

COMPEER ADULT & SENIOR REFERRAL PACKET

What Is the Compeer Program?

The Mental Health Association of Cleveland County's Compeer Adult & Senior Program matches community volunteers with adults in mental health recovery programs and isolated seniors (62+) at risk of worsening mental health concerns. Volunteers provide one-to-one supportive friendship to offset the loneliness and social isolation that can accompany mental illness and/or aging.

Who Are Compeer Volunteers?

Volunteers are individuals, eighteen and over, from all walks of life. Volunteers are screened through background checks, references, and in-person interviews. They are then trained and matched by the Compeer Coordinator and referring provider. Volunteers understand that they are supportive friends and mentors, not counselors or therapists. Volunteers submit monthly reports to help monitor the Compeer friendship.

What Do Volunteers and Friends Do Together?

One-to-One Friendship - Volunteers and friends agree to meet weekly for an hour, or every other week for two hours. The relationship is expected to last at least one year. The choice of activities varies and depends upon mutual agreement. Both friends are expected to pay for their own expenses. Compeer also sponsors socials for friends to attend.

Phone Friends - Phone friends make weekly phone calls to those who are waiting to be matched in a one-to-one Compeer friendship or prefer distance communication.

Community Supported Friendship (CSF) – Volunteers create handmade gifts to contribute to monthly “friendship bags” that are delivered to our adult and senior participants. A newsletter, featuring stories of connection, is included. Those waiting to be matched in a One-to-One or Phone Friendship will be immediately invited to participate in the CSF project.

How Are Compeer Matches Made?

Agencies make referrals to Compeer on behalf of their client(s) by submitting the attached referral form. If the client meets the admission criteria, the application then goes into a pool of referrals. Compeer will only make same sex matches. Compeer **does not** match on a first come first serve basis. Instead, it is our goal to make compatible matches so that friends will enjoy their time together. For this reason, there may be a waiting period before a match is actually made. Those on the waiting list will be included in our CSF Project and invited to Compeer events and activities.

ADMISSION PROCEDURES

Admission Criteria

1. Compeer for Adults

Referrals must be 18 years of age, have a mental health diagnosis, and be stabilized in their recovery to allow active participation in a reciprocal Compeer relationship in the community.

Compeer for Seniors

This program is for individuals 62 and older who would benefit from supportive friendship to prevent worsening mental health concerns. Those who are homebound or living in a facility are still eligible to participate.

2. Referrals must have a desire to participate in a one-to-one friendship and have consistent respect and tolerance for others.
3. Referrals must not exhibit any violent, destructive, or antisocial behaviors.
4. Referrals must not currently be abusing alcohol or other substances.
5. Referrals must have a willingness to participate in the treatment plan of their mental health providers. Psychotic and behavioral symptoms must be managed.
6. Referrals must not be currently utilizing enhanced mental health services. However, Compeer may be an appropriate part of a discharge plan from enhanced services.
7. The Compeer Coordinator will work with the referring provider to address inappropriate behaviors on an individual basis. Any concerns in items 2 - 6 may result in being discharged from the Compeer program until issues can be resolved.
8. Any prior criminal history will be reviewed by the Compeer Coordinator to determine appropriateness for participation in the program.
9. Referring providers must approve their client's participation in the program and provide a current crisis plan to the Compeer Coordinator.

Referral Procedures

1. Discuss and explain the Compeer program to your client(s). Review the "About Compeer" & "Admission Procedures", as well as the attached Referral Form.
2. Fax or mail the completed Referral Form to MHA. You may also request an electronic referral packet to be completed securely online. All forms must be received to initiate the referral process.
3. Once the referral packet is received, the Compeer Coordinator will meet briefly with the referral to get a better sense of his/her interests, personality, etc. in order to make a compatible match.
4. The Compeer Coordinator will notify the referring provider when an appropriate volunteer is identified so that he/she can be introduced to the referring provider (by phone or in person) prior to a match being made. It is best not to inform your client about the volunteer until the match is confirmed to avoid disappointment.
5. During this meeting the referring provider can ask questions and/or share information with the volunteer that may facilitate a healthy relationship with their client.
6. After the referring provider approves the volunteer, the Compeer Coordinator will arrange a meeting to introduce the Compeer volunteer and referral to one another.
7. The referring provider is expected to monitor their client's satisfaction with the match and communicate with the volunteer and/or Compeer Coordinator as needed.
8. The Compeer Coordinator will review monthly reports submitted by the volunteer. If any concerns arise, they will be presented to the referring provider.
9. The referring provider will keep the Compeer Coordinator updated on any changes in client status, address change, concerns, etc.
10. The referring provider and client are asked to complete an annual survey to monitor the success of the program.

Compeer Adult & Senior Referral

PROVIDER INFORMATION

Referring Provider Name:	Agency:
Phone:	Email:
Today's Date:	Best time to call:
Duration of relationship with client:	

CLIENT INFORMATION

Client name:	Date of birth:	Age:
Ethnicity:	Gender and/or pronouns:	
Marital Status:	Work/School Status:	
Current Address:	Zip:	
Home Phone:	Cell Phone:	
Work Phone:	Email:	
Program of interest (check all that apply): _____ One-to-one-(adult) _____ One-to-one (senior) _____ Phone Friends _____ CSF		

EMERGENCY CONTACT

Name:	Relationship to referral:
Daytime Phone:	Evening phone:
Address:	

CLINICAL INFORMATION

PRIMARY MENTAL HEALTH PROVIDER	
Name:	Agency:
Phone Number	Email:
Mental Health Diagnoses (please list primary & secondary):	
PRIMARY PHYSICAL HEALTH PROVIDER (if applicable)	
Name:	Agency:
Phone number:	Email:
Physical Health Diagnoses:	
Medications (please list any side effects volunteers should know about):	
Please list any hospitalization in the past year:	
Please list symptomatic behaviors for both mental and physical health concerns:	
Please include an overview of your client's current crisis plan: (Attach additional documentation if needed)	

PSYCHOSOCIAL INFORMATION
Describe your client in the following realms:

Strengths:	Challenges:
Social interaction (one-to-one):	Social interaction (groups):
Unique personality traits:	Unique environmental circumstances:
History of substance abuse? ___ yes ___ no Current substance abuse? ___ yes ___ no Please describe:	
History of aggressive behavior? ___ yes ___ no Please describe:	
History of self harm? ___ yes ___ no Please describe:	
History of charge or conviction of crime (other than minor traffic violations)? ___ yes ___ no Please describe:	
Please share any additional information. These details will support the Compeer Coordinator in identifying a compatible match for your client. Include additional pages if necessary.	

REMINDERS

1. Please have your client review and sign the attached: Compeer Friend Agreement, Compeer Friends Rights & Expectations, Participation Waiver, and Release of Information.
2. You may submit your referral packet by Fax: 704-448-2016 or Mail: Mental Health Association of Cleveland County PO Box 623 Shelby, NC 28151.
3. Please keep Compeer updated on any changes to information provided and/or referral status. You may reach the Compeer Manager - Stacey Costner - at 980-429-4037, scostner@clevelandcountymha.org. Thank you!

COMPEER FRIEND AGREEMENT

I understand that Compeer is a program of the Mental Health Association, and

I have received information about Compeer, its goals, and procedures.

I have the right to have my privacy and confidentiality protected and respected by the Compeer volunteer and staff.

I will spend at least one hour each week or two hours every other week with my Compeer volunteer.

I am willing to participate in the Compeer Program for at least one year.

I will comply with the Compeer Program guidelines, which prohibit the use of alcohol or other non-prescription drugs when I am with the volunteer.

I understand that overnight or out of town trips with my volunteer must be approved by my mental health provider and the Compeer Coordinator.

I will report any concerns about the volunteer to my referring agency and the Compeer Coordinator.

I understand that volunteers are required to inform Compeer and my referring agency about any serious concerns regarding my welfare.

I understand that my involvement with my Compeer friend may be terminated if deemed necessary by Compeer staff.

I agree to the release of any information between Compeer staff, my referring mental health provider, and Compeer volunteers.

Compeer friend signature

Date



Participation Waiver

In consideration for participating in any Compeer Event, I assume responsibility for all my actions while at the Mental Health Association of Cleveland County, traveling to and/or from any such facility, or engaged in any activity under the supervision of the Mental Health Association of Cleveland County and/or Compeer program staff and volunteers. Furthermore, I will not hold the Mental Health Association of Cleveland County, the Compeer program, the Board of Directors and their officers, employees, agents, or volunteers responsible for any loss, personal injury, accident, misfortune or damage to myself or my property, with the understanding that reasonable precautions shall be taken to ensure the health and safety of myself and my property.

Signature of Participant

Printed name

Date



CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

I, _____(CLIENT’S NAME), hereby authorize the **Mental Health Association of Cleveland County** and _____(REFERRING AGENCY) to exchange information or records, verbally or in writing, pertaining to services or treatment received by me. This information can also be shared with _____, (COMPEER VOLUNTEER) my Compeer Volunteer, who will be named at a later date.

Information and records covered by this authorization include details of my admission, discharge, course of medical & psychiatric treatment, and all other services with which I have been involved.

The purpose of this consent is to assure continuity of my care and the timely communication between these agencies of information & events, including my hospitalizations, that may be pertinent to each agency in offering services to me.

I certify that I am at least 18 years old and have given my consent voluntarily. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent will terminate upon _____ (mm/dd/yy) (not to exceed one year from date of signature).

Signature

Date

Witness (when required)

Date