusively to hiring peers as full-time employees. This is a positive development in many aspects, since full-time work ensures that employees have better wages and benefits, more sustained access to supervision and participation in agency life, and career pathways and possibilities. Even so, accommodation may still be a desirable option in the arrangement. For some, a flexible or part-time schedule may be an important fallback to allow peers to live well. For others, part-time work is the key to maintaining benefits, since peers who receive Social Security Income (SSI) or Social Security Disability Income (SSDI) must make informed decisions about how much to work. Although DOHMH offered benefits counseling to staff, this resource was not always communicated to line staff or taken up where made available. Several missteps occurred in which peers took full-time jobs only to find out that their total monthly income was going down because their SSI/SSDI benefits had been reduced so dramatically. Even those able to manage a reduction in benefits while working should be confident that they will get assistance in reactivating benefits should the job not work out or circumstances change—and this process is notoriously cumbersome and plodding.

Poorly Defined Jobs/Role Conflict

Gates and Akabas (2007) describe role conflict and confusion developing in situations where peer jobs are poorly defined or operationalized. This occurred in both crisis respites and mobile crisis teams during the life of the Parachute NYC project. In the respite centers, which are staffed primarily by peer specialists but supervised by clinicians,[44] two key conflicts arose around the role of peers. The first conflict was the extent to which peers were required to do regular maintenance work to keep a clean and functioning respite. Having been hired for their distinctive expertise—lived experience with having been diagnosed with a mental illness and all that came before and after—peers understood their distinctive role to be connecting with people in crisis, and establishing hopeful and health-promoting relationships. So many were surprised to find that running a respite required a considerable amount of physical labor—from regular cleaning of the rooms, to laundering sheets after guests departed, to washing dishes, to scullery work in the kitchen. While understandable, such labor became *problematic* when it seemed to dominate the peer job function or when it was felt to be a burden not shared equally by all staff (by clinical leadership in particular). Many were not hired with the understanding that this would be part of their job and resented the fact that clinical staff were not expected to perform these tasks. Notably, one respite managed to resolve this issue by hiring a non-peer maintenance worker whose job was to take care of the respite facility.

The second conflict was of the opposite nature. If one mistake was giving peers jobs seen as being below their skill set, (or not related to their job description), on occasion, peers were asked to do work that required skills outside of those they could be expected to have without additional training and experience. How far peers should be responsible for mediating conflict among guests, for example, is not entirely clear. Should they be tasked with resolving cases of guest-on-guest sexual harassment? To what extent are they equipped to deal with serious instances of self-harm on site?[45] Peers told us they were often reluctant to bring up questions like this to respite leadership because they were worried about job security. Nor were they productively addressed in supervision (which focused more on building and sustaining respectful relationships, not operational issues of running a respite).[46] But the extent to which peers are troubled by these issues—and may even feel unsafe at work because of them—seems essential to any effort to support peer employment (more on this below). At the very least, these types of conflicts suggest that ongoing work should be done to ensure that actual job expectations, training, and supervision are all in line with what the work will actually require.

Role conflict and confusion looked quite different on mobile crisis teams, in part because they were dominated by non-peers[47] and in part because these teams had previously operated as traditional mobile crisis teams without peer staff. In addition, owing

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[44] Who, we have learned, may be peers as well but do not necessarily identify as such.

[45] Peer-staffed respites are still in development; fewer than two dozen are known to be operating nationwide. As noted earlier, two issues – dealing with suicidality and unstable housing – appear to be common problems in respites in the limited research that exists (Ostrow and Croft 2015).

[46] There seems to be continuing disagreement over the extent to which IPS consultation was solicited/engaged to address operational issues of running a respite.

[47] As noted earlier, not all clinicians were well-versed in recovery-oriented practice and peers often had gone through more training than non-peers in both IPS and NATM.

to the novelty of the design, these issues could *not* be clearly specified or considered in advance as a part of overall project planning. On the mobile teams, it simply hadn't been done before, and the track record of peer-staffed respites was still patchy and conflicted. Questions about the role of peers were therefore more pronounced. Were they supposed to play the same role as a junior case manager or social worker (or one in training who was "interning" with the team)? Should they have the same job responsibilities like writing up case notes? Or did they have a different role altogether? Should peers be able to meet with clients on an individual basis? Should they meet only with clients with whom they had similar experiences, or was the exact nature of the crisis not so important? Should they take on special responsibility for case management type needs, such as linking people to employment services or benefits? These questions were made all the more difficult because of the tension between trying to treat peers (as NATM trainers advised) "like anyone else on the team" and trying to honor their particular form of expertise. They remain ripe for further exploration in future iterations.

The mobile teams evolved ways of dealing with the role definition and conflict differently; peer positions therefore looked quite distinctive depending on the borough. On one team, virtually every network meeting was facilitated by a clinician paired with a peer (and, it might be noted, these meetings were more commonly staged at the local respite center). In another, peers met with clients in their homes one-on-one regularly (as an adjunct to or substitution for a network meeting). In still another team, although part of network meetings, peers never met one-on-one with clients in their homes but did take clients out for social opportunities (e.g., to get a client more comfortable with riding public transportation or visiting public places). Despite clear recognition that peers on mobile teams were overwhelmingly seen as positive additions to the team and the work, much remains to be learned about how to best formalize and clearly define the peer role. That process might well benefit from additional/ongoing outside consultation (with IPS and others), as well as from cross-team exchanges sharing proven ways to make the peer role flexible, clear, and more equitably collaborative.

Lack of Opportunities for Support

Especially because peer employment is so relatively new in New York City and because agencies have different levels of experience in employing peers, the opportunity for peers to receive adequate supervision and support during their tenure at an agency is paramount. Peers may very well need—and are entitled to under the Americans with Disabilities Act—additional training, support, and accommodation for their work (Gates and Akabas 2007:301). However, there were no consistent guidelines or recommendations for the kinds of support that peers might need on this project, nor was there a forum for peers to meet outside of their individual agencies, except for perhaps informally. Supervision, the learning collaborative, direct outreach from the City were all offered, but none of these seemed to meet the need. As with other areas, direct feedback from peers on what additional supports they think are needed in their jobs would be particularly helpful in shaping future supervisory systems. Further consultation with more mature respites, and those which are more conversant with the therapeutic modalities used in Parachute (whose practical knowledge often eludes research documentation), may also assist.

One suggestion made by a peer is to have a technical support and assistance position or program (possibly including services like those in an Employee Assistance Program) specifically for peers in Parachute- like projects This program would be led by an individual with direct experience in peer integration (likely a peer herself) and peers from all agencies would have access to this person and program for workplace concerns. Importantly, this person or organization would be independent of all agencies and might thus serve as a resource for peer-specific issues in program implementation; to whom this person would report remains an important issue to resolve.

Commodification of Lived Experience

A final challenge with peer integration that is more existential is worth mentioning here. A distinctive set of questions arises in the very process of converting personal lived experience into a formal job role. If the sine qua non of peer work involves sharing of self and history, then what sort of distortion might occur when such sharing is extended as paid labor (salaried or per diem)?[48] What happens to the claim or currency of authenticity and mutuality when one's offer of connection is paid for and offered as a formal service—and how has this tension taken shape in the work of engaged peers in Parachute NYC? Are unusual difficulties encountered when trying to "value" such work and compensate it appropriately? Our experience on this project suggests that there are no easy answers to these questions, but that an essential part of the longer term project of peer integration must be to wrestle with these issues and to come to a working resolution that at once honors the peer experience and allows it to be leveraged for paid work.

5. Design/Functions of Respites

The four crisis respite centers (CRCs) developed and launched by Parachute NYC were designed to "offer respite for people who need a higher level of care than that offered at home, [are not]… an imminent risk to self or others and [who] present no acute medical condition requiring complex medical attention, whereby persons seeking temporary residential/respite care can stay in a warm, friendly, safe, and supportive home-like environment where they are taught to use new recovery and relapse prevention skills. This is achieved through 24-hour peer support, self-advocacy education, and self-help training." Specifications beyond ensuring the physical safety of the CRCs, complying with HIPPA standards and providing IPS training were minimal in the CRC contracts, permitting each agency wide discretion in establishing and maintaining warm home-like environments with a revolving composition of guests. As a result, the respites were shaped by external and internal factors that evolved during the course of the project.

[48] In anthropological terms, the question can be put starkly: Once commodified and framed within a service-relationship, can the "gift" of self (and the radical equality that implies) be sustained? Additional analysis of this quandary is underway in a separate working paper.

Referrals and Outreach Efforts

Particularly at start up, Parachute's CRCs (as with others nationwide) had to work hard to enroll guests. Although the NYC peer community had advocated for peer staffed alternatives to hospitalization for many years, it was a challenge to position Parachute CRCs as a known and valued resource that Emergency Departments, outpatient providers, families of individuals in crisis, and the individuals and families served by Parachute Mobile Teams could access. Extensive outreach to potential referral sources by DOHMH seems not to have done the trick, and an aggressive outreach effort slated for the later years of the project never materialized. For the Parachute NYC team that concentrated on clients experiencing a first episode of psychosis, referrals may also have been impacted by the simultaneous implementation of other innovative programs in the city serving the very same population. Respites expanded entrance criteria over time, forged relationships with providers, and also reached out to their agencies' internal pool of services users for potential guests. In turn, there were times when respite staff felt they had to balance competing demands to meet enrollment expectations and to maintain space for the guests initially envisioned for the space (people experiencing a psychosis-related crisis) All of this operated in the complicated context of healthcare and housing needs and services in New York City.

As CRC directors worked to expand referral sources, the requirement that guests be stably housed upon leaving CRCs could make for troubling dilemmas, especially in the context of housing demand in New York City and the complex relationship between mental health and housing. Individuals in crisis who reported living with family or friends were sometimes more accurately doubled-up or "couch surfing," often in strained and untenable environments. Frequently, individuals in supportive housing linked difficulties in their home environment to their current distress and felt that a new permanent housing situation would significantly improve their mental health. As a result, individuals with varying degrees of stable housing became CRC guests (again, something CRC's have had to grapple with nationwide).

Outreach efforts to community providers promoted the CRCs as an option, but it was the real world positive experiences of individuals weathering crisis at CRCs that solidified referral mechanisms case-by-case and provider-by-provider. Along with Parachute NYC providers, DOHMH developed a promotional video and pamphlet describing Parachute NYC services (www.nyc.gov/html/doh/html/mental/parachute.shtml). Despite these efforts, CRCs could not meet quotas when they limited access to individuals whose crisis was related to experiences of psychosis. CRCs expanded their criteria to include anyone diagnosed with a serious mental health issue, offered respite to individuals enrolled in their own housing programs, and, in the third year of the project, expanded the upper age limit in the respite designed specifically for young people (from age 25 to age 30, and then to 65). The flow-chart in Appendix F describes the evolution of respite entry criteria from design through full implementation.

Impact of Expanded Criteria

While expanding the criteria for each respite allowed agencies to meet quotas, serve more individuals in need, and engage newly trained staff in the practice of IPS, it also sometimes interfered with their original purpose. At least two respites occasionally instituted what some staff referred to as a waiting list for guests—because at a given moment they were full. Although infrequent, such occurrences may have been discouraging to potential guests seeking immediate access in their home borough. Expanding entrance criteria also meant that respites at times took individuals with less immediate needs, such as housing. On a larger scale, this can shift the nature of peer support, the skills and services offered, and the atmosphere of the respite.[49]

> *"My first impression was the warmth with which I was greeted, and this helped to put me at ease. The next experience was the ambience and decor of the facility. It was and is inviting, as opposed to a sterile clinical environment of a hospital. But what is also paramount to my feeling of safety and wellbeing is that many of the staff are peers with their own mental health diagnosis, and whom I have found to be particularly empathetic to me."*
>
> ~Respite guest at follow-up survey

It is noteworthy that while each respite developed a unique culture and atmosphere over time, some elements of the respite's mood remained dynamic and responsive to the composition of guests and creativity of staff. For example groups designed to promote wellness like yoga, art, writing, or developing WRAP plans were birthed and maintained through the inspiration and dedication of respite workers but remained dictated by the interest of guests in those topics. Cohorts of guests could radically change the tone of common areas. For example, respite staff voiced varying issues when respites are at capacity with all male guests or all female guests.

> *"Although I know it isn't their job to help with housing, and it isn't a complaint, but it would have been more helpful to have more choices and options around housing."*

Functions of Respite

As outreach efforts succeeded in recruiting enough appropriate referrals, respite staff were shaping the culture and atmosphere of each respite, significantly informed by their training in the principles and tasks of IPS and ongoing guidance in applying them. Although their understanding and practice of IPS, their lived experiences, and their commitment to advocacy and social justice varied, a sample of respite leaders and workers across boroughs agreed on primary and sometimes competing functions during a focus group on the subject. They agreed that the primary functions of Parachute NYC respites are to:

- Provide a safe space to weather a crisis, free of substances, safe from physical or emotional harm, and outside of the hospital;
- Develop new ways and strategies to overcome challenges;

[49] A related discussion involves how many days respite should be offered to guests, especially in terms of what is "optimal" in relation to future inpatient or ER use. Croft and Isvan's (2015) recent research found that program benefits of respite were larger for guests who stayed no more than 9-10 days (additional respite days predicted negligible reductions in inpatient and emergency service use). The shortage of affordable housing in New York City makes this discussion all the more complicated, especially since a person's mental health crisis may be related to their housing situation.

- Engender hope by reorienting individuals to recovery principles;
- Introduce individuals to the peer movement and advocacy community;
- Enable individuals to advocate effectively for shared decision making;
- Provide an oasis to rest;
- Encourage and support guests in moving toward personal aspirations and the lives they want;
- Change guests' worldviews that may be hindering their recovery;
- Connect guests to community resources including the Parachute NYC mobile teams;
- Provide opportunities for human connection; and
- Reclaim and/or celebrate their identity as valued and respected citizens.

One of the core tasks of Intentional Peer Support is "mutuality"—ensuring that everyone's worldview and perspectives are honored. "If it's not working for everyone, it's not working." As a result, many of the primary respite functions are achieved through the efforts of peer specialists whose support for guests requires their own vulnerability, authenticity, and tolerance of a variety of guests' behaviors and worldviews. Depending on the composition of respite guests and their challenges, managers made critical decisions to ensure mutuality by balancing what respites did when a primary function such as safety was threatened. For instance:

- Tolerating guest's words and actions versus…
    - maintaining an environment that was safe for all (Examples: providing a space for guest to voice complaints that escalate to threats versus ensuring the physical safety of all guests and staff; understanding guests are often in states of distress; witnessing inebriated guests risk falling down a flight of stairs)
    - maintaining authenticity and "professionalism" (Example: peers listening for the untold stories behind guest worldviews they find prejudiced and personally offensive while remaining truthful to their own and other guests' reactions and feelings)
    - supporting individuals in their aspirations (Example: a guest who shares sexist views but wants to overcome challenges to being in a romantic relationship with women).
- Providing respite that includes rest, as well as supporting and challenging guests to develop new ways and strategies to overcome challenges (Example: respite workers shared frustration when guests chose only to sleep instead of engage with respite workers for support).

"Respite workers take time to explore your specific needs- not general needs like taking meds, getting stable but rather personal needs like helping to go back to school."

When safety was threatened, respite management sometimes chose to ask guests to leave in order to maintain an environment free of substances or threats of violence. At other times, management expected the staff to keep working with difficult or disruptive guests in order to meet expectations of original purpose. Thresholds for intervening and asking guests to leave, mediating a conflict, or tolerating behavior varied by situation and borough. In some cases, these experiences and decisions shaped the policies and atmosphere of the respite. On at least one occasion, the respite staff and management disagreed with each other on the decision to evict a particular guest. These disagreements,

in particular when guests are allowed to stay against staff counsel, have led respite specialists to struggle with how to connect and develop mutuality when they feel their recommendations are not heard and their workplace unsafe.

6. Milestones & Practice Difficulties: Mobile Crisis Teams

New York City had four operational need-adapted mobile treatment teams by March 2014. These teams offered immediate help to people in crisis (seeing clients within 24 hours), take a social network perspective (including family members and other relevant actors in the treatment), and integrate peer providers into treatment. Their charge was to meet people where they are, to listen to them, and to help them use their personal strengths to weather the crisis at hand. Psychiatrists were part of teams and joined meetings as needed; medication was available if necessary and desired. Importantly, clients and their networks drove the treatment process—from deciding how often the mobile team should visit them, to whom should be included in meetings, to what ancillary services they would like the team to help them access; full transparency in treatment planning through a dialogic approach was the aspiration.

Between January 2013 and April 2015, Parachute NYC's need adapted mobile crisis teams enrolled 614 unique clients and conducted 5316 face-to-face meetings.[50] It is clear from the profile of clients described earlier that these mobile teams serve a population that is particularly disadvantaged and often difficult to engage. The four mobile crisis teams in this project have thus made incredible strides in connecting with a hard-to-reach group of New Yorkers and introducing them to an alternative approach to crisis.

Even with such demonstrated success, there are areas for improvement within Parachute NYC's mobile teams and particular challenges that need attention if these teams are to achieve their goal of providing a qualitatively different kind of care for people in crisis that leads to better health and lower costs. In what follows, some of the still unresolved challenges that have not yet been detailed in other areas of the paper are highlighted in order to specify where improvement efforts might be focused.

> *"I think the Parachute team is very supportive… They help you with emotional support, psychological support, and they have great peer support. The peer support is someone relatable. It helps you feel supported during what you are going through… [Clinician] cares about you as a person. He looks at both sides of the sides of the situation and tries to mediate. He doesn't take any side. They are always fair."*
>
> ~Mobile team client

- *Eligibility Criteria:* Parachute NYC eligibility criteria were modified over time in response to both demonstrated need and referral and enrollment patterns. Although referrals to mobile crisis teams were initially limited to individuals 18-65 with a serious mental illness experiencing symptoms of psychosis (defined as having a diagnosis of

[50] Teams had been operating for different lengths of time as of the end of April 2015: Manhattan (28 months), Brooklyn (25 months), Bronx (20 months), Queens (14 months).

Schizophrenia, Schizophreniform Disorder, or Psychosis NOS)[51]—and in Brooklyn, to individuals 16-30 who had been experiencing psychotic symptoms for one year or less—these criteria were eventually widened and adjusted at the discretion of the teams. As revised, eligibility would not necessarily be restricted to specific diagnostic criteria. Instead, some teams focused on general distress related to psychosis (irrespective of the assigned diagnosis), as well as overall fit with the Parachute model -- such as willingness to engage and availability of a network. Future adaptations of any of Parachute's subcomponents described in this document, may need to grapple with whether inclusion/exclusion criteria should rely on specific diagnoses. Providers will also need to consider how the following should be weighed in determining eligibility:

- Current substance use
- Issues pertaining to risk of harm to self or others
- Stable housing requirement
- Criminal justice involvement
- A referral diagnosis of "personality disorder" as primary presentation

Clarifying eligibility criteria dialogical mobile treatment teams will help hospitals and community-based providers make more appropriate referrals to mobile teams over time.

- *Scheduling/Logistics:* Home-based crisis work is inherently logistically complicated since teams must navigate an entire borough's span, manage schedules of multiple team members and clients, and—in Parachute—take account of the competing agendas of network members required for meetings. Transportation and scheduling loomed as paramount issues throughout the duration of the project and caseloads had to be adjusted to accommodate those realities. Teams were able to cobble together viable working arrangements but this sometimes meant poor continuity in team members across network meetings and shortened visits. Additional consideration should be given to scheduling and transportation and whether extended working hours with staggered shifts might make sense.

- *Medication Protocol and Management:* The principles of the Need Adapted Treatment Model suggest that in a new crisis situation (and especially in "first breaks"), neuroleptic medication should not be introduced in the first meeting, should be talked about in at least three meetings if medication is a possibility, and should be used minimally in the event it is needed—this is the (once classic) "start low, go slow" approach that has recently been endorsed internationally (International Early Psychosis Writing Group 2005) and by the New York State Office of Mental Health (PSYCKES 2011)). This aspiration was never fully realized in Parachute NYC, in part because many referrals came from inpatient units and/or included people who had previously attended or were currently

[51] Parachute NYC did not enroll individuals with dementia, organic brain disorder, traumatic brain injury, acute medical conditions, or those who were an imminent threat to themselves or others. They also did not enroll homeless individuals, since the model relies on in-home care.

attending outpatient services; clients were thus often exposed to medication prior to their first contact with the Parachute NYC team. Furthermore, psychiatrists (few of whom came seasoned in "recovery-oriented" treatment) rarely completed the full complement of training and were not always well integrated into the mobile teams. And, as noted earlier, for many the shift to a more egalitarian, team-based approach to treatment planning was already a reach and medication is one of the most clearly marked domains of professional dominance. Although Parachute NYC never managed to develop a specific medication protocol, teams did take the collaborative approach to medication management seriously (some more than others). They may have had different views on whether they could serve clients taking depot antipsychotics, but in the end all found ways of doing so. Teams also differed in their proficiency in introducing medication (or working with clients who indicated they wanted to reduce or go off their medications) as part of regular network meetings.

- *Clinical Liability & Risk:* Mobile teams have made significant strides in adapting their practices to the principles of need-adapted treatment while at the same time operating within an American healthcare context that places heavy emphasis on risk assessment and clinical liability. There were fears voiced at the beginning of the project around issues such as beginning treatment without a full blood workup and physical, and about integrating risk assessment into the first face-to-face client contact. Feedback from mobile team staff suggests that although some clinicians still adhere to more standardized risk and assessment practices upon meeting a Parachute NYC client for the first time, many others have developed more creative and flexible solutions—by integrating risk assessment across several sessions rather than explicitly up front, for example.[52] Even so, certain challenges remain in regards to liability and risk. In particular, although network meetings should vary in frequency according to the network's needs, some staff do not feel comfortable meeting irregularly if they are technically liable for the client. Several issues converge here and will require creative thinking to resolve them: a flexible schedule that is attuned to both shifting network needs *and* the team's assurance of safety; ancillary treatment options for therapeutic work independent of network meetings; training and support to challenge traditional paradigms and practices; and provisions for reliable clinical back-up in the case of scheduling glitches and/or surges in crises needing attention.

[52] Specifically identified by one of Parachute's NATM trainers as an innovation engineered in response to VNSNY clinicians' insistence that integrating such assessment was simply responsible practice in the U.S. setting.

- *Supervision:* Supervision in dialogic practice is an essential element in the sustainability of Parachute NYC. Mobile teams were scheduled to receive 1.5 hours of weekly group supervision in NATM to build on their training experience and guide their work in the field. City administrators struggled to ease what was the limited availability of local trainers and other logistical issues, and the teams themselves worked hard to find viable solutions for regular supervision. One team was able to use Skype successfully to receive ongoing supervision with Petra Hohn in Sweden (though frequently faced frustrating technical issues in connecting). Other teams relied on two local trainers—Peter Stastny and Edward Altwies—but faced scheduling challenges that made supervision less frequent than originally anticipated.

<u>Guidelines: Supervision in Dialogic Practice</u>

- Ideally, two supervisors present
- All team members are included; clients and families could ultimately be included
- The frame for supervision is dialogical; expect polyphony, focus on the here and now
- Use methods that are coherent with the model and taught in training
- Team members and supervisors are viewed as interdependent players
- Be present and attentive during supervision
- Be friendly and expect positive, benevolent willingness from the people present
- Trust the team
- Encourage a slow pace and time for reflective language and reflection ("I think," "It comes to my mind," "It could be like this or completely different," "What do you think?" "Could you help me understand?")
- The experience of being heard during supervision furthers a dialogical stance
- A supervision session can be viewed as successful when more questions arise than are answered and the state of mind of team members changes from "either/or" to "both/and" as well as

Carving out time for supervision in dialogic practice is essential for ongoing efforts and for maintaining the dialogic frame. Trainers note that in order for supervision to be successful, it must focus rather strictly on the method; separate spaces or times should be found for covering organizational, administrative, or logistical issues that teams face. The guiding principles for supervision in dialogic practice are captured in the accompanying text box. The driving idea is that new or deepened knowledge of dialogic practice comes into being through the relational connections between a network of practitioners. Often, supervision includes experiential exercises such as role plays and reflecting teams. These practices aim to bring to life the multiple ways of understanding and responding to specific clinical encounters. By practicing supervision in a dialogical way, insight and experience of different views are created in the space and relationships between team members. In turn, teams move away from "case discussion," where they take on the role of the outside expert, and toward a stance where they elicit multiple perspectives.

Researchers noted that supervision was impacted by the intrusion of organizational issues best addressed in other forums. Furthermore, quite a bit of time was taken up deciding how to structure supervision time (e.g., which cases to cover), and discussion of cases was often limited to presenting them at a specific point in time, with little follow up with external supervisors on the impact the discussions had or decisions made within supervision. Future supervision will benefit from additional planning at the individual team level and from the

inclusion of follow-up on reviewed cases in order to ensure that a narrative is maintained.

Apart from regular supervision in dialogic practice, team members have voiced a desire for additional supervisory forums. For example, staff have voiced a desire for more field-based supervision where a more experienced NATM practitioner can observe and give feedback on their technique in vivo. And, with that in mind, the supervisor in the Bronx contrived to make several such visits and staff found it helpful to receive real time feedback. Other staff have suggested that role-specific supervision (e.g., supervision just for social workers or just for peers) would be valuable – whether done within teams or, even better, across teams. In a focus group with peers on mobile crisis teams, for example, peer staff voiced a need and desire to meet with each other in a private space in order to debrief and to learn from each other. Trainers have noted that additional forums for role-specific conversations and support can be useful as long as NATM supervision remains separate, consistent, and regularly attended by all team members. Again, because supervision can mean different things in different contexts, it is important that supervision in dialogic practice be kept distinct from other supervision opportunities if teams expect to learn and embody the methods.

- *Culture:* As with most public mental health interventions delivered in a city as diverse as New York, Parachute NYC has had to grapple with issues of cultural competency as well as with the cultural translatability of the NATM model itself. Mobile team staff generally had experience working with people of different linguistic, ethnic, religious, and socioeconomic backgrounds prior to joining Parachute NYC. Even so, the nature of the approach—its heavy emphasis on dialogue, its open-ended nature, its focus on privileging of all voices and destabilizing the role of the expert—may face unique challenges from the standpoint of culture. On the most basic level, a model that relies so heavily on dialogue is challenging when members of the team and network do not all share a common language. Although there were cases where mobile team staff spoke a language other than English in common with one client (most often Spanish), translation throughout a 90 minute meeting could be hard work and disrupt the flow of dialogue; the situation was even more difficult when an individual's language was not known by any team member and the team had to rely on a phone translation service. On a deeper level, the NATM approach can seem especially foreign to some depending on their cultural assumptions about things ranging from appropriate gender roles, to the role of medical providers, to the juxtaposition of biomedical and religious frameworks. Research team staff saw issues come up repeatedly and mobile team staff shared reflections about the sometimes uncomfortable fit between families and the approach being used—families who only trusted someone with a medical degree, whose religious beliefs conflicted with suggestions from a psychiatrist, or who described deep

stigma around mental illness in their culture. Additional consideration should be given to these cultural issues over time.[53]

- *Discharge/Handoff:* In contrast to some European implementations of NATM/OD, which tends to be open-ended, the design of Parachute NYC called for mobile teams to provide up to one year of community based treatment in accordance with the strict cost-savings imperative behind the enabling federal funding. The plan was to begin with the presenting crisis, engage and develop a treatment planning network, and then gradually taper off contact as the client stabilized. But all of this was, in principle, "need-adapted" and so subject to modification as circumstances warranted. But beyond contractual guidelines regarding the number of new enrollments and frequency of contact, ongoing supervision, and ad hoc consultations with other teams, the critical clinical decisions—discharge planning, bridging or handoff to outpatient providers, provision of ancillary treatment modalities, ongoing aftercare—were left to the discretion and clinical expertise of the individual mobile teams. The once envisioned availability of Parachute-friendly outpatient providers available for transfers of care never materialized, and teams were at markedly different stages in cultivating their own resources. In consequence, discharge and handoff practices varied widely across boroughs. Repeated concerns on the part of trainers and providers that one year of treatment may be insufficient translated in practice to treatment extending beyond a year if the client and network remained engaged.[54]

  A large majority of Parachute clients who were surveyed felt positive about their experience with the Parachute team. In final surveys conducted to date, 84% said they would reenroll in Parachute if they were to experience a crisis again and 92% said they would refer a friend in crisis to Parachute. Even so—or perhaps because people were so positive about their engagement in Parachute—the picture that took shape over time about the mechanics of discharge is decidedly mixed. In exit surveys, many respondents voiced confusion or disappointment after being discharged with little pre-planning or overlap with linked providers. Others were upset to see Parachute end but felt the mobile team left the door open for them if they were to experience a new crisis.

  In practice, discharge decisions were often driven by competing demands of current caseloads, the judgment of the prescribing psychiatrist, client's level of distress, frequency of contact/engagement with the team, and staff burn out—and, when feasible, a viable treatment referral option. While some teams relied upon the one-year time frame to dictate when to refer to outpatient treatment, others deferred to the client's wishes or behaviors. When engagement proved difficult, clients formally disengaged, declined services, or repeatedly dodged home visits, discharge planning could resemble mobile crisis closures with

[53] A companion paper from NKI on cultural competency in Parachute NYC can be accessed upon request (Cubellis 2014)

[54] Following consultations with trainers, the year-long limit was officially relaxed so that teams could ensure clients of their availability in the event of crises for an additional year.

clients receiving a final phone call and/or a letter ending treatment. Where network and client participation were more robust, final meetings coming to closure and planned handoffs to an outpatient provider were more likely to occur.

To ensure that gains realized by Parachute NYC participation are maintained, a thorough review of current discharge and handoff practices would be well-advised. Future trainings should reiterate the need to integrate "discharge planning" into network meetings, and simulate effective ways of doing so through role plays. Cultivation of a range of referral options, further development of treatment partnerships, enhanced relationships with local providers—these are all, obviously, also indicated. Team practice and contextual facilitation, to recall an earlier point, are both needed.

- *Model Fidelity*[55]*:* Because so much emphasis was placed on getting Parachute NYC off the ground in four separate boroughs during the first three years of operation, less attention was given to how the need-adapted treatment model was actually being used by staff in the field. Staff rarely had in-field supervision from more experienced practitioners and weekly "case conferences" were a useful but limited surrogate. The research team also was only able to observe network meetings sporadically (in part due to the sensitivity of inviting an outsider to participate in such intimate gatherings). As we move ahead, it would be worthwhile to consider how to best track model fidelity in New York City and assess the extent to which the work of mobile teams is faithful to the core principles and key elements of NATM and OD. This would include more explicit

[55] O.D. theorists sometimes speak as though *the entire psychiatric system* needs to be dialogically committed and tuned if the slow-paced deliberations of any one team are to be successful (see, e.g., Seikkula and Arnkil 2014:50ff., 143ff). Elsewhere, they are more pragmatic and measured, a concession perhaps to the uneven record of O.D. uptake to date (see ibid, pp.60ff, arguing that its "core aspects" are "viable in any treatment system."). Matters are clearly unsettled on this point, but it is worth noting that Ziedonis and colleagues (in preparation) have circulated draft "systemic fidelity" criteria for the wholesale redesign of public mental health systems. Were they in place, a host of "contextual" (or structural) determinants of Parachute's success would be in play—reliable and efficient referrals of people in early psychiatric crises (even before actual "first break" psychosis) to Parachute-like teams for assessment *before* hospitalization and medication, would be one example; established reimbursement formulae, regularized schedules, and established caseload and case-mix protocols are others. (A few promising efforts aside, fully integrating peers into the public mental health workforce has not been systemically vetted). Moreover, many of Parachute's clients come to the program having already experienced the "package deal" of segregated treatment, default medication, ruptured networks, stigmatized settings, and existential shame (Link and Phelan 2013:528ff). (Unlike some variations elsewhere, Parachute adopted NATM/OD to deal not only with "first episode" crises, but with long-running commonplace users of public mental health services—and their families—as well.) Under the best of circumstances, the most a disruptive innovation can hope for is a kind of benign neglect: widespread lack of interference and willingness to collaborate on a provisional basis. System *reform* is the much larger, slower, and more complicated project of altering the course of the massive tanker known colloquially as the de facto mental health system (Regier et al. 1978). In the meantime, any commitment to Parachute-like practices will mean taking on the *anticipatory* labor, difficult and frustrating, needed to master unfamiliar techniques, manage the logistics of long-distance supervision, grapple with novel challenges of mixing peers and professionals, weather the skepticism of old guard clinicians, and cope with institutional indifference where cross-sector cooperation is sought. Nor, as our own exchanges with fledgling dialogic practice efforts elsewhere in Europe suggest, is this a U.S. anomaly.

attention to tracking the consistency and flexibility of team members in meetings with networks, for example, or the extent to which teams are able to draw upon complementary treatment approaches. It might also take guidance from Olson and colleagues (2014) recent work outlining the 12 key elements of dialogic practice such as using open-ended questions, responding to clients' utterances, and emphasizing the present moment.

7. Milestones & Practice Difficulties: Crisis Respite Centers

As detailed in depth earlier, Parachute NYC launched four crisis respite centers over the course of the project to provide community-based, open-door settings that offer people experiencing a psychosis-related crisis a short-term alternative environment. Guests have the opportunity to connect with peer staff who have lived experience, to weather crisis in a safe, home-like environment rather than a hospital, to share meals with staff and guests, and to stay connected to their outside lives (continuing to attend school or work, or visit family, for example).

Parachute NYC's crisis respite centers served 710 unique individuals between January 2013 and April 2015. The average stay was 10.68 nights, and people utilized respites an average of 1.52 times per year. It is clear from the cost savings data presented earlier that respites have been effective at providing people in crisis an alternative to emergency room and inpatient services. This is particularly significant since respite guests had extensive service use in the prior five years (as detailed above, respite guests who were surveyed had a median of 3 ER visits in the five years prior to using the crisis respite).

"You feel welcome, comfortable, like a second family. You need that. You gain confidence here. You have motivated me to do better things, to excel, not to feel like just because I have a disability, that I cannot progress."

~ Respite guest

Just as mobile crisis teams have experienced certain challenges in doing the work of Parachute NYC, so too have crisis respite centers faced difficulties in certain areas that deserve further attention. Some of these difficulties have already been highlighted above when we detailed conflicting ideas about the function of respite. Additional areas on which to focus include:

- *Leadership:* Parachute NYC respites are led by professionals with a clinical background but staffed by peers. This was seen as a necessary accommodation when designing Parachute NYC because peer run services remain an exception in New York City to date. Even so, some felt this requirement was in conflict with the principles of IPS and the wider peer movement and many continue to advocate for respites that are entirely peer run, led and staffed. The newly released New York State Home and Community Based (HCBS) provider manual for 1915i services indicates that peer-led respites will be reimbursable under Health and Recovery Plans (HARPs).[56] Thus, agencies running crisis respite services will have to decide whether they want to grapple with this issue in coming years.

[56] Which Parachute DOHMH staff were instrumental in drafting; see footnote 2.

- *Supervision/Co-Reflection:* Crisis Respite Centers were offered co-reflection (an alternative to the hierarchical model of traditional supervision) once a month via Skype with IPS staff. Just as mobile crisis teams struggled to find adequate time and space for supervision, crisis respite centers faced challenges in designing an adequate supervision arrangement. Persistent technical difficulties and scheduling difficulties notwithstanding (respite shift work made it especially difficult to find a time for co-reflection that all could attend), the group structure of co-reflection was at times difficult for with a model that focuses on dyadic relationships. IPS co-supervision/reflection differs from management and administrative supervision in that the intent is to focus solely on the relationships with people using the respite and the practice of Intentional Peer Support. Thus, co-reflection is not only the peer support equivalent of clinical supervision, it also serves important personal growth and community development functions.

  Respites grappled with different supervisory requirements—having to balance internal agency requirements to provide supervision to each staff member, with DOHMH requirements that all staff participate in IPS co-supervision. This took time to work out from a logistical standpoint but even then questions remained, such as whether peers should have a peer-only forum for supervision and whether staff should get individual supervision or only supervision in groups. In addition, some felt that having IPS co-supervision once a month was not enough at a time when they were still learning the approach of intentional peer support. Mobile crisis teams received NATM supervision weekly and there was a feeling expressed in respites that this frequency of supervision in the IPS approach would have been beneficial for maintaining the program philosophy and interpersonal skill building that enables personal growth.

- *Staff Wellbeing*: Related to the issue of supervision and co-supervision is how to ensure staff wellbeing. Crisis respite centers can be particularly stressful places to work (particularly when all spaces within the respite are full) and the cost of emotional labor can be high. As we have already cited, burnout is a real concern in this field (Maslach et al. 2001; Morse et al. 2011). Because the very idea of respite is to create a safe, warm, home-like environment, however, it is important to ensure that staff are supported in their own endeavors to live well. Creating and maintaining a positive work environment that limits and acknowledges stress and promotes a sense of community and well-being among the peer workers in a given respite has been an ongoing challenge in this project and will remain an issue to grapple with moving ahead.

- *Integrating IPS and Respite Operations:* A final challenge to consider is how to integrate the primary approach in which respite staff are trained—Intentional Peer Support—with daily respite operations and management. As the trainers of IPS suggest, IPS is chiefly a relationship training. Although the IPS team has extensive experience helping to develop respites, including their policies, they were only contracted to provide training to staff for Parachute NYC. There

> seemed to be an assumption, however, that IPS training alone would also provide staff with all the information they needed to know about running and developing policies for a respite. It is clear that more attention should be given to consultation around developing respite operational issues and how they can be managed effectively, both in the development of the project and in the ongoing implementation. Intentional Peer Support requires a significant paradigm shift which affects many aspects of how an organization works, so it is essential for providers to carefully consider how their policies and procedures match up with the principles and tasks of IPS and what might be needed to establish a respite that is more consistent with IPS.[57]

Integrating Mobile Crisis Teams and Crisis Respite Centers

Having reviewed some of the remaining practice difficulties for both mobile crisis teams and crisis respite centers separately, it is worth mentioning that one additional challenge that remains is how to better integrate these services. As originally envisioned, Parachute NYC's mobile crisis teams and crisis respite centers were supposed to provide an integrated approach to care, with mobile team clients using respites as an option during crisis and with respite guests linking up with mobile teams for ongoing care if necessary. Mobile team clients did receive priority at crisis respites during the project but the overall integration of these services was never well established. This may have been due to several factors such as the geographic location of respites (which may not have been convenient for some mobile clients), quite disparate agency cultures, and the fact that mobile and respite teams ended up serving quite different populations (see demographic chart on p. 11).[58]

Moving forward, enhanced integration of these services might be accomplished in a number of ways. On the most basic level, agencies could establish better documentation and communication around shared clients. Mobile crisis teams might also consider establishing office hours at crisis respite centers during which they could hold network meetings, provide individual psychotherapy, or conduct respite assessments. A larger project will be to continue the work of integrating the NATM and IPS approaches. There is considerable overlap between these approaches to care but much work remains to be done in terms of deciding how they might be joined more explicitly in both training and in the field. The Nathan Kline Institute has been working with trainers on this effort in recent months and hopes to continue work on this in the future.

8. Monitoring/Governance/Midcourse correction

As described earlier, pursuant to obtaining funding for this pilot and pioneering approach to psychiatric crisis, the City made provision for real-time, on-the-ground feedback to be part of the actual implementation process. Having been involved in the 2009

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[57] IPS's recently published "materials for Parachute review and co-reflection" (2015) rehearses the core "practice essentials" and goes on to offer seasoned counsel, guided inquiry, and background readings both for peers newly employed in mental health systems *and* for the providers who hire them.

[58] Respite and mobile team staff working together through the Train-the-Trainer process significantly enhanced their collaborative relationship.

conference on alternative approaches to early crises and in drafting the original proposal, the NKI team was engaged to design an ethnographically-based track-and-report-back protocol. This involved regular shadowing and coverage of all mobile crisis teams and crisis respite centers as well as attendance at meetings with project partners. The motivation was twofold: to convert the inevitably messy "noise" of implementation into useful, potentially corrective data (Hohmann and Shear 2002); and to keep the City abreast of progress on the ground, especially with respect to easily-missed difficulties. As per federal specifications, the contract also included an outcome evaluation that measures the extent to which the project meets its intended goals related to better health, improved quality of care, and lower utilization of costly services. All research was reviewed, approved, and monitored by the NKI institutional review board. And, as a counterweight to what could possibly be too parochial a watchful presence, the City also convened a Community Advisory Board.[59]

Access, interpretation, rapid turn-around: the research group

As we hope is clear from the reach and detail of the reportage in this document, access was rarely a problem. But persistent ambiguity over terms of reference[60] made disputes over what sorts of monitoring work we had signed on for all but inevitable. Our unbrokered presence at trainings, team meetings, clinical consultations, and periodic troubleshooting sessions was a welcome courtesy. And, as in Bosk's (2003) study of surgical error, the expectation that we would produce memos documenting such proceedings normalized our note taking, informal exchanges, and sometimes extended debriefing of participants. At the same time, we found we had inadvertently played into the City's expectation that we would attend *all* such gatherings, even routine and uneventful ones. On occasion, disagreement over what we could feasibly be expected to cover devolved into testy exchanges over "scope-creep." Much like the service contracts with agencies described earlier, the range and frequency of our documentary responsibilities had been strategically vague in our contract—neither party having had a clear idea of what to expect.

In practice, overreach proved the least of our difficulties. Far trickier was how and when the analyzed "noise" produced under ethnographically-based qualitative research *should* be converted into processed feedback with potentially corrective power (Rapkin and Trickett 2005). As one example—it's one thing to summarize the clarity, content, pacing and reception accorded a training session, and well within our remit to identify features that struck us as problematic. But it's quite another to make specific suggestions for how the format, language, or pedagogic packaging should be changed. At issue was not only the accuracy of our shopfloor diagnosis or the utility of our prescribed intervention,

[59] Mathematica was contracted by the Centers for Medicare and Medicaid Innovation to conduct a cross site evaluation of all projects funded under Funding Opportunity # CMS 1C1-12-0001. These results are forthcoming.

[60] "Terms of reference" is a business/management term that refers to formal specifications for how a proposed project is to be carried out. They detail how scope of work will be defined, developed, paced, modified and, eventually, verified (as "deliverables"). Aside from agreed-upon goals and objectives, they should also provide a record of procedures for resolving differences, adjusting timetables, and securing consensus among stakeholders. What counts as success, what risks may be run, what restraints are to be expected, how/when improvisation may be justified—all are specified in carefully thought-out terms of reference.

but also our ongoing relationships with those whose work we were monitoring and whose trust we counted on.

What was eventually worked out—like so much else in Parachute NYC—was an improvised arrangement. Some of our feedback found its way to the City as formal "dispatches": detailed accounts of problematic aspects of the intervention to date, often filed with some urgency, with recommendations for how to fix them.[61] Some was offered in casual exchanges with and/or memos to City officials, designed to alert them to a potential trouble spot that had not yet ripened into a real problem—suggesting a field visit, for example, to a site that seemed unusually resistant to recovery-informed practice. Some, too, was communicated informally, on the ground, in our role as observer-notetaker, either identifying an unremarked problem or informing one group of how other teams or respites were dealing with a given issue. (And on a number of occasions, we staged feedback sessions with respite staff or mobile teams.) One emergent theme—the challenges posed by the multi-cultural diversity of Parachute's clientele and the unforeseen difficulties this could make for dialogic practice—proved of such interest to a sister program at NKI that it funded an exploratory study (Cubellis 2014). At times, too, we were positioned to take a much more active role, as happened with the NATM Train the Trainer effort described earlier, or in presentations to Grand Rounds at local and state hospitals, some jointly with DOHMH.

That said, we would be remiss in failing to mention mishaps and missteps: occasions when we moved too fast to make suggestions, banking on too little information, or with insufficient appreciation of the background to the presenting problem, and became a gratuitous part of the "disruption" caused by disruptive innovation.[62]

Routine updates: the Community Advisory Board

The City also made provision for a Community Advisory Board to meet quarterly, to receive updated progress reports and research briefings on Parachute NYC's implementation, and to make recommendations as appropriate.[63] Over the course of 7 meetings, substantive issues discussed by this group included:

- Providing a regular sounding board, requiring periodic presentations of implementation progress and glitches, data production activities, and provisional analyses
- Vetting Parachute's public image/reputation—for example, voicing early worries about holdovers from "blaming the family" versions of systemic treatment

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[61] All told, we filed over two dozen of these formal dispatches, ranging in topic from training to supervision to everyday practice to missing venues for building solidarity to discharge, etc. *Will add statement about City response and/or examples of issues/corrections.*

[62] Further discussion of converting time-sensitive information into action, and our unfolding recognition of the limits of our corrective influence in a setting as diverse and complicated as New York City, can be found in Research/Reflexivity section below.

[63] After some self-selection and substitutions, the durable members of that group were: Kristina Akbar, Wendy Brennan, Angela Hebner, Naomi Jones, Ann Marie Louison, Hunter McQuiston, Digna Quinones, Rachel Saloman, Edye Schwartz, Jody Silver, Jackie Williams, and Bill Woolis.

- Early airing and rehearsing of suggestions that would eventually become endorsed recommendations—e.g., exploration of including "family peers" in network meetings
- Consistent reminders to clarify/simplify language of presentation and analysis
- Advice for recovery-oriented outcome study design and implementation
- Early orientation to organizational and finance issues that would figure into sustainability—case load, case mix, pending changes to Medicaid reimbursement
- Assistance with supervision strategies and practicalities for integrating peers into established mental health agencies
- Serving as informal conduit for peer access to Parachute NYC leadership at and between CAB meetings (e.g., with respect to working conditions; respite availability)

Research/reflectivity: Second thoughts on ethnography in harness

This was a complicated evaluation undertaking: field-based, labor-intensive and logistically challenging, with 9 sites spread across 4 boroughs, a total of 170 baseline and 557 (and counting) follow-up outcome interviews conducted in parallel with the fieldwork, all coordinated by staff at a research institute located 20 miles north of the City. It was also a heavy lift for participants: an unfamiliar and non-manualized approach to psychiatric crises was paired with an aggressive effort at peer integration into the workforce, and both had a tendency throw recruits back on their heels. Nor was there any existing program of record to which they could turn for live-action advice or reassurance. The effort was also, we soon learned, cross-cut with a host of cultural fault-lines – some acknowledged, others submerged; some expected, others not: between research and practice, trainers and trainees, clinicians and peers, administrators and practitioners, peer staff and non-peer supervisory personnel, and across the different agencies enlisted (some of whose home cultures, especially with regard to recovery and employing peers, aligned more closely with Parachute's express ambitions). And finally, instead of research's usual "balloon payment" upon project completion, we contracted with the City to provide ongoing feedback with an eye toward informing mid-course corrections as the implementation took shape in four separate stagings.

Like all ethnographies, ours is inevitably a partial account – and the mauled prose, furious dissents, and patient corrections returned to us by Parachute principals in response to earlier drafts of this Report made for an unforgettable lesson in "member-checking" as rude comeuppance.[64] But this technique is purpose-built for a reason: the alternative readings and contested interpretations are not only reminders of the need for ethnographic humility, but function as data-quality gauges in their own right. In the event, they prompted an extended round of supplemental data-collecting, during which we turned to companion research activities,[65] secondary sources, post-hoc interviews with players both central and peripheral to the enterprise (veterans of earlier mental health reform efforts, fallen-away Parachute enthusiasts, strategists of "fifth column" approaches to peer integration, agency

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[64] See Emerson and Pollner 1988 for an account of a similarly unsettling effort at member-checking conducted as part of research in a public mental health program.

[65] The periodic interviews done as part of the outcome evaluation proved an invaluable source of commentary on how clients perceived Parachute to be working.

administration, etc.), as well as to updates in the relevant research literature (re peer-staffed respites, for example). For the most part, though, this was old-fashioned institutional ethnography in the classic "imagine-yourself-suddenly-set-down" vein: long-term, closely-observed and participatory to the extent feasible. With some notable exceptions – incidents with high profiles when they occurred, but low salience overall (and since corrected here) – we're fairly confident that what we report is faithful to the facts, "an honest story, honestly told" (as anthropological elder Clifford Geertz once put it).

True, we made missteps, overreached, occasionally lost sight of the larger context, and were perforce excluded from critical sites of practice.[66] We also found ourselves recruited (as ethnographers often do) as de facto scribes (and more) to sub-endeavors, which won us favor even as it strained our resources.[67] We gladly joined public presentations on Parachute's launch and progress (at which no hint of censorship ever arose), and celebrated and commiserated (as the occasion demanded) with Parachute staff, trainers, administrators and advisors at a medley of local bistros. Probably our most serious gaffe was to offer corrective feedback (especially on one training occasion) with too little hard information at hand – or, better, too thin an appreciation of the healing effects of time and practice. But we also flagged, early on, issues that were to prove thorny throughout Parachute's tenure – the deficiencies already rehearsed with respect to supervision, a community of practice, discharge planning and enrollment.

This was all made possible through what can only be described as the generosity of the trainers, mobile teams, peer respite staff, consultants and City administrators, all of whose dedication to Parachute amounted at times to a studio in "committed work" – and invited a commensurate investment on our part. It was that access, and the trust slowly built up over time, that enabled us to do what we'd been retained to do: produce developmentally tuned (and so site-specific) information on implementation's progress, with particular attention to things that needed clarification, reconsideration, or correction. The net result – however halting and uneven it seemed at the time – was an unmistakable arc of deepening competence: trainings improved significantly, teams grew more confident and varied in what they offered; respites swiftly resolved problems that had earlier been knotted with indecision; and skeptical recruits turned avid practitioners, in ways and with partners markedly at odds with their routines in the past.[68]

That said, this White Paper has been unflinchingly critical and a predisposing factor may be worth mention here. If nothing else, it may help to account for the somewhat disillusioned tone a few readers of earlier drafts claim to have detected. Without having taken the time to recognize (let alone process) the fact, the research team was writing from its own redoubt of disappointment. The NKI group had come to Parachute on the heels of a working conference (described earlier when recounting origins) convened to explore

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[66] As noted earlier, confidentiality concerns and staff/trainer misgivings about the contaminating effect of having researchers present conspired to exclude us from most dialogic network meetings. Nor were we able to give respite operations the full 24-hour coverage they warranted, or to attend a host of regularly scheduled meetings between the City and contracting agencies.

[67] This was especially the case with the Train-the-Trainer efforts, where Jen Van Tiem played a crucial coordinating role and the team itself provided much-needed logistical support.

[68] All three teams were offered bridge funding to continue leapt at the change – and all but one with nearly full complement of original members. Similarly, all four respites will continue virtually unchanged.

alternative responses to "early psychiatric crises." With over 300 attendees (some of whom would later play major roles in Parachute), it was clear that a constituency existed for *something* radically different from the usual mental health routine. Having logged 20 years of partnered work with peers in research (including a peer-run crisis hostel, collaborative research on recovery, and peer-designed shared decision-making), we were keen to see participatory parity extended to practice. Add to that the striking transparency of the NATM/Open Dialogue approach – apparent even in the brief video clip shown at the conference – and it's clear that we were primed to set our sights high. Finally, there was the sheer nerve of the effort: bold proclamations of transformational change are not only rare in public mental health, but are usually (like Assertive Community Treatment) the work of a committed cadre of true believers. This time around, they came – with no hint of irony and none of reservation – from City government, and that fact of public ownership held out the prospect of both systemic change and a pre-existing inclination to replicate whatever was shown to work. (Both turned out to be true.) But like the path-breaking PACT (the original Assertive Community Treatment program), ethnographic stocktaking – whether present at the creation (Estroff 1981) or "revisiting" 30 years later (Brodwin 2013) – tends to be gimlet-eyed, tuned to oversold hopes, undermet promises, unrecognized difficulties and unintended consequences.[69]

Still . . . temporal and institutional contextualization is *also* part of ethnographic tradecraft and in that respect our audit comes up a bit short. As we've noted earlier, reform is hard – reform in public mental health especially so – and it must seem both churlish and naïve to hold Parachute accountable for unmade changes it was never equipped to address.[70] No demonstration program, no matter how promising its results, reworks the reigning paradigm through sheer force of example; structural persuasions are hard-won, long-in-coming, and adapted to serve a number of converging interests. At the same time, by its own unembarrassed admission Parachute's remit was "transformational" and – co-investors no less than co-investigators – we were caught up in the enthusiasm. Throwing ourselves into training sessions, rehearsing with accomplished practitioners subjecting themselves to techniques that rendered them neophytes all over again, debriefing fresh recruits to a field that (seemingly overnight) trans-valued what had been a currency of shame into a marketable asset, volunteering to play a critical support role in training-the-trainers: in short, *participating in order to observe* – we couldn't help but set ourselves up for disappointment as the slow pace of real change and inertial resistance of what stands in the way were quietly revealed.

Whether viewed as extension of unfinished work begun decades ago, or as the singular opportunity presented by an unusual conjunction of a neoliberal "redesign" agenda and the unlikely band of progressive bureaucrats charged with enacting it, the not-unhappy marriage of research and reform that made for both Parachute and this record of its transit was never itself subject to second thoughts. Younger researchers – postdoc, fresh

[69] Then, too, the nature of our engagement – find out what's not working and suggest ways of fixing it – positioned the research team to hone in on dysfunction and to provide a ready conduit for complaints that bore no risk retaliation.

[70] That said, its success at the regulatory level re Home- and Community-Based Services, and its critical role in the Peer Certification process, paving the way for peer-provided assistance to be Medicaid-billable, are (to say it again) noteworthy structural legacies.

out of college, masters-level and peer – underwent a kind of baptism by fire; veterans, a refresher boot camp in collaborative fieldwork. None of us, it's fair to say, appreciated just how deeply engaged and personally affecting the work would be.

9. System Linkages and Connections to Opportunities

Parachute's approach to treatment planning is intended to allow for flexible and need-adapted care that best serves the needs of clients and families. Ideally, as seen in parts of Scandinavia where Need-Adapted Treatment and Open Dialogue first emerged, systems are linked together in collaborative working arrangements so that people in psychiatric crisis are able to get help both during and *after* a crisis has been resolved. That way, looking to rebuild their lives and access meaningful opportunities, they'll find informed cross-sector support available. In New York City, this work was made particularly challenging by the city's complicated public sector and the multiple emergent needs of Parachute clients.

To begin, the disjointed nature of the city's various government agencies (and strict "protected health information" regulations) made it challenging for providers in various systems of care to communicate with each other about a particular client or to collaborate on care. Many Parachute NYC clients (or their family networks) are involved in multiple systems—from the public school system, to the criminal justice system, to the Administration for Children's Services. It was not always clear, however, whether these outside systems could be brought into the Parachute fold or when it might be appropriate to do so—by inviting them to participate in a network meeting or by forging collaborations at a more systemic level. For example, in the case of a client who became involved in the criminal justice system and was court mandated to mental health treatment while being seen by the mobile crisis team, it was decided that Parachute could not serve as his mandated mental health provider (since it is a voluntary program). When the client was subsequently mandated to a PROS program, however, Parachute dropped off rather than exploring whether it might be possible to provide ongoing, voluntary network meetings for the family. In other examples, timing seemed to be at issue, particularly with respect to substance abuse treatment. NATM specifies that substance abuse treatment providers should be brought in as soon as possible but more work needs to be done to make this feasible. The frequency of marijuana use (itself a predictor of poor outcomes in first episode follow up studies (Lambert et al. 2005; Addington and Addington 2007)) suggests that mobile teams could benefit from closer links to substance abuse treatment providers.

The equally important question of how Parachute accommodates outside providers or meets individual needs (e.g., whether someone can have an outside treating psychiatrist or receive individual psychotherapy from an outside provider in addition to having network meetings with the Parachute team) also remains unresolved. Although trainers of the Need Adapted Treatment Model told teams repeatedly that many clients in Northern Europe have individual psychotherapy in addition to network meetings (Seikkula et al. 2011 report rates between 46-67%), this was never explored in a meaningful way in New York City. In part, teams may have been unsure if it was allowed or unclear about whom to refer their clients to for therapy; in part, too, teams sometimes found themselves trying to accommodate existing treatment relationships without the opportunity or interest to turn them into collaborative partnerships. Clarification on these points and guidelines for

helping teams put appropriate linkages in place seem especially important for future iterations of Parachute-like services.

Additional discussion is also needed about the extent to which Parachute providers are responsible for the case management needs of clients. Because Parachute NYC serves a population that is especially disadvantaged—and often disconnected—it is not surprising that service-users at either the respite or mobile crisis teams often see Parachute NYC staff as available to assist them in meeting other needs, whether those needs are related to housing, benefits, employment, education, substance use, or something else. In many instances, a Parachute team has linked someone to services (one mobile team regularly links its clients interested in working to a respite-related work readiness training, for example). And peer respite specialists often take on a heavy load of linking respite guests to needed services. The City has repeatedly encouraged providers to refer clients to Health Home care coordination for case management needs, arguing that case management is not the responsibility of respite or mobile team providers. But it is not clear how frequently this happened, especially since Health Homes are a relatively new and untested development in New York. Further discussion is thus warranted on how Parachute teams should handle the complex case management needs of their clients.

One reason this question is so important is that Parachute NYC serves a large population of disconnected people, particularly disconnected young men.[71] Survey data and interviews with some of the young men served by Parachute who had experienced a first episode of psychosis were particularly revealing about how what is deemed a psychiatric crisis can leave young people with few connections and scant options for social re-entry, let alone advancement. (This is particularly true when the psychiatric crisis has interrupted formal schooling, which is often the case). To achieve a recovery-oriented approach on the teams—one which insists that full lives are possible after a diagnosis of serious mental illness and maintains that public mental health systems should be accountable for helping to rebuild such lives—further Parachute-like initiatives will need to take up the work of expanding meaningful opportunities for people that allow them to flex their renewed sense of possibility, regain competencies, and reconnect with a social world. Seen through Amartya Sen's (1992, 2000) capabilities approach, such opportunities importantly make space for citizenship as well as health, for equality as well as healing (Hopper 2007).

Moving Forward: The Future of "Parachute-like" Services in NYC and Beyond

In our judgment, future re-design and implementation efforts should be guided by a twofold commitment:

(1) Deepening Peer Integration: to ratify and extend provisional progress made with respect to peer integration, paying special attention to formalized role dimensions,

[71] Strictly speaking, it's *disenfranchisement*—the joint product of class disadvantage, minority status, disrupted development and the lengthening shadow of psychiatric disability—which needs to be addressed. Doing so would take us beyond the compass of this document's remit, into the world of "just therapy" (Waldegrave 2012).

intensified/standing offer of supervision, *and* informed agency-level support and accommodation;

(2) Strengthening Dialogic Practice: to protect/preserve the three "core aspects" of dialogic practice in early crises—rapid response; network mobilization/ activation for treatment planning purposes; and creation of secure space for therapeutic work with a consistent team, so far as feasible[72] (Seikkula and Arnkil 2014:61); in particular, the benefits of flexibly-configured, peer-supported, continuity of care (Ware et al. 1999) should be offered to service users and families at various stages in their public mental health care experience.

With those stipulations in mind, what follows is a working agenda for future efforts that identifies five key areas of focus.

1. STRATEGIC DESIGN

Extending Parachute NYC must begin with an honest acknowledgment of the short-cuts, placeholders, and leaps of faith imposed by the original project's rapid design, launch, and operational pressures. It is especially vital to celebrate the participants' success in engaging people in crisis and their families using an unfamiliar approach. It is also important to appreciate just how massive an undertaking Parachute NYC was for the agencies involved, especially in so far as they were asked to reorient their work and the approaches they used.

From a strategic design perspective, partners must continue the work of aligning the vision, mission, and values of Parachute NYC with the operational procedures of the agencies carrying out the everyday work. Concretely, this involves:

a. Ensuring the commitment of agency leadership to the organizational investment required to implement dialogic practice and integrate peers into teams (a commitment which, ideally, is predicated on participation in a type of executive leadership training in both NATM and IPS);
b. Ensuring that policies and procedures of agencies contracted to work on Parachute NYC are commensurate with IPS and NATM practice and philosophy (and working to ensure this in advance of proceeding);
c. Building in ongoing evaluation and quality assurance feedback loops to monitor implementation; and
d. Ideally, including trainers in project's design phase and consulting with them on an ongoing basis during implementation.

2. WORKFORCE DEVELOPMENT

The sustainability of Parachute NYC depends in large part on recruiting and retaining a strong cohort of leaders and staff who are motivated to carry out this type of work (and who self-select to be members of Parachute teams as opposed to being reassigned to such work). In turn, it is vital for partners to review and revise job descriptions and hiring strategies, to thinking strategically about how new staff will be

[72] The last item is our interpretation of "taking charge of the psychological continuity as far as possible" (Seikkula and Arnkil 2014:61).

trained and how teams are supervised (more on this is described in (3) below), and to consider what opportunities exist or should be created for professional advancement.

A related part of this work is placing additional focus on the long-term project of peer integration into the healthcare workforce. As recounted several times in this paper, the integration of peers into mobile crisis teams and crisis respite centers has been one of the signature features of Parachute NYC, and one that is likely to serve as a possible model for efforts elsewhere. But much work remains to be done here, too, especially since a peer certification process has been introduced in New York State as part of Medicaid redesign (and, importantly, is linked to the future ability to bill/pay for peer services).

A more detailed view of what should be considered as part of workforce development is outlined below:

a. Staffing challenges and treatment team composition:
    i. Build teams of motivated individuals who self-select, as opposed to being designated for or re-assigned to this kind of work
    ii. Use this next phase to develop guidelines for staffing, case loads and capacity (respites)
    iii. Broaden the cultural and linguistic composition of teams to better accommodate the diverse populations served by Parachute NYC.
    iv. Create consistent hiring practices and job descriptions commensurate with the philosophy and practices of the project
    v. Consider the possibility of incorporating family peer specialists in some network meetings
    vi. Promote and reward dedication through professional advancement opportunities
    vii. Revisit the role of the psychiatrist on mobile teams
    viii. Identify a team member to serve as a liaison to evaluation efforts
b. Hiring strategies:
    i. Continue efforts to reform the hiring process to clarify job expectations and roles, as well as desirable qualities, qualifications, and experience
    ii. Address persisting barriers to recruiting peers (e.g., advising applicants with minor criminal justice involvement how to disclose it on forms)
c. Enhance peer integration
    i. Address unique difficulties raised by the move to formal status in the public mental health system and established agencies; review how peer support aligns with peer certification requirements and agency policies
    ii. Make provision for workplace-based acknowledgements: salary increases and professional advancement and career pathway opportunities for peer specialists
    iii. Include resources and training to support peers in their unique roles (e.g. peer-specific technical assistance). Peers would welcome a venue where they could discuss common issues of managing their own "integration" into the system with more experienced peers (see e.g., recently released IPS workbook with advice for both peers and those who hire them)

3. COMMUNITY OF PRACTICE

Because Parachute NYC has involved a significant paradigm shift for teams long engaged in crisis work, it is crucial to explore what it takes to support this shift over time and to highlight how important it is to build a community of practice that can offer both the sustained possibility of learning and the moral support to continue this hard work. Indeed, with the formal end of the Train the Trainer sessions and the future of team supervision not entirely clear, it is essential to ensure ongoing attention to keeping practice fresh and advancing proficiencies. Some sort of "center" for ongoing practice might well be indicated. This would be a place of inquiry, ongoing assessment and commentary, and technical assistance—both for both pragmatic troubleshooting and cadre esprit (in the Berlin model: "generosity in small things"). Even in the absence of an organizing center, however, there must be some hub of activity and information for Parachute NYC that can integrate teams and practice over time (e.g., seek out ways of increasing interaction between mobile teams and crisis respites), provide space for cross-borough and cross-team exchange, and cultivate relationships with programs elsewhere (e.g., Berlin, UK).

Additional recommendations attuned to training and supervision and co-reflection specifically include:

a. Continue/ expand training and professional development opportunities:
    i. Consider a period of on-the-job practice prior to, and interspersed with, formal training sessions
    ii. Ensure representation of trainers from across boroughs and professional roles
    iii. Ensure that all staff (including management and psychiatrists) are trained in at least the basic principles of IPS and NATM, and have a clear understanding of the roles of each on the team
    iv. Build team rotations across boroughs in practice or supervision
    v. Invest in new trainers by dedicating time to learn and refine training/coaching skills
    vi. Continue adapting training materials
    vii. Develop and build upon a dynamic learning community that engages in a range of learning opportunities
    viii. Create a continuing education program with recommended supplemental and complementary trainings available (e.g., increased attention to cultural competency)
b. Enhance clinical supervision/co-reflection:
    i. Ensure that all practicing staff have regular opportunities for supervision/co-reflection; and
    ii. Continue to invest in supervision from external trainers
    iii. Work to ensure the availability of an external employee assistance program for all staff and/or external supervision that is familiar with core components of the Parachute model and the modality that the staff person is practicing
    iv. Consider restructuring supervision from reactive discussions predicated on urgent issues needing action to dedicated weekly meetings that allow teams to share a network's developing narrative and changing priority issues over time; consult with kindred teams elsewhere to discuss other supervisory options

v. Consider case reviews after certain critical events occur—e.g., involuntary hospitalization, suicide attempt, workplace injury, ACS or APS intervention
vi. Consider regular co-supervision/refresher sessions for all staff (including clinical staff and leadership) to revisit NATM and IPS on an annual basis

4. REVISED CHARGE/CLINICAL OUTCOMES

While the three areas of focus just described emphasize more global issues that are important in setting up teams to do their work, additional attention is also warranted at the level of team practice—particularly in terms of how mobile teams enroll and discharge clients, how they define success for participants, and how they strengthen linkages both to the crisis respite centers that are part of Parachute NYC, and, more broadly, to the various other city systems in which Parachute NYC clients are often involved. Teams have learned an enormous amount in the last three years about how to make Parachute NYC work on the ground and can build on this information to revise some of the logistics of how they work and who they take on as clients. For mobile teams in particular, it is paramount that teams continue to work on ways to ensure they are flexible teams that can offer a rapid response to people in crisis and a consistent team over time. As described above, these "core aspects" of dialogic practice must be maintained even with all the practical exigencies of this type of work in New York City.

A more detailed list of recommendations for the pragmatics of implementation include:

a. Define success and delineate useful markers of success
b. Build and monitor team case loads:
    i. Define a viable case load that makes economic sense based on staffing models. Anticipate future need to bill for services.
    ii. Consider incorporation of or simultaneous referral to long-term individual psychotherapy for clients (as specified in the NATM model) as a way to build a stronger web of support for clients and make larger caseloads feasible.
c. Address problematic enrollment issues:
    iii. Define target population
    i. Review and revise enrollment criteria
    ii. Continue to strengthen referral mechanisms to engender appropriate referrals
    iii. Conduct "in reach" prior to discharge from acute wards or psychiatric centers
    iv. Conduct onsite network meeting prior to discharge from hospitals
    v. Create introductory material and train staff to introduce new clients and guests to Parachute and to explain what to expect that is different from other interventions
d. Address problematic discharge and hand-off issues:
    i. Define feasible markers of success (e.g. warm hand-off to an informed outpatient provider)
    ii. Use outcome-based, instead of time-based, criteria to initiate and monitor discharge and hand-off. The model should be available to clients for more than one year when necessary.

iii. Conduct monthly telephone check-ins following the transition and hand-off for at least 3 months
iv. Improve hand-offs to new providers
    - Promote services offer trainings to community providers to develop a dialogic practice-friendly network
    - Connect individuals to peer support groups (e.g., groups at respites that may be open to former respite guests or clients of the agency)
    - Conduct a final network meeting with the new provider
v. For respites, consider new possibilities for discharge and aftercare, including:
    - Possibility of respite for more than two weeks if deemed necessary
    - Creation of a specific follow-up period where respite guests receive outreach and enhanced support in accessing needed services in the community

e. Improve integration with respite centers:
    i. Require respites to reserve space for mobile team staff "office hours," during which teams can provide psychotherapy, hold network meetings, and conduct respite intakes
    ii. Enhance documentation and communication of shared clients between teams and respites
f. Improve integration with other systems and models of care
    i. Revise and revitalize strategies for Parachute NYC to integrate physical and behavioral health service. Develop solid links to support overall wellness, including formal partnerships with FQHCs for physical health
    ii. Develop links to other systems including EMS/911, criminal justice, employment, substance use, and child welfare services
    iii. Continue to research and integrate best practices in delivering mental health care. This should include attention to trauma-informed and trauma-specific models of care, as well as collaboration with outside consultants who can address different topic areas as needed by staff.

5. DOCUMENTATION AND EVALUATION

Finally, and because Parachute NYC is both a dramatic departure from current practice and a project that has the possibility of informing other reforms in the public mental health system, it seems paramount for partners to review the scope of documentation and to consider what type of ongoing evaluation is warranted. Continuous quality monitoring and feedback from an outside agency is one valuable way to ensure that Parachute NYC remains need-adapted itself—that it is both aware of and responsive to the dynamics of the project within the shifting healthcare landscape of New York and that it keeps innovation at the forefront. Meanwhile, an outcome evaluation of clients enrolled in Parachute NYC—with a built in mechanism for longer-term follow up—is an essential part of building the case for these types of services as capable of both improving the lives of clients and reducing costs for the system.

More details of what documentation and evaluation efforts might include are detailed below:

a. Review and revise the full scope of documentation and data management procedures
    i. Review and specify the minimum data elements needed to monitor team performance based on revised definitions of success, discharge markers, and information needed for clinical practice and future billing
    ii. Based on these revised indicators, review and enhance data management infrastructure (e.g. *Awards* system) for consistency, adherence to legal and ethical boundaries, and with minimal burden. Support the ongoing training and procedures needed to integrate with management information systems
    iii. Establish dual purpose documentation procedures that benefit clinical and evaluation efforts (e.g. evaluators may track the supervision narrative over time)

b. Include evaluation expectations for provider staff and participants from enrollment onward
    i. Define the relationship and feedback mechanisms between teams and evaluators[73]
    ii. Develop procedures to inform clients of evaluation efforts at the earliest engagement point

Begin to compile a “casebook” illustrating successful resolutions of network crises through peer-integrated dialogic practice, the Parachute NYC approach

[73] If an external evaluation is not funded, teams should be encouraged to continue collecting critical data.

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Appendix A. Parachute NYC Partners 2013-2015

Department of Health and Mental Hygiene

Pablo Sadler, Parachute NYC Director and Bureau of Mental Health Medical Director
Jamie Neckles, Chief Program Officer, Bureau of Mental Health and former Parachute NYC Program Manager

Milen Beyene, Administrative Coordinator
Jonathan Edwards, Training Specialist
Elizabeth Hyde, Acting Program Manager
David Lee, former Data Analyst
Sungwoo Lim, Statistician
Trish Marsik, former Assistant Commissioner, Bureau of Mental Health
Meggan Schilke, former Chief Program Officer, Bureau of Mental Health
Jody Silver, former Director, Consumer Affairs, Division of Mental Hygiene

Nathan S. Kline Institute for Psychiatric Research

Mary Jane Alexander
Dave Bertollo
Donna Brophy
Scott Cicero
Lauren Cubellis
Brian Gandel
Kim Hopper
Kris Jones
Deborah Layman
Seana O'Callaghan
Leah Pope
Christina Schaefer
Judy Sugarman
Jennifer Van Tiem
Molly Woodriff

Trainers

Need Adapted Treatment Model	*Intentional Peer Support*	*Peer Health Navigation*
Volkmar Aderhold	Chris Hansen	Peggy Swarbrick
Petra Hohn	Beth Filsen	
Edward Altwies	Sarah Knutson	
Peter Stastny	Shery Mead	
	Steven Morgan	

Mobile Crisis Team and Crisis Respite Center Agencies

Community Access
Health & Hospital Corporations – Woodhull Hospital
New York City Children's Center Community Respite Program

Riverdale Mental Health Agency
Services for the Underserved
Transitional Services of New York, Inc.
Visiting Nurse Services of New York

Community Advisory Board
Kristina Akbar
Wendy Brennan
Angela Hebner
Naomi Jones
Ann Marie Louison
Hunter McQuiston
Digna Quinones
Rachel Saloman
Edye Schwartz
Jody Silver
Jackie Williams
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Additional Consultants
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