Central East (HHS Region 3)

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Conversations

Trends in Behavioral Healthcare

2012 Edition

The Central East ATTC is a program of

THE DANYA INSTITUTE

Changing Communites Through Change in Practice™

The Danya Institute is pleased to present this regular series of original articles on trends in the field of behavioral healthcare.

THE ROAD MAP TO 2014

by Douglas Canter

"Specialty care knowledge is valuable," said Ryan Springer, the Executive Director of The Danya Institute, at an April 25, 2012, healthcare reform symposium in Towson, Maryland. "You come from a place of strength," he told the audience of behavioral and substance abuse healthcare workers.

The April 25 symposium was presented by The Danya Institute, the Open Society Institute of Baltimore, and NIATx. It focused on the transition to January 2014, when key provisions of the Affordable Care Act become effective. The Supreme Court largely affirmed the Affordable Care Act in June 2011. The overall theme of the symposium was the importance of integrating behavioral health care into the broader healthcare field.

The concept and what it means generated some conversation at the meeting. Mr. Springer emphasized key concepts that behavioral and substance abuse health care providers should keep in mind during the transition to 2014. "Collaboration is key," Mr. Springer said. He also highlighted finding diversified funding sources, using technology to streamline staff efficiency, being open to change, and collecting and applying "best practice" data.

Aileen Wehren, who holds an Executive Staff position at Porter-Starke Services, Inc., and Todd Molfenter, co-Deputy Director of NIATx, also spoke. Porter-Starke is an Indiana community mental health center. NIATx is a research, training, and consulting group on behavioral health and addiction treatment within the University of Wisconsin-Madison. During Ms. Wehren's presentation, she asked, "Where are we going to be a year from now, two years from now, three years from now, and how are we going to get there?" She posited "Behavioral healthcare is switching to a different business model." Ms. Wehren also highlighted concepts that behavioral and substance abuse healthcare providers should consider during the transition to 2014. She emphasized the need to provide immediate access to care, the ability to demonstrate clinical improvements, the importance of keeping good electronic records, and the value of becoming part of one of the new health care exchanges.

Dr. Molfenter followed with a discussion of healthcare reform readiness. He identified a number of "readiness factors" for behavioral and substance abuse health care providers, such as "accountability for patient care" and "tracking outcomes."

Integration can mean integrating behavioral healthcare into addiction treatment, a process that Wehren said began several years ago at Porter-Starke. But it also can mean integrating behavioral health and addiction treatment into primary care, which was the focus of the meeting.

The video of the conference appears in three parts. In the preceding Parts 1 and 2, Dr. Molfenter explains how the anticipation of healthcare reform has driven behavioral health and substance abuse providers toward integration, electronic health records, and billing/reimbursement changes. Then, Ms. Wehren discusses case studies and real-life experiences with integration of behavioral healthcare into mainstream care.

http://youtu.be/VVBSG-vaRkQ

LAURA GALBREATH ON TACKLING CHALLENGES IN THE INTEGRATED HEALTH WORKFORCE

by Gayle Morris

Laura Galbreath was the guest speaker from the SAMHSA/HRSA Center for Integrated Health Solutions, and she is presenting “Tackling Challenges in the Integrated Health Workforce.

Galbreath begins by introducing herself and her company, and by giving a brief overview of a few topics for discussion. Her first key point is the topic of integrating primary care with behavioral health. She also opens up with her explanation of a “medical home” and its impact on the work force and its way of delivering care. She mentions that this will happen more on a state level rather than federal or local if the progression happens slowly.

A major point that Galbreath makes is that healthcare is not just an issue in the United States, but rather that it is global. According to the World Health Organization (WHO), “there are 4.3 million workers, and this is by very narrow standards. This does not take into account the administrative workers in healthcare.” The next major point Galbreath brings up is the health workforce shortage. She then explains what this means: there are fewer trainees in the field, less people willing to work in healthcare, and fewer jobs in healthcare. She follows up by saying there is no new money coming in, so she wonders what the best way to use what we have is. This question is answered later in her presentation.

Next Galbreath speaks about the two types of competition: competition with other sectors, and competition with “self”, meaning behavioral health. She asks how an institution can be competitive and provide the services that customers need so that instead of choosing to go to another place, they will choose yours.

Her answer is that the institution must be a service economy; it must be customer-oriented, respond to its client, and be able to get clients the services they need.

Next in the presentation, she comes back to the topic of using what you have to be the best. She poses a question about hiring someone who does not have the necessary qualifications. What do you do in the case that there are no applicants who have the qualifications? One solution is to cross-train. This may not always be the correct or best answer, but it can help when budgets are cut and when there are no qualified applicants. Galbreath speaks of what is called the “Tipping Point.”

She argues that mental health is a huge part of overall health. She then provides a type of assessment for healthcare professionals; she poses questions for them to ask themselves about what is called “Triple Aim.” The three guidelines to aim for are helping to reduce cost, providing quality care, and giving access to those who do not have insurance, Medicare, Medicaid, or other means of receiving the care they need.

Galbreath’s final few points are based around how we can train and educate healthcare providers to be even more effective in treating patients. She mentions that Maryland is fortunate in their training programs and internships and urges professionals to use their connections. She comments on how healthcare professionals can help patients self-manage their care; her ideas are technology based: there are numerous apps based around health, and there are plenty of other types of technology that can be utilized for this purpose.

Galbreath closes her presentation with a reminder of things that are needed in the healthcare community, some being constant and ongoing training for doctors, case managers knowing their role, and social workers learning more about their role as well. She then entertains questions and directs listeners to the website where her facts and figures can be found, as well as other useful information for those in the healthcare profession.

http://youtu.be/YqrvWKR9yTg

DR. IJEOMA ACHARA ON THRIVING IN AN ERA OF CHANGE

by Jeremy Mohler

Dr. Ijeoma Achara of Achara Consulting, Inc. delivered her presentation titled “Thriving in an Era of Change: Promoting Wellness and Recovery Through Recovery Oriented Systems of Care” on May 11 at the 2012 Mid-Atlantic Behavioral Health Conference in Annapolis, MD.

Dr. Achara spoke to managing the intersection of recovery oriented systems of care (ROSC) and the widespread change within the healthcare field nationwide. Recovery oriented systems of care offer a community-wide solution and a value-driven approach to structuring behavioral health services and supports. One organization cannot be a system of care; one organization can be part of a larger network of unified services. With the level of current technology and abilities available surpassing anything the industry has done in the past, providers and system administrators contend with multiple challenges and changes simultaneously. Dr. Achara urges the behavioral health field to be proactive as systems integrate with primary care: the adoption of a recovery oriented system of care framework will aid the integration by giving the field a shared vision and common language.

Nationwide, only 10% of those who need treatment for addiction access services, and most that actually complete treatment relapse into use. Only half of those that need mental health services nationwide access services, and many with serious and persistent mental illness are institutionalized and not put on the path towards recovery. Dr. Achara suggests that the behavioral health field conduct a fearless inventory of what is working and not working as the integration with primary care evolves. Everyone in the field must develop strategic partnerships to develop a robust system of recovery oriented services. She believes this transformational approach will allow the field to scrutinize every strategy, service, approach, policy, and fiscal practice through the lens of recovery. Every provider and system administrator should ask: does this help or hinder recovery?

Dr. Ijeoma Achara currently consults with state and local government entities as well as provider organizations regarding the provision of recovery oriented care and the development of recovery oriented systems of care. Prior to her consultation activities, Dr. Achara served as the Director of Strategic Planning at the Department of Behavioral Heath and Mental Retardation Services (DBH/MRS) where she was responsible for leading the transformation of Philadelphia’s behavioral health system into a recovery oriented system of care.

http://youtu.be/wDBtKqluock

FULFILLING AMERICA'S COMPACT WITH OUR VETERANS

by Ron Manderscheid, PhD

Ever since the founding of our Republic during the Revolution, persons from all walks of life have agreed to serve in the military during periods of national mobilization. They have done so with the realization that they could be killed or injured during the ensuing conflict. Their patriotic actions create an implicit compact between each of them and our society. Clearly, our society owes each of these citizens a great debt of gratitude for their contributions. If they have been killed, we also incur an obligation to their families; if they have been injured, we also incur an obligation to address their health problems. As an honorable people, we must fulfill this compact with those who have served on our behalf.

Yet, there are important lessons in our recent history that we must heed. Those who served for us in the Vietnam Conflict were neither welcomed home nor cared for very well, particularly when they experienced the psychological wounds of war. From that very unfortunate period of our history, we have learned the importance of welcoming all veterans home, which we have done very well for those returning from Iraq and Afghanistan. However, we still have major difficulties in addressing the psychological wounds of those who have served on our behalf in these continuing conflicts.

Those who served in Vietnam were required to complete only a single duty tour of 12 months. Thus, their service had very clear beginning and ending points. For those who have served in Iraq or Afghanistan, it has not been uncommon to be deployed on four or five separate tours over the past 10 years. The long-term uncertainty of the continuing risk of death or injury coupled with the daily threat of death or traumatic brain injury (TBI) from an improvised explosive device (IED) has produced a very large number of psychological casualties in Iraq and Afghanistan. The Department of Defense itself estimates from 20 to 40 percent of those who actually have served in Iraq or Afghanistan ("boots on the ground") have TBIs, post traumatic stress disorders (PTSD), other psychological conditions, such as depression or anxiety, or substance use conditions, such as problems with alcohol or prescription or illicit drugs. These are very, very disturbing numbers. Translated, they mean that 300 to 600 thousand of the 1.5 million who have served in these conflicts over the past 10 years are returning to our shores with these problems. These psychological wounds have many serious adverse consequences.

Today, the US Army is experiencing the largest suicide rate in its entire history. Further, when veterans return home with psychological wounds, they frequently have great difficulty in adjusting to civilian life. Many develop family problems, sometimes including violence in the home and divorce; many are unable to find or hold civilian jobs; and many remain disconnected from their own communities. Because a majority of our current veterans originate in rural communities that are at or near the poverty level, community resources frequently are not available or adequate to provide support to these veterans and their families.

Clearly, the Department of Veterans Affairs is unprepared to deal with this problem. First, numbers this large simply overwhelm the capacity of the VA system. Second, VA hospital and outpatient clinics are located principally in urban areas as a consequence of the distribution of World War II veterans. However, most veterans from Iraq and Afghanistan are from rural areas, particularly in the South. An indicator of the problems currently faced by the VA is the fact that it currently has a backlog of more than 750 thousand veterans who are seeking disability benefits.

We must recognize that an urgent need exists to develop new solutions to address the psychological needs of our returning veterans and their families. One very promising avenue is the development of service contracts from the VA to county mental health and substance use programs to provide needed services in a timely way. Clearly, current VA contracting practices will need to be modified to make this possible.

If we are to continue to ask persons to serve in the military on a voluntary basis, as we have done since the end of the Vietnam Conflict, they must have the assurance that America will fulfill our implicit compact with them when they are killed or injured. Right now, that is not occurring.

HUMAN TRAFFICKING AND HIV IN DC

by Abby Charles, MPH

"It ought to concern every person, because it's a disablement of our common humanity. It ought to concern every community, because it tears at the social fabric. It ought to concern every business, because it distorts markets. It ought to concern every nation, because it endangers public health and fuels violence and organized crime. I'm talking about the injustice, the outrage, of human trafficking, which must be called by its true name—modern slavery."

–President Barack Obama,
September 25, 2012[i]

On September 29, 2012 thousands of people took to the streets of Washington, DC for the 2012 Stop Modern Slavery Walk. This annual walk, held on the National Mall, brought together thousands from the DC community with dozens of local, national, and international nonprofit organizations to raise awareness and increase funding to end human trafficking[ii]. The walk created a great deal of buzz in the DC region, which has led me to do some research on the issue. In a scan of recent news articles I came across a story released by the US Attorney's office on September 14, 2012. The article recounts a conviction in Virginia that illustrates the complex exploitation issues people who are trafficked face[iii]:

After the victims were initiated into the scheme, the gang members would purchase condoms at local pharmacies and convenience stores, provide the victims with drugs and alcohol and drive them to neighborhoods in Alexandria, Springfield, and Arlington, Virginia.

As part of the operation, the victims were instructed to find apartments with multiple males inside to minimize walking in the open and to maximize profit. The gang advertised their victims through online sites such as Craigslist.org and Backpage.com and solicited customers for "in-call" prostitution services that were provided in the basement of the leaders home. The going rate for sex with an underage girl typically was $30-$40 for 15 minutes of sex, and each victim often had sex with multiple men in one night—usually about 5-10 customers—and over the course of multiple weekdays or weekends, including as much as seven days a week.[iv]

I could not stop thinking about how vulnerable these trafficked persons were to violence and HIV & STD infection, and how limited our HIV prevention and care programs are at reaching this population. This then led me to this question: Are we doing our best to address their needs? In a city where HIV prevalence rates are among the highest in the country, what role does human trafficking play in exposing individuals to HIV, and how does this crime affect access to HIV care for persons living with HIV?

What is human trafficking?

The U.S. Trafficking Victims Protection Act (TVPA) states that human trafficking has occurred if a person was induced to perform labor or a commercial sex act through force, fraud, or coercion. Any person under age 18 who performs a commercial sex act is considered a victim of human trafficking, regardless of whether force, fraud, or coercion was present.[v] Traffickers prey on those who are vulnerable, such as migrants, refugees, ethnic minorities, women and children, but trafficking can affect anyone. Today, there are an estimated 27 million individuals who are trafficked around the world, including within our DC Area communities. Little reliable data exist about the exact scale of human trafficking in the DC metropolitan area because often this crime is clandestine. This is not surprising. How many of us

have worked with or know of a young girl or woman who is a survivor of sexual exploitation, but who has never reported it because of fear of criminalization for their drug use or prostitution?

How does human trafficking relate to HIV?

According to the United Nations, "where data exist, the prevalence of HIV infection has shown to be disproportionately high among people trafficked for the purpose of sexual exploitation, ranging from 40% to up to 90%."[vi] The risk of HIV infection is directly related to conditions in which sexual exploitation occur. Specifically, trafficked persons may be subjected to high numbers of clients, violent and/or unprotected sex, poor hygiene, voluntary or induced drug use including unsafe injecting practices, and inadequate screening and treatment of common sexually transmitted infections. In addition, because of the concealed nature of trafficking, trafficked persons are often not reached by HIV prevention or care services. In the DC region, these factors coupled with high HIV prevalence make this issue especially concerning.

What can we do?

We must talk more about this issue. The topic of trafficking touches on some of the most sensitive issues in our communities such as sex, exploitation of vulnerable populations, prostitution, drug use, and violence against women and children. Understanding these interrelated issues is necessary for coming up with the most effective solutions.

We must engage survivors in developing the solutions.

I do not have the answers for how to effectively provide HIV prevention and care services for persons who are trafficked. Nevertheless, effective engagement of survivors of human trafficking is important to develop successful interventions that address, substance use, mental health and HIV among this vulnerable population. It is our responsibility to ensure that people vulnerable to human trafficking receive evidence-informed comprehensive and cross-disciplinary HIV prevention, treatment and care services.

We need to challenge our funders and policy makers to address human trafficking.

These advocacy efforts are critical not just in the nation's capital but also nationally. We must commit to addressing human trafficking and HIV in a more integrated manner, through both programs and policies.

We who are working in the HIV field must do more than what we are doing now. This is a national problem that requires our focused attention on people who are vulnerable to and survivors of human trafficking.

Human Trafficking Resources in DC:

- Polaris Project- www.polarisproject.org
- Polaris Project's national trafficking hotline number: 1-888-373-7888
- Fair Girls DC - fairgirls.org/about
- DC Human Trafficking Task Force: DC-Human-Trafficking-Task-Force/191489050882793

[i] www.whitehouse.gov/the-press-office/2012/09/25/fact-sheet-obama-administration-announces-efforts-combat-human-traffickі

[ii] www.kintera.org/faf/home/ccp.asp?ievent=1012952&ccp=101900

[iii] www.fbi.gov/washingtondc/press-releases/2012/virginia-gang-leader-sentenced-to-40-years-for-leading-juvenile-sex-trafficking-ring

[iv] www.fbi.gov/washingtondc/press-releases/2012/virginia-gang-leader-sentenced-to-40-years-for-leading-juvenile-sex-trafficking-ring

[v] bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=40

[vi] www.unodc.org/unodc/en/human-trafficking/what-is-human-trafficking.html

HUMAN TRAFFICKING 101 FOR SERVICE PROVIDERS

by Denene Yates

Twenty seven million are enslaved today. That is more than at any other time in history! Human trafficking is modern-day slavery; and it happens everywhere in the world – including in our own neighborhoods. According to the last United Nations report, human trafficking is the second largest organized crime in the world, grossing over $33 billion last year. That is more than the profits of Apple, Nike, Reebok, and Google combined.

Human trafficking is victimization involving labor and sex. A victim need not be physically transported from one location to another (as implied by the term "trafficking") in order for the crime to fall within these definitions. Examples of labor trafficking in Maryland include the work of migrants, debt bondage, domestic servitude, crab picking, the work of those in the chicken industry, and the use of unpaid labor in the hotel and food service industries.

The federal definition of sex trafficking is the recruitment, harboring, transportation, provision or obtaining a person under the age of 18 for the purpose of a commercial sex act as induced by force, or fraud, or coercion. Examples of force, fraud, or coercion include beatings, sexual assault, confinement, false or deceptive employment, false marriage/ promises, lies, coercion via direct or implied threats to family, coercion via direct or implied threats of criminal process or deportation, and drugs.

Commercial sex acts may include prostitution, stripping, and pornography. The profile of sex trafficking victim is complex. The majority are teens who have been victims of some type of abuse – especially sexual abuse within the home – who are runaways or "throwaways" who have been recruited into "the life" by a pimp or madam. ("The life" and "the game" are what victimized teens and their abusers call teen sex trafficking in the United States.)

In Maryland, the average age of children entering prostitution is 12. The pimp "breaks them in" through rape or violence, and sometimes they have already been "turned out," a term used for the first time a victim is put out for prostitution, by a parent or guardian. Traffickers often use drugs to better control and coerce victims; therefore many of these victims have chemical dependency issues. Many of these victims got ensnared in this life because they were looking for "family" – sadly many of these girls refer to their pimps as "boyfriend" or "daddy."

Pimps exploit this situation and keep their girls "in line" through a combination of love and fear, a process known as "trauma bonding." Similar to Stockholm Syndrome, this phenomenon makes victims extremely loyal to their abusers/kidnappers. Furthermore, traffickers isolate their victims and may even use threats against the victim's children or family. Continued physical and mental abuse by the trafficker and buyers causes mental health issues such as post-traumatic stress disorder, bipolar disorder, anxiety disorder, and depression.

Many service providers may have already unknowingly had sex trafficking victims as clients. These sometimes difficult clients will not share their whole life readily and are especially ashamed of their life in prostitution. How can we help these victims? Teen sex trafficking victims refuse to see themselves as victims and may refuse help. Victims of trafficking have been brainwashed to believe that "the life" is their own choice and that they are owned by their trafficker. Thus they may have an attitude of mistrust of anyone who is outside of "the game."

Therefore service providers need to

approach these victims with a great deal of understanding and patience. Sex trafficking victims need more extensive attention in the beginning of their recovery. Strength-based advocacy, wherein a service provider concentrates on the strength of the client and their ability to adapt and survive under extreme conditions, is a must. The strengths perspective emphasizes the individual's capacities, talents, competencies, possibilities, visions, and hope.

Key concepts include empowerment, resilience, and membership to a viable group or community. Important sources of strength are personal and cultural stories, narratives, and lore. Therefore, it is wise to begin to empower these victims by helping them set small, attainable goals – such as, taking a shower each day, eating at least two meals a day – and then having them text the service provider once they have completed an agreed upon task.

Another critical step to these victims recovery is to have multiple service providers collaborate to create and implement the client's service plan. Advocates must build trust and respect with the victim in the first few weeks, and the client must believe that the providers will be available for them through their struggles. In order to provide the best level of care it is critical that all providers involved on a particular case communicate with one another while the client is present.

Sex trafficking victims are accustomed to playing the game and may use their skills to play service providers against one another. Most of these clients have lost all sense of hope and do not believe they have any future or that they could ever live a healthy, productive life. Thus they may respond to efforts to help in a manipulative or destructive manner. Thus clients need to know that each person on the team is working together for the sole purpose of helping him/her secure a better future. The client must always have a buy in to his/her future and be included in every decision.

Advocates and providers should never make any false promises or unsure plans. These vulnerable clients will stop accepting services if they feel lied to or played by the system. This holistic approach has been implemented by the non-profit organization Safe House of Hope (SHO Hope). It is based in Baltimore Maryland and provides services to former and current sex trafficking victims.

SHO-Hope trains volunteers to conduct community outreach initiatives in areas known for prostitution, such as distribution of free condoms, or offering free health screenings, to help break the isolation these women often feel. As clients realize their intrinsic value we offer healing to grow and dream again. SHO-Hope supports and empowers its clients to attain their goals and change their lives. Finally, SHO-Hope maintains a 24-hour talk/call line that also refers women to the drop-in center and other local available services.

Most recently, SHO-Hope has piloted a program that brings sex trafficking victims together with volunteer host families who received special training and continual support, to provide victims with new, healthy support systems so that they can grow and begin to dream again. To date, five host families have been paired with five survivors of sex trafficking, with some of the clients only remaining with their host family for three weeks while others have remained with their family for nine months. All five victims have successfully matriculated back into the community – some have returned to school (both high school and community college) and others have gotten legitimate jobs; most importantly, all five survivors have reported no desire to return to the life of prostitution, and all plan on keeping in contact with their host family after moving out.

Human Trafficking Resources

Www.safehouseofhope.org

sharedhope.org

www.polarisproject.org

LETTER FROM THE EXECUTIVE DIRECTOR: WORLD AIDS DAY 2012

by Ryan R. Springer MPH

The Status

Current information from the Center for Disease Control (CDC) indicates that approximately 1.2 million people in the United States of America live with HIV, but about 240,000 do not know that they carry the virus. That is 1 in 5 individuals within the Unites States living in ignorance of their HIV/AIDS status. That 1 in 5 can now possibly *infect* others with the virus, and they themselves are now at a higher risk of developing serious medical problems and early death.

The global scope of the HIV/AIDS epidemic is captured in the UNAIDS 2010 Global Report. The data shows that 33.3 million adults and children were living with HIV in 2009, with 2.6 million newly infected during that same period. Broken down by region, adult prevalence rates in the top three regions rank as shown in the chart below (with North America and Central and South America both coming in at 0.5%). The good news is that recent UNAIDS data also shows that 25 countries have reduced new infections by more than 50%! We will continue our work to support the getting to zero campaign: - Zero new HIV infections - Zero discrimination- Zero AIDS -related deaths

The Solution

The national and global data clearly shows that this is not a small matter to address, but there are concrete steps that you can take to reduce the risk of new infection, and the continued spread of the disease.

• GET TESTED! Knowing your status is the first step in preventing the spread of the disease. If you're in the US, text your zip code to "KNOWIT" (566948) for a testing site near you, of go to www.aids.gov/to find testing, substance abuse, mental health, housing, and other available services!

• There is an important role for the faith based community to play, especially in many minority populations where their communities are disproportionately affected by health disparities, and where the faith community can play a very strong role in community life. Please see some of the resources below for more information:

• The Balm In Gilead: www.balmingilead.org/index.php/resources/resource-materials.html

• NAACP Faith leaders manual: naacp.3cdn.net/93e02bcd4b6cef2aad_pam6yxw29.pdf

• If you test negative, CONGRATULATIONS! Continue to use protection when having intercourse, avoid other risky behaviors such as using or abusing drugs, having multiple sex partners, being non-compliant with psychiatric medications, etc.

• If you test positive, know that the number of individuals living with HIV who get AIDS has decreased over time, because of the advances in drug treatment, specifically antiretroviral therapy (ART).

• Be compliant when taking your HIV medication, because medication keeps the virus under control and lowers the risk of transmission of the disease.

• Continue to seek prevention counseling and services, as behavioral change is a key component in this fight against the spread of the disease.

The Danya Institute

- Has supported several articles and events to move the regional and national HIV/AIDS agenda forward. CLICK HERE for a list of resources.
- Has developed, and made available several HIV/AIDS media products from its events:
  - AIDS and the Older Adult (Audio)
  - Living with HIV/HCV-We are all Affected (Audio)
  - CSAT's Public Health Approach to HIV and Hepatitis and Drug Users (Audio)
  - How Substance Use Really Affects HIV Transmission and Treatment (Audio)
  - Relationship Dynamics among African American Women: Risk for HIV (Audio)
  - What's New Update: STD, HIV, Hepatitis, Family Planning and Addiction (Videos)

There are many partners at various tables working on national and global HIV/AIDS initiatives, and although much has been done, we know that there is always more to do. Please JOIN us as we continue to expand the work of the Institute and its Center for HIV, Hepatitis & Addiction Training and Technology, so that we can have a greater impact on those suffering with the disease, by improving the skills of the professionals in the field.

GROUP FOR GRADUATE STUDENTS IN RECOVERY PROVIDES OPPORTUNITIES FOR PEER SUPPORT AND COLLABORATION

by Laysha Ostrow, MPP

Many people with lived experience of mental health or substance use recovery (collectively referred to as peers here) choose to give back to the community of people in recovery. This may be in roles as advocates, peer support providers, clinicians, government officials, or researchers. For many of these positions, a graduate degree is required – particularly researchers, who may have to travel all the way to a doctoral degree.

Graduate school is a difficult endeavor for anyone who chooses to go that path, but peers face distinct challenges in higher education settings. In addition, peer graduate students face different challenges than those faced by peers who have finished their education and are in the field. Peer graduate students often struggle to get accommodations (and are without parents to advocate for them the way that they can for undergraduate youth). Peer graduate students fear accusations of being biased in our research endeavors or clinical practice, and, as we are just beginning our careers, it is hard to prove otherwise. We often have to sit through classes and seminars where people use language about addictions or mental disorders that we find demeaning, but that is still commonly used in academia. Many face stigma from other students, but most concerning is the stigma from the institutions themselves. As a person struggling in my recovery during college, I was encouraged by the school to leave the university. Some peers still face this kind of stigma as graduate students.

There can also be advantages to being a peer and a graduate student. There are special funding opportunities for students with disabilities. Our lived experience (if we choose to share it) brings unique perspectives to the discussions in classes and seminars. The same experience of being a person in recovery that may make others question our bias also affords us the ability to frame research questions and interpret results in ways that those who have not had those experiences cannot. Having that advantage so early sets the stage for our career trajectories.

The Peer Graduate Students Support and Collaboration group was started as a forum for us to provide peer support to one another through our unique challenges, and to share knowledge about opportunities. I was fortunate that another graduate student reached out to me for support and advice, and inspired me to start this group. It has allowed me to re-examine some of my own challenges and achievements. I hope the group brings the same kind of awareness to others, and provides a safe place to seek and provide peer support.

Masters, doctoral, and post-doctoral students with behavioral health or other disabilities are welcome to join. The group functions through a Google-groups email list currently. In the future we might incorporate blogs, discussion boards, or chat rooms. The web-based nature of the group allows us to reach students across the country – perhaps even across the world. We have found that experiences vary widely from school to school, program to program, so reaching a broad group of people is very valuable.

You may read more about the Peer Graduate Students Support and Collaboration group at the Peer Support Research Initiative website (and click on “Graduate Students.”)

Your identity remains anonymous to the group until you decide to post. All posts and discussions are confidential.

Resources

www.peersri.org

Credits

PHOTOS:

Front cover upper left; Michele Egan

Front cover lower right; Kordea Henry

“Human Trafficking and HIV in DC”; Simone Fary

GRAPHIC DESIGN:

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