Mental Health Wellness Act Peer Respite Funds Project

Background

The Commission for Behavioral Health's (CBH's) Peer Respite project has explored opportunities for investing $20 million in Mental Health Wellness Act (MHWA) one-time funds into promoting the peer respite model across the state. The MHWA is a grant program that provides $20 million each year to improve community response to people facing behavioral health crises.

A peer respite is defined as *a temporary residence offering peer support services provided 24/7 in a homelike setting, staffed and operated entirely by peers*. Guests are usually invited to stay anywhere between 7 and 14 days, with most respites offering extensions up to 28 or 30 days, if necessary. While at the peer respite, peer support specialists offer linkage to community services, life skills development, and empathy, but the focus is on guests determining their own care.

Peer respites operate on a peer-based, self-determined care model, with no clinical staff on-site. Experts and peers agree that the absence of clinical staff or a medical model driving service delivery is key to the success of peer respites. Services are provided without a diagnosis, and guests are empowered to care for themselves, however they see fit.

The Evidence Behind Peer Respite

The evidence base for peer respite is still forming, but there are promising outcomes from the peer respites in California:

- Garden Gate Peer Respite in Modesto and 2nd Story Peer Respite in Aptos report that only **5% of guests exit to a higher level of care**.
- Peer respite stays at 2nd Story were associated with **70% lower** odds of inpatient/emergency department use.[1]
- Satisfaction rates are high (**91%** at Insight Respite Center in Grass Valley, **98.5%** at Garden Gate in Modesto).
- At SHARE! in Los Angeles, **83% do not return to shelters or the street** after 2 weeks, with 59% moving into SHARE! Collaborative Housing.

Nationally, research has found significantly fewer hospitalizations and thousands in Medicaid cost savings for peer respite clients.[2]

Community Engagement

To inform this proposal, the Commission conducted extensive community engagement, including:

- Seven site visits to peer respites in California (see table in Finding 1)
- One listening session with two former guests of Insight Peer Respite

[1] Croft & İsvan, 2015; Croft et al., 2020
[2] Bouchery et al., 2018

- Interviews:
    - Twelve interviews with county behavioral health directors, MHSA/BHSA coordinators, and/or other behavioral health staff
    - Six interviews with current or former peer respite operators/staff
    - Nine interviews with leadership of Peer-Run Organizations (PROs) in California
    - Two interviews with current/former Commissioners (Rayshell Chambers and Khatera Tamplen)
    - Two interviews with other state agencies, Department of Health Care Services (DHCS) and Department of Health Care Access and Information (HCAI)
    - One interview with the California Association of Mental Health Peer-Run Organizations (CAMHPRO)
    - One interview with two national experts and operators of peer respite
    - One conversation with a current guest at Monarch House Peer Respite
- Communication by email with 58 of the 59 behavioral health jurisdictions in California about interest in peer respite and any challenges or barriers to establishing a peer respite
- Communication by email with three other PROs in California

Peer Respite Funding

In California, peer respites are most often funded by the MHSA (through Community Services and Supports)/BHSA (through Behavioral Health Services and Supports and Housing Interventions). Some peer respites are drawing down Medi-Cal for billable peer support services, and others are building their capacity to do so in the future. On average, peer respites cost between $750,000 and $1 million per year to operate. For future funding, Medi-Cal Managed Care Plans can cover peer respite under three different pathways: 1) Transitional Rent, 2) Recuperative Care, and 3) Short-Term Post-Hospitalization Housing.

Peer Respite in the Crisis Continuum

Respites are intended for people struggling with mental illness, substance abuse, or other behavioral health challenges, particularly those that may lead to one of the seven negative outcomes (including hospitalization, involvement with the criminal justice system, or homelessness). They offer an alternative to psychiatric hospitalization, incarceration, or the loss of housing, and can also act as a step down or transition from any of these. Guests can use a peer respite in the pre-, during-, and post-crisis stages. They offer refuge for those struggling with a mental health and/or substance use disorder (i.e., behavioral health) condition, and often serve those with the most severe and co-occurring illnesses. Peer respites are situated within the continuum and have close connections with other behavioral health and housing services. Guests are often referred to peer respite from county behavioral health case managers or the county's mobile crisis team, and they frequently move from a peer respite into treatment or permanent supportive housing.

Best Practices for Peer Respites

Based on community engagement and review of the relevant literature and resources available, there are some distinct best practices for peer respites. These best practices include:

1. The environment should be homelike and welcoming with both private and shared space for rest and recreation.
2. Peer respites must be led and staffed entirely by peers, including the organization (whether that's a PRO or a peer-run wing of a community-based organization (CBO)).
3. Peer respites must have strong relationships – with the county behavioral health department and other CBOs for easy linkage to services and supports for guests, and with other peer respites to share knowledge and resources.
4. Strong policies and procedures should be in place (e.g., for eligibility, guest intake, discharge, complaints/grievances, house rules).
5. There must be a system in place for tracking outcomes to demonstrate effectiveness.
6. Peer respites rely on sustainable funding, which often means braided funding (Medi-Cal, BHSA, general fund, etc.).

Project Findings

1. **Peer respites are an emerging and promising strategy for filling gaps in the pre-, acute, and post-crisis care continuum, but uptake of this model has been slow.** Lack of awareness about peer respites and their model has been a barrier, as well as the lack of startup funding and low capacity to bill Medi-Cal for services. Some counties do not have the infrastructure in place to staff the peer workforce.

   There is no definitive list of peer respites in California, but based on communications with CAMHPRO and 56 of California's 59 counties and behavioral health jurisdictions, CBH has identified 9 peer respites (based on the definition provided) currently in operation. (Site visits were conducted to the peer respites in bold.)

Name	County
Safe Harbor	Alameda
Sally's Place	Alameda
Hacienda of Hope	Los Angeles
SHARE! Recovery Retreat	Los Angeles
Insight Peer Respite	Nevada
Monarch House	Placer
Second Story	Santa Cruz
Garden Gate Peer Respite	Stanislaus
Cedar Home	Trinity

2. **To promote the peer respite model across the state, partnerships between county behavioral health departments and local PROs must be incentivized.**
   The lack of partnerships between county behavioral health and PROs acts as a barrier for establishing peer respites. All current peer respites in California are sustained with commitment from county leadership and close relationships between county and CBO/PRO partners.

   Although some peer respites in California are being operated by CBOs, the "pure" peer respite model embraced by the experts dictates that peer respites be run by PROs. This ensures separation from the medical or clinical model of behavioral health and adherence to the peer support model, which underpins peer respites' success. However, many counties do not have close partnerships with PROs in place, and this makes it unlikely that a PRO can successfully establish a peer respite within the county. The first step to establishing a sustainable peer respite is building a partnership between county behavioral health and a local PRO.

3. **Technical assistance on partnership development, implementation, and sustainability planning would boost the capacity of county and CBO/PRO partnerships to operate peer respites.**
   Uncertainty and complexities of sustainable funding inhibit the establishment of new peer respites by the PROs that are eager to do so. If peer respites are not established with sustainable funding sources, they are unlikely to succeed. Many peer respites are sustained at least in part through drawing down Medi-Cal, although some organizations struggle with the complexities of billing Medi-Cal. There are many PROs that have the capacity and expertise to provide peer support services, but lack the knowledge and training to bill Medi-Cal or secure other sources of long-term funding, like contracts with the county.

4. **California is currently making investments in peer respite infrastructure, but infrastructure funding alone is not enough.**
   Investments include the Behavioral Health Continuum Infrastructure Program (BHCIP) and Proposition 1/Behavioral Health Services Act (BHSA) funding earmarked for housing (including transitional rent and BHSA Housing Interventions). There are five BHCIP grant recipients who are planning to build a peer respite with the funds. However, some PROs have struggled with BHCIP's 10% match requirement, and there are needs beyond infrastructure funding.

   The Commission has an opportunity to use MHWA funding to supplement and expand on this funding to promote sustainability. County and contractor partnerships need the knowledge, expertise, and guidance from experts in peer support to effectively run a peer respite. With the infrastructure funding that is currently being awarded, there is a chance to

capitalize on the momentum and provide the additional support that will support the establishment and continued success of peer respites.

5. **PROs in California received a recent capacity boost, and they are ready to take the next steps in establishing and operating a peer respite.**
   Dozens of California PROs received capacity building from DHCS's Behavioral Health Workforce Development Initiative, through the Peer Workforce Investment (PWI) grants (38 grantees) and the Expanding Peer Organization Capacity (EPOC) grants (21 grantees). Based on interviews and email communications with PRO leadership, these PROs are ready and eager for opportunities to provide vital peer support services in their communities, including peer respite.

6. **Peer respite is an emerging and promising practice, but there has been little research published on the subject.**
   These funds provide an opportunity to bolster the evidence base behind the peer respite model and identify the practices tied to better outcomes. Further, it could also be used to raise awareness and encourage counties, Medi-Cal Managed Care Plans (MCPs), and other organizations of the cost-effectiveness of peer respite.

Staff Recommendation

Based on the findings gleaned from this project, CBH recommends establishing a pilot project, a learning collaborative, and funding tailored to the community to fill the gaps outside of what DHCS has offered (BHCIP infrastructure funding plus Behavioral Health Workforce Development grants) and what HCAI is providing (Peer Personnel Training and Placement Program). Counties and PROs have shown interest in establishing peer respite, but lack the knowledge of best practices and the flexible funding required. This funding will be used to provide guidance on how to establish and operate a peer respite sustainably and collaboratively, along with funds to initially support it.

The funding will be offered as follows:

1. **<u>PHASE 1: Pilot Project and Learning Collaborative ($10 million; awarded by June 30, 2026)</u>**
   a. A **pilot project** with interested counties that builds partnerships between 6 to 8 county behavioral health departments and a local Peer Run Organization (PRO), culminating in a business plan for establishing and operating a peer respite together.
   b. **Technical assistance** will be provided by subject matter experts to partnerships from the pilot project and existing peer respites on partnership development, business planning, securing sustainable funding, and best practices in peer respite.

c. An ongoing **learning collaborative** focused on establishing and sustaining a peer respite that is integrated into the local behavioral health continuum of care, open to all interested counties and organizations.
d. **Research and evaluation***

2. **<u>PHASE 2: Tailored Funding and Continuing Learning ($10 million; awarded by June 30, 2028)</u>**
    a. **Tailored funding** will be offered via RFP to new and existing peer respites to meet their unique needs (including renovations, facility maintenance, nutrition and health support, recovery and wellbeing activities, etc.).
    b. The peer respite **learning collaborative** will continue.
    c. **Research and evaluation***

*Research and evaluation will be paired with each step to contribute to the evidence base on peer respite and assess effectiveness of the pilot project, startup funding, and learning collaborative. The Commission or contracted partners will conduct the research and evaluation bolster the evidence base behind peer respites, particularly around recovery-oriented outcomes.