A Vision to Scale California Peer Services

Because the amount and quality of social support in people's lives accounts for 40% of whether people are ok or not ok, an effective behavioral health system must emphasize social support. Peer Services are evidence-based practices intentionally designed and proven to enhance social support, and they are the only mental health intervention that specifically builds social supports. Peer Services are one of the most requested services in surveys of people receiving mental health. In fact, Self-Help Support Groups have the highest consumer satisfaction of any mental health intervention.

California has a unique opportunity to realign its behavioral health funding and services. While the Cal-AIM initiative is revising Medi-Cal services, the passage of SB 803 is standardizing Peer Services. Clinical services will nonetheless be better positioned and structured to maximize the Cal-AIM initiative. Peer Services are not ideally aligned with Medical models, and will be prioritized after clinical services.

Currently, most Peer Services in California are funded through MHSA. These programs include peer-run respites, peer-run housing, client-run centers, peer crisis response, self-help referral lines, warm lines and others. Originally, MHSA dollars were designed for new, community-based services that emphasized Recovery and reduced stigma. In Los Angeles County, the System Leadership Team voted that 7% of MHSA funding be specifically designated for Peer Services. Shortly thereafter, the recession of 2008 forced LA County and others to re-align MHSA dollars, and MHSA was used as a safety net for existing clinical services.

CAMHPRO recommends that the distribution of statewide MHSA funds be revised so that 7% of MHSA funding be specifically designated for Peer Services and programs. The passage and framework of MHSA specifically addresses a "Recovery Vision" and "consumer-operated services" in section 5813.5:

> (d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers: (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self responsibility, and self-determination. (2) To promote consumer-operated services as a way to support recovery. (3) To reflect the cultural, ethnic, and racial diversity of mental health consumers. (4) To plan for each consumer's individual needs.

To support the workforce expansion critical to the successful implementation of SB 803, the California Department of Health Care Services is directing SAMHSA funding for its Peer Workforce Investment project. This project serves as start-up funding to support grantees in:

(1) Expanding the number of mental health and SUD peer staff;
(2) Improving access to behavioral health peer support services for individuals with SUDs;
(3) expanding peer-run programs' information technology (IT) and tele-health infrastructure;
(4) developing peer-run programs' capacity and infrastructure

This one-time, 18 moth funding, must be supported to ensure the sustainability of the services and workforce created through the project. California can implement the full vision of the Mental Health Services Act, transform its behavioral health system to emphasize social support and effectively scale Peer Services.

A Community Continuum of Peer Services

A community-focused system that emphasizes Peer services and programs would ensure that every California resident has access to:

- 250 client-run centers client-run centers, each staffed with up-to eight (8) Peer Specialists and two (2) Peer Supervisors
- 1 Alternative Peer Crisis center for every UCC to support people coming out of hospitalizations, staffed by 14 Peer Specialists – research shows that Peer Crisis services have more effective outcomes that psychiatric hospitalizations (1)
- 2 Peer Respites for each Urgent Care Center staffed by 14 Peer Specialists
- Peer Run Residential alternative to hospitalization (Greenfield et al). *(see footnote)*
- Peer-run housing – California based Peer-run programs have successfully run Shared Recovery Housing, a SAMHSA evidence-based best practice since 2005, moving thousands of people with SMI directly from the street to housing:
    - If California opened 480 Shared Recovery Housing houses each year for the next 4 years, California would house 24,000 people with SMI in Shared Recovery Housing over four (4) years.
    - 480 Shared Recovery Housing houses would require 160 Peer Specialists to provide supportive services.
- Forensic Peer Specialists in every State/County run incarceration facility
- All non-violent crisis response teams include Peer Specialists
- All Outreach efforts to people experiencing homelessness include Peer Specialists

California's existing network of Peer-run organizations and programs has the experience and background to scale these services, and are best positioned to effectively deliver services as they are aligned with the core competencies and values of Peer Support.

The current opportunity to build capacity through MHSA, SAMHSA/DHCS, and Medicaid billing will create a foundation for the efficacy and scale of Statewide Peer Services that California must elevate immediately.

Sincerely,

Jason Robison
Chief Program Officer
SHARE!
CAMHPRO Board Member

With,

Sally Zinman
Executive Director
California Association of Mental health Peer Run Programs (CAMHPRO)

(1)A Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis

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- Beth C. Stoneking,
- Keith Humphreys,
- Evan Sundby &
- Jason Bond

This experiment compared the effectiveness of an unlocked, mental health consumer-managed, crisis residential program (CRP) to a locked, inpatient psychiatric facility (LIPF) for adults civilly committed for severe psychiatric problems. Following screening and informed consent, participants (n = 393) were randomized to the CRP or the LIPF and interviewed at baseline and at 30-day, 6-month, and 1-year post admission. Outcomes were costs, level of functioning, psychiatric symptoms, self-esteem, enrichment, and service satisfaction. Treatment outcomes were compared using hierarchical linear models. Participants in the CRP experienced significantly greater improvement on interviewer-rated and self-reported psychopathology than did participants in the LIPF condition; service satisfaction was dramatically higher in the CRP condition. CRP-style facilities are a viable alternative to psychiatric hospitalization for many individuals facing civil commitment.