ASSOCIATION FOR CHILDREN'S MENTAL HEALTH
ACMH
Hope for Families, Shaped by Lived Experience

Agency Information

PIHP: ..... **CMHSP:** .....

County(ies) Peer will serve: .....

Address: .....

Family/Contract Organization (if applicable) : .....

Address: .....

Primary CMH Supervisor-Provides Clinical Supervision to PSP

Full Name: ..... **Email:** .....

Work Address: .....

Mailing Address: .....
(if different):

Primary Phone: ..... ☐ Office ☐ Cell

Alternate Phone: ..... ☐ Office ☐ Cell

☐ **Please indicate if this is a new supervisor.**

Additional Supervisor (if applicable)

Full Name: ..... **Email:** .....

Work Address: .....

Mailing Address: .....
(if different):

Primary Phone: ..... ☐ Office ☐ Cell

Alternate Phone: ..... ☐ Office ☐ Cell

☐ **Please indicate if this is a new supervisor.**

Contact in case of emergency/last minute cancellation/other event:

Full Name: ..... **Contact:** .....

Please indicate the type Peer Professional you are registering:

- ☐ Parent Support Partner
- ☐ Youth Peer Support Specialist
- ☐ Crisis Support Partner

Date of Cohort Training: .....

Please indicate the type Peer Professional service(s) your agency has experience providing:

- ☐ Parent Support Partner
- ☐ Youth Peer Support
- ☐ Crisis Support Partner

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Peer Information:

Full Name: ..... **Email:** .....

Work Address: .....

Mailing Address: .....
(if different):

Primary Phone: ..... ☐ Office ☐ Cell

Alternate Phone: ..... ☐ Office ☐ Cell

Which option best describes your racial identity:

- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Single Race (please specify below)
- ☐ Two or More Races (please specify below)
- ☐ I prefer not to disclose
- ☐ Hispanic or Latin or Spanish Origin of any race
- ☐ Other (please specify below)

Other (please specify): .....

Sex: ☐ Male ☐ Female ☐ Not Listed ☐ I prefer not to disclose.

Dietary Needs:

☐ None ☐ Vegetarian ☐ Allergies/Other (Please list): .....

While we will make reasonable efforts to accommodate dietary needs, accommodations are based on vendor availability and preparation practices. Participants with severe allergies may wish to take additional precautions.

Accessibility & Participation Needs: ☐ Yes (Please describe): .....

.....

Do you have any accessibility or participation-related needs that ACMH may be able to assist with for this training? Please note that this question is intended for accommodations related to the training environment or participation (e.g., mobility access, sensory considerations, technology needs). We may not be able to accommodate all requests.

Emergency Contact:

Name: ..... **Relationship:** .....

Primary Phone: ..... ☐ Cell ☐ Work ☐ Home

Alternate Phone: ..... ☐ Cell ☐ Work ☐ Home

I, ... authorize Association for Children's Mental Health, to contact the individual listed above should a situation arise while I am at an ACMH function which the Executive Director or designee deem to be an emergency.

Signature: ..... **Date:** .....

Media Release:

I, ... give my permission for the Association for Children's Mental Health to print or publish (including electronically), or share via ACMH social media platforms my name, artwork, poetry, photographs, and video of me and/or to use quotations from me.

Signature: ..... **Date:** .....

Association for Children's Mental Health
in partnership with
Michigan Department of Health and Human Services

Hiring Expectations Agency Agreement

Following are the expectations for the agencies that hire and employ Parent Support Partners (PSP) and Youth Peer Support Specialists (YPSS).

- The PSP/YPSS will be hired and employed by the CMH or contract agency before they attend training.
- PSP/YPSS and their supervisor will complete a training orientation call with Director of Peer Programs prior to start of cohort training.
- All pre-training paperwork will be completed by the given deadlines (registration, supervisor contact information, media release and emergency contact).
- The agency will assure that their PSP/YPSS(s) have equipment and all technology to perform their job.
- The agency will ensure that their PSP/YPSS is aware that 100% participation in all certification requirements is required. NO EXCEPTIONS.
- If the PSP/YPSS is employed through a family or contract organization, a supervisor from that organization will be identified and will participate in a minimum of monthly supervision with the CMH and PSP/YPSS.
- Employers establish a work schedule that includes a consistent number of hours of work per week and meets the needs and availability of the youth and families being supported.
- The workload will be individualized to assure that individuals receive a high-quality PSP/YPS service.
- The agency will ensure that the PSP/YPSS will be an active member of the treatment team and will participate in team and planning meetings.
- The PSP/YPSS will continue to actively provide this service to a minimum of one parent/primary caregiver/youth/young adult to be seen on a regular and ongoing basis as outlined in the IPOS.
- Upon completing Part One of training, the PSP/YPSS will begin to work with parents/caregivers/youth/young adult.
- All MDHHS requirements for PSP/YPSS training, Part 1 and Part 2, and ongoing certification requirements will be met. This includes all MDHHS requirements for recertification.
- Supervisors will attend a new supervisor training and will attend one supervisor roundtable annually, thereafter. Supervisors will continue to participate in additional TA/training as required by the PSP/YPS model or requested by the Director of Peer Programs.
- Individual supervision will be provided on a regular basis by a qualified children's mental health professional (CMHP) identified by the agency. Weekly or bi-weekly supervision is highly recommended.

We have read all information in the Hiring Expectations Agreement above, and we understand and agree to all requirements.

CMH/Agency: _____

Peer Provider Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

PSP PRE TRAINING QUESTIONNAIRE

Name:
Agency:
Cohort:

1) What is your understanding of the role of the Parent Support Partner?

2) Why do you want to become a Parent Support Partner?

3) What does “Empowerment” mean to you?

4) How do you feel you can use your lived experience or story to support or encourage others?

5) What do you hope to learn at the Parent Support Partner training?

Building Your Timeline

An essential skill for people employed as parent partners is to tell one's own story.

As a Parent Support Partner (PSP) you bring a unique ‘expertise’ to the family and treatment team. Your experience as a parent/caregiver of a child with mental health challenges will help the family realize that their child and family are not alone. Your real-life experience will help both family and others on the treatment team understand the importance of family partnership in the treatment process.

In preparation for your face-to-face PSP training, we would like you to reflect on your personal history, develop a timeline related to your experience as a parent/caregiver.

Directions: Take a stroll down memory lane - reflect on your personal journey and develop a timeline highlighting the milestones of your child and family. The length of your timeline does not matter. Make it as short or long as you need to communicate the timeline for your personal story. Each box will grow as you type in it if more space is needed.

To give you a better idea of what a timeline might look like, the timeline on the following page is provided as an example:

My Timeline

Name: Danielle Washington (fictional PSP)

My Life with Johnny

2011 Johnny is born – beautiful baby-his 'big brother' Jason calls him his 'baby boo'- Johnny has trouble sleeping and is difficult to calm down

2014 Johnny is three years old; temper tantrums make normal family life difficult.

2015 Johnny starts day care and immediately I start getting calls about his behavior. Johnny is biting other children and soon I am told that they can no longer care for him at the center. I wonder what I'm doing wrong. I'm starting to have trouble at my job for missing work due to all the last-minute calls to come to day care to talk about Johnny.

2017 Johnny starts school. His teacher is nice and seems to like Johnny and wants to help. I start getting calls about Johnny's behavior on the playground. He is picking fights with other kids. In March, another kid got hurt because Johnny knocked him down and Johnny started getting sent home from school for his behavior. The school tells me to contact Community Mental Health. At the end of the school year, I call Community Mental Health and meet with them for an intake appointment. A social worker starts coming to the house.

2019 Nothing is working. My new job is in jeopardy and Jason starts asking questions about why we can't do cool things like his friends' families. I know Jason needs more attention. The school wants Johnny and me to see a school social worker, and they again press me to put Johnny on medication. Meeting with the school folks takes a lot of time and doesn't help much.

2020 The school sets up a positive behavior support plan. We see some improvements, but the school doesn't follow through.

2021 I finally agree to try medication for Johnny. It seems to help and I feel guilty for not trying medication sooner.

2022 Better school behavior, but grades are suffering because Johnny is tired all the time and some of his 'zip' is gone. I worry about tomorrow and what life will be like when Johnny is an adult. I want him to get a high school diploma!

My Timeline

Name:

My Life with:

Year	Significant Events

