Peers Across the Crisis Continuum (National Landscape)

988 Crisis Jam
September 27th

Presented by:

Amy Brinkley, CRS/CHW, CAPRCII, NASMHPD

Justin Volpe, CRPS-A, NASMHPD

Crisis Peer Paper Sections

Paper is structured into 8 different sections with 8 recommendations scattered throughout each section.

1. Introduction
2. National Perspective – Peers in Crisis Services
3. Peer Support History and Evolution
4. Current Utilization of Peer Support in Crisis Services
5. Realizing the Potential for Peer Roles within the Crisis Continuum (largest section)
6. Co-Responder Models and Alternative Approaches
7. Funding for Peer Services
8. Conclusion

Peer Support Worker Defined

Peer Support Workers are defined in accordance with SAMHSA's definition:

'Someone who has been successful in the recovery process who helps others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse.'

In terms of addressing recovery needs for people in crisis and following up post-crisis, the definition's focus on meeting people's needs beyond the clinical setting and helping people reduce their risk of relapse points to the need for peer support workers to have a significant role in crisis services.

Peer Support Workers for those in Recovery | SAMHSA

Maintaining peer support values in crisis service settings

- The practice of involuntary commitment and involuntary transport is common in the crisis services space, and peer support workers working in these settings may be involved or complicit in these practices against their will and/or best judgment by virtue of their employers' practices and policies.

- SAMHSA's Peer Core Competencies that are guiding peer certification trainings, standards, and best practices nationally specifically point out that peer support services should be Recovery Oriented, Person-Centered, Voluntary, Relationship Focused, and Trauma-Informed. Considerations for how Peer Support workers in crisis service settings can maintain these competencies in all situations should be taken into account.

https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers

SAMHSA Advisory
Peer Support Services in Crisis Care (Key Considerations)

Here are the key considerations of SAMHSA's Advisory on Peer Support Services in Crisis Services:

Key considerations listed were:

- ❑Role Integrity
- ❑Stigma
- ❑Recruitment and Retention of Peer Support Workers
- ❑Sustainability and Funding of Peer Support Services
- ❑Certification and State Requirements

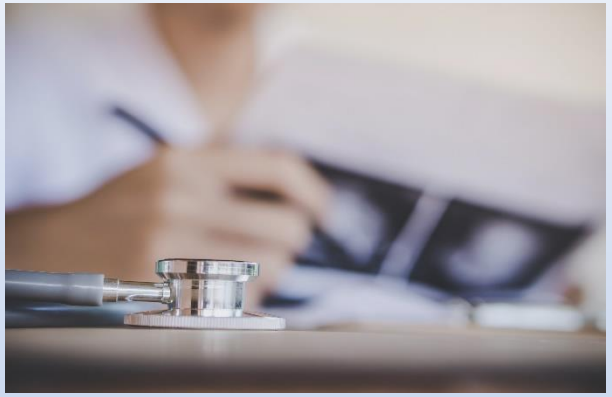
https://www.samhsa.gov/resource/ebp/advisory-peer-support-services-crisis-care

NRI Workforce Report (November 2022)

Out of 44 states who responded to the survey, the following number of states reported Peer Support Workers as being short staffed as well within the categories identified below:

NRI Workforce Report

- 17 States Reported a Shortage of Peer Support Workers within Call Centers
- 24 States Reported a Shortage of Peer Support Workers within Mobile Crisis Teams
- 23 States Reported a Shortage of Peer Support Workers within Crisis Stabilization
- 18 States Reported a Shortage of Peer Support Workers within Crisis Residential



Of the 44 states that responded, 75% indicated that they were actively recruiting peer support workers.

https://www.nri-inc.org/media/4dzhgyv1/peer-specialists_final.pdf

The Data

- On May 18, 2023, NASMHPD sent a feedback form to 44 state and territory recovery leads in state government roles through the NASMHPD Division of Recovery Support Services (DRSS).
- Out of the 44 states and territories who received the request to provide their feedback, a total of 17 states provided responses.
- The settings were listed across Pre-Crisis Care, Sub-Acute Care, Acute Care, Stabilization, and Post-Crisis Care within the SAMHSA Crisis Advisory which the feedback form modeled.

Crisis Continuum	SAMHSA's Recommendations for Integration of Peers	In a Sample of 17 States How Many Had These Integrations
Pre-Crisis Care *Services Intended to avert a crisis*	Outreach	14
	Warmlines	14
	Crisis Planning	14
	Linkage of Resources	16
	Individual and group digital support	10
	Harm Reduction	13
	Peer Run Organizations	16
	Mobile Recovery Centers	6
	Outpatient	13
	Rehabilitation Programs	10
	Homeless Outreach	12
Sub-Acute Care *Services provided to those who experience a mental and/or substance use disorder crisis, but do not require acute care*	Inpatient hospitalization care	14
	Partial hospitalizations care	5
	Short term Intensive Treatment	9
	Linkage to Resources such as 23-hour stabilization units/bed, inpatient hospitals, and partial hospitalizations, Hospital diversion houses	14
Acute Care *Services Provided to de-escalate a crisis and/or when acute BH is required:*	Crisis Hotlines	11
	Emergency Department care/advocacy	15
	Intensive treatment and services	10
	Linkage to resources such as Emergency Department, Mobile Crisis Teams, Crisis Intervention and response teams, Police and Correctional Diversion	15
Stabilization *Services designed to assist with symptoms stabilization before returning to community.*	Residential Stabilization	9
	Step- down services	11
	One-on-one services	12
	Linkage to Resources such as crisis receiving and stabilization facilities, Crisis Respites, Recover Residences, and Living Rooms	15
Post-Crisis Care *Services aimed to support the individual after the crisis has subdued*	Post crisis supports groups	12
	Recovery supports	16
	Social inclusion and structure	10
	In home peer companionship	4
	Self-care supports and digital support such as Peer run organizations, ACT teams, other outpatient and rehabilitative settings	16

The Data

- **Pre-Crisis Care**
  - Warmlines – 14 states
  - Crisis Planning – 14 states
  - Peer Run Organizations – 16 States
  - Homeless Outreach – 12 States
- **Sub-Acute Care**
  - Inpatient Hospitalization – 14 States
  - Partial Hospitalizations – 5 States
- **Acute Care**
  - Crisis Hotlines – 11 States
  - Emergency Departments – 15 states
- **Stabilization**
  - Step Down Services – 11 States
- **Post – Crisis Care**
  - Post crisis support groups – 12 states

Crisis Continuum	SAMHSA's Recommendations for Integration of Peers	In a Sample of 17 States How Many Had These Integrations
Pre-Crisis Care *Services Intended to avert a crisis*	Outreach	14
	Warmlines	14
	Crisis Planning	14
	Linkage of Resources	16
	Individual and group digital support	10
	Harm Reduction	13
	Peer Run Organizations	16
	Mobile Recovery Centers	6
	Outpatient	13
	Rehabilitation Programs	10
	Homeless Outreach	12
Sub-Acute Care *Services provided to those who experience a mental and/or substance use disorder crisis, but do not require acute care*	Inpatient hospitalization care	14
	Partial hospitalizations care	5
	Short term Intensive Treatment	9
	Linkage to Resources such as 23-hour stabilization units/bed, inpatient hospitals, and partial hospitalizations, Hospital diversion houses	14
Acute Care *Services Provided to de-escalate a crisis and/or when acute BH is required:*	Crisis Hotlines	11
	Emergency Department care/advocacy	15
	Intensive treatment and services	10
	Linkage to resources such as Emergency Department, Mobile Crisis Teams, Crisis Intervention and response teams, Police and Correctional Diversion	15
Stabilization *Services designed to assist with symptoms stabilization before returning to community.*	Residential Stabilization	9
	Step- down services	11
	One-on-one services	12
	Linkage to Resources such as crisis receiving and stabilization facilities, Crisis Respites, Recover Residences, and Living Rooms	15
Post-Crisis Care *Services aimed to support the individual after the crisis has subdued*	Post crisis supports groups	12
	Recovery supports	16
	Social inclusion and structure	10
	In home peer companionship	4
	Self-care supports and digital support such as Peer run organizations, ACT teams, other outpatient and rehabilitative settings	16

Medicaid Rates for Peers

- The Medicaid rate for both peer and group peer support services largely varies between states.
- Among 23 SMHAs reporting individual Medicaid reimbursement rates, the average reimbursement rate is $13.26 per 15-minutes (ranging from $7.83/15 minutes to $24.27/15 minutes).
- Among eight SMHAs reporting group Medicaid reimbursement rates, the average reimbursement rate is $6.12 (ranging from $1.61/15 minutes to $13.20/15 minutes)

https://www.nri-inc.org/media/4dzhgyv1/peer-specialists_final.pdf

Bridging Gaps in Underserved Communities

- Communities that have experienced historical trauma caused by emergency response systems, including Black, Indigenous, and People of Color (BIPOC), may have mistrust of behavioral health crisis response systems and providers.
- It is crucial to expand the crisis response system to meet the unique needs of people of color. Without trust in the services provided, individuals in these communities may be less likely to seek help during a crisis.
- It is essential to establish a crisis response system that is culturally competent, responsive, and inclusive to build trust and increase accessibility for communities that have been historically underserved.

Working with Diverse Populations

- Due to national workforce shortages, crisis service providers serving more than one specialized population will require peer support workers to adapt to serve diverse populations.
- Peer support workers need training and experience to be able to interact with all people in crisis, including Veterans, LGBTQI+ individuals, racially and ethnically diverse populations, immigrant populations, neurodivergent individuals, people with criminal and Juvenile Justice System involvement, older adults, Youth, children and young adults, and linguistically diverse populations.
- Specialized training for people without the lived experience of the target population is difficult but can be achieved in environments that are trauma-informed, in which employees are aware of their own implicit biases, and in which there is a positive and open and welcoming organizational culture.

T McGilloway A, Hall RE, Lee, et al.: A systematic review of personality disorder, race and ethnicity: prevalence, aetiology and treatment. BMC Psychiatry 10: 1–14, 2010.

Co-Responder and Alternative Model Approaches

- Nationally there is increasing interest in adopting co-responder models to improve engagement of people experiencing a behavioral health crisis.
- Co-responder models vary in practice but typically involve law enforcement and behavioral health clinicians (sometimes peers) working together in responding to a person in a behavioral health crisis.
- There is no consensus on which model is most effective and programs should be adapted to the local context as pointed out in the August 2020, NASMHPD Paper on 'Cop, Clinicians, or Both?'.
- A co-responder model identified in the paper includes (but is not limited to) the RIGHT (Rapid Integrated Group Healthcare Team) Care model which operates out of Dallas Texas and deploys a three-member team consisting of a clinician, Law Enforcement Officer, and a paramedic.
- There are also co-responder model variations to consider as well as is highlighted in a January 2020 Policy Research Inc. (PRI) Publication titled 'Responding to Behavioral Health Crisis via Co-Responder Models'. In this PRI publication it is noted that 'co-responder teams fall into Intercepts 0 and 1 within the commonly used Sequential Intercept Model[1] to inform community-based responses to the involvement of people with mental health and substance use disorders in the criminal justice system.'

NAMI/MHA Policy Stances:
Alternatives to Co-Responder Model Approaches

NAMI (National Alliance on Mental Illness) Policy Statement

- According to the NAMI (National Alliance on Mental Illness) 44% of people incarcerated in jail and 37% of people incarcerated in prison have a mental health condition — and people with mental illness are booked into the nation's jails around 2 million times every year.
- Millions more end up in emergency departments that are often ill-equipped to address mental health crises, often waiting hours or days to access care.
- Communities that currently have robust crisis services estimate that more than 80% of crises are resolved on the phone, and mobile crisis teams, staffed by behavioral health professionals, are dispatched when an in-person response is needed — with most dispatches resolved in the community.

Mental Health America Policy Statement

- Mental Health America (MHA) National issued a policy statement calling out the need for alternatives to calling 911 and the dispatching of law enforcement personnel in response to mental health and substance use crises. The cited reasoning for alternative approaches to behavioral health Crisis was that 'non-behavioral medical emergencies, such as heart attacks, strokes and non-vehicular accidents are often handled by the 911 system. But rather than dispatching a police officer, an ambulance is sent.
- 'A law enforcement response to a mental health crisis is almost always stigmatizing for people with mental illnesses and should be avoided when possible.' Peer crisis services are considered an alternative to psychiatric ED or inpatient hospitalization. Peer crisis services are operated by people who have experience living with a mental illness (i.e., peers) (Ostrow and Fisher, 2011). Peer crisis programs are designed as calming environments with support for individuals in crisis.

Position Statement 59: Responding to Behavioral Health Crises | Mental Health America (mhanational.org)
Criminalization of People with Mental Illness | NAMI: National Alliance on Mental Illness

Recommendation Summary

- Need for toolkits, resources, and organizational readiness tools for organizations to implement peer support
- Need for more robust data to inform policy and understand the landscape.
- Clear communication within organizations that employ peers is needed to ensure peers do not drift into roles other than the peer role
- Should be a requirement for peer support via contracts with vendors providing peer support services.
- Funders should increase funding for peer run respites, warmlines, step-up, step-down programs and other peer-led services in the crisis system.
- Increase the amount of Peer Respites and non-clinical settings for people in crisis. Expand mobile crisis and diverse peer outreach to underserved communities.

Not all inclusive.