Report from the Alternative Services Plank
National Summit of Mental Health
Consumers and Survivors
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I. What is the role and function of these services? Are they to be viewed as an integral and essential part of the range of service options, including traditional mental health services, or are they to be seen as an alternative to traditional care?

Educational session:

Questions to think about:*What are our common goals*? *How can alternatives help*?

Examples of alternative services (not a comprehensive list):

1. Peer counseling
2. Employment assistance
3. Drop-in centers
4. Wilderness camping
5. Housing assistance
6. Holistic medicine
7. Herbal medicine
8. Spirituality

What is the role and function of alternative services?

- Peer services developed, implemented and monitored by consumers
- Empowerment for consumers
- Peer-to-peer support
- Individualized recovery model
- Empathy
- Safe place
- Control choices over own lives
- Learning responsibility

- Meeting needs
    - Housing
    - Dual diagnosis, etc.
    - Teaching life skills (shopping, etc.)
- Advocacy (self, collective and individual)
- Empowerment
- Safety
- Voluntary
- More understanding
- Hope, inspiration
- Personal experience
- New perspectives
- Breaks down stigma
- Available when traditional facilities closed (holidays, etc.)
- Explore new funding
- Better outcomes
- Teach professionals
- Lived and learned (experience and education)
- Match people together who have similar life experiences to learn from each other
- Crisis assistance
- Cut through red tape — linkage to traditional services and other resources

The group came to consensus on the following:

*The **role** of alternative services is to provide peer-to-peer support by and for consumers (C/S/X) as a choice, within a broad range of services.*

*The **function** of alternative services is to provide inspiration, hope, and personal experience to peers, provide education and training, and an array of consumer-run services in safe, coercion-free environments, as an integral part of a full system of resources.*

To answer the following questions the Alternatives participants reverted to the **role** and **function** of these services.

II. Some peer-operated programs no longer encourage user participation in progam decisions; instead they operate more like traditional, professionally run services, with a clear line of demarcation between staff and clients. Should these programs still be considered part of the spectrum of peer-run services?

No, they should not be considered a part of the spectrum of peer-run services because that cannot be defined by the role and function of peer-run services.

The consensus in the group is as follows:

Alternative services, by role and function, encourage active and ongoing user participation in all aspects of program decisions. Without user participation, programs should not be considered part of the spectrum of peer-run services.

III. Some peer-staffed drop-in centers are operated under the auspices of community mental health centers and in state hospitals, which have final authority over these programs, including control over access, and which impose rules on them. Should these programs still be considered alternative services?

The consensus in the group is as follows:

The presence of peer-run programs at state hospitals, community behavioral health centers and other relevant facilities shall be encouraged and support solicited. However, all peer-run programs shall be administered and managed by peers, and peers will have final authority over access, programming and management.

IV. What is the best way to document the effectiveness and value of alternative services in order to ensure their funding and continuity?

SURVEY: A qualitative, quantitative data collection method that includes:

- Demographics
- Identification of services
- Service data (tracking)
- Outcomes
- Satisfaction

The consensus in the group is as follows:

Documentation for alternative services shall consist of both quantitative and qualitative data collection, which includes but is not limited to: demographics, identified services, service data, outcome measurement, and satisfaction. Instrumentation, implementation processes and analysis shall be designed from consumer-generated research.

V. Should alternative services consider establishing program standards and staff certification/credentialing requirements in order to adapt to managed care and the possible concerns of public funders?

The group came to a consensus on the following:

Program standards, staff certification and/or credentialing as well as program accreditation shall be designed by consumers for consumers based upon their unique experience and knowledge and consumer-generated research. Upon completion of the pertinent criteria, the standards, certification and/or credentialing shall be integrated into the system of services.