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California Peer Providers in Transitions of Care

by Susan A. Chapman, Lisel Blash, Joanne Spetz

University of California, San Francisco
School of Nursing, Department of Social and Behavioral Sciences
Philip R. Lee Institute for Health Policy Studies
Healthforce Center at UCSF

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Abstract / Overview
Peer providers are individuals with lived experience who are hired to provide direct support to persons in recovery from mental health (MH) and/or substance use disorders (SUD). These workers are increasingly being used to support individuals transitioning out of inpatient mental health or substance abuse settings, or incarceration, and back in to their communities. Our research explores the growth and development of the peer provider workforce in inpatient and forensic settings in California.

The mission of the Healthforce Center is to equip health care organizations with the workforce knowledge and leadership skills to effect positive change.

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Executive Summary

The purpose of this study was to explore care models and policies that enhance the utilization of peer providers in California in transitions of care. Our focus was on services and programs that employed peers to help individuals transition out of incarceration and hospitalization. While some evaluation studies and reports indicate that these programs may have the potential to reduce recidivism and re-hospitalization rates and improve participant well-being, a review of peer-reviewed literature revealed relatively few studies; often with inconclusive outcomes. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a peer provider as "a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience." The key factor that defines peer providers is that they use their own lived experience(s) of recovery from mental illness and/or substance use disorders (SUDs), in conjunction with specialized training, to assist others on their path to recovery.

Background and Policy Framework

Peer providers are part of the transformation of behavioral health systems to a recovery-oriented model of care. This model empowers consumers and focuses on long-term recovery. It extends and expands the traditional medical model of care with its emphasis on professionals providing diagnosis and treatment. Peer providers, once employed only in alternative recovery organizations, have become more common in traditional treatment settings.

California has relied on federal grants, state grants, and county-level funding mechanisms to provide sustained funding for behavioral health services, including peer provider services. These include the Mental Health Services Act (MHSA), or Proposition 63, which imposes a 1% income tax on personal income in excess of $1 million and provides annual funding to county mental health departments. The MHSA specifically called for an increase in consumer (peer) services. Newer sources of funding include the Public Safety Realignment Act, or AB 109 which allows non-violent, non-serious, and non-sex offenders to serve their sentence in county jails instead of state prisons. AB 109 draws on Vehicle License Fees, as well as a portion of the state sales tax, to provide a sustained source of funding for supervision and rehabilitative services for adult felony offenders subject to probation and for evidence-based rehabilitation programs that include drug, alcohol, and mental health treatment, including peer support.

Whole Person Care Pilot programs, authorized through California's 1115 waiver in 2015, will provide up to $3 billion in funding to coordinate health, behavioral health, and social services for high utilizers, which includes the homeless, those with mental health or substance use disorders, and those who have recently been released from institutions. Peer provider services, including support in navigating the community and obtaining needed social and health care services, are included in several of these programs.

Most states have an official statewide training and certification system for peer providers; California does not. A bill (SB614) proposed in 2015 would have required the State Department of Health Care Services to establish a statewide certification program for peer providers in mental health and substance use disorders and to recognize peer providers as providers in the Medi-Cal program. Supporters withdrew support for the bill due to technical amendments and planned to submit a new bill. In January of 2018, Senator Jim Beall (D-San Jose) introduced SB 906, a new bill proposing statewide training and certification for peer support specialists in mental health and addictions recovery.

Methods

We selected sites via a snowball sample and website searches. We contacted over 20 possible sites that met our basic eligibility criteria of currently employing at least three paid peer providers in roles intended to assist individuals with mental illness or substance use disorders in transitioning from hospitalization or incarceration. After an initial telephone interview we selected and conducted site visits to eight organizations in California. At each site, we interviewed program staff including program directors, supervisors of peer providers, human resources representatives, clinicians, peer providers, and other staff involved with the programs. We analyzed our interview notes to explore key themes that arose, which are outlined below.

Findings

The purpose of this study was to explore care models and policies that enhance the utilization of peer providers in California in transitions of care. We found that extensive collaboration across agencies and/or departments is a distinguishing characteristic of forensic (programs found in jails and prisons) and hospital discharge programs. Peer providers in this study were all employed, usually by an agency or department other than the entity in which consumers were hospitalized or incarcerated. Peer providers had varying degrees of direct access to consumers/participants in these facilities. Hospital discharge programs assisted individuals in leaving short-term holds in county psychiatric hospitals. In these programs, peer providers usually worked with a clinical team. Forensic programs were often a part of the AB109 or Public Safety Realignment initiatives that were county-based. Peer providers met with consumers post-release at drop in reentry centers. Only one program had extensive jail clearance to allow preliminary peer support services pre-release.

Peer providers were reported to be effective and valuable members of the team in assisting consumers with transition back into the community because they establish a rapport with consumers based on their lived experience. They served as role models and spent time with consumers to link them with resources. Most peer providers felt that colleagues in their agency or department accepted them, but reported difficulties with stigma in collaborating agencies where their role was less clear and accepted.

Training length and curriculum varied widely by site, from no pre-training required to extensive training and certification by recognized training providers. Opinions about the potential utility of statewide training and certification varied. Many peer providers and supervisors felt it would provide legitimacy and visibility, while some peer providers were concerned that it could lead to professionalization that might jeopardize their ability to establish rapport with consumers.

Reported challenges included difficulty with access to consumers pre-release. Problems with risk management at hospitals, and issues around background checks and prior criminal justice involvement for forensic programs, were common.

The outcomes measured by each site varied depending upon reporting requirements by funders or the county organizations. A frequent measure and outcome was a reduced rate of recidivism in forensic programs and rate of re-hospitalization in hospital discharge programs.

Policy Recommendations

- Statewide certification and training for peer providers may ensure high quality training and competency standards in peer support. Establishing statewide certification and training standards may enhance the visibility and legitimacy of peer providers.
- Defined state requirements for training and certification would help meet the requirement for billing Medicaid for peer support and could lead to more sustainable funding for peer provider employment.
- With the launch of several new, state level and local initiatives that have the option for peer support components, it may be useful to establish a learning collaborative for a training and resource-sharing to prepare organizations to implement successful peer support programs.
    - This type of program would become even more vital if statewide training and certification is established.
    - A forum for peer provider programs in forensic and hospital discharge programs to share best practices to be shared across sites could be useful to assist and build new programs.
- Peer provider programs in transitional settings show considerable promise in reducing re-hospitalization and recidivism. However, they may be more effective if greater direct access to hospital and jail/prison populations is possible prior to release.
- Additional research on the efficacy of these types of transitional programs is needed to establish what models and elements of these models are most effective in reducing re-hospitalization and re-incarceration.

Conclusion

Transitional peer provider programs such as hospital discharge and forensic programs are similar in the services provided and the role of peer providers. Peer providers can play an important role in transitional programs because of the rapport they establish with consumers and because they can provide linkage to services and support.

Some research suggests that these programs may have the potential to reduce recidivism and hospitalization rates in California. However, there is relatively little peer-reviewed research on the outcomes of transitional programs. To be successful, these programs require considerable collaboration between the programs employing the peer providers and hospital and corrections facilities. Greater recognition and legitimization of the peer provider role could enhance program success by increasing peer provider access to work with participants at host sites (hospitals, jails, and prisons). Peer providers have the potential to become an important part of the California behavioral health care workforce and could help alleviate current and future workforce shortages in public behavioral health.

Introduction

The purpose of this study was to explore care models and policies that enhance the utilization of peer providers in California and to identify and describe best practices in peer support roles and practices for individuals with mental health and/or substance use disorders in California. Our focus was on peer providers employed in programs that help individuals transition out of incarceration and hospitalization.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a peer provider as "a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience."[1]

Hospital Discharge Peer Providers

Programs that utilize peer support to assist in the transition from inpatient hospitalization for mental health conditions have been called "Peer Bridger" programs.[2,3] There is relatively little published research on the efficacy of these programs,[4,5, 6, 7, 8] although Optum Health, Yale University, and others have produced evaluation reports, descriptive reports, and scientific posters about these programs.[9-11]In 2011, Sledge and colleagues found that individuals who had experienced multiple psychiatric hospitalizations who were assigned a peer mentor had significantly fewer rehospitalizations and fewer hospital days than a comparison group.[6] A recent pre-post study[4], a randomized control trial[7], and a prospective study[8,] found limited evidence of efficacy on key measures such as rehospitalization. However, these studies did find positive impacts on community functioning, community integration, and quality of life[4]; quality of life and functioning[7]; and internalized stigma and personal recovery.[8] Optum reported that its Peer Bridger programs in Wisconsin and New York reduced inpatient days by 30% and produced health care cost savings of 24%.[10] Researchers in Washington state reported that participants in a King County Peer Bridger program reduced rates of hospitalization, reduced hospital stays by an average of 18 days per participant, and increased rate of enrollment in outpatient mental health services and Medicaid.[11]

Forensic Peer Providers

Programs that assist in the transition from incarceration (jail and prison) are called forensic peer programs. Rowe, Bellamy, and Guy described forensic peer support as "the employment of trained peer specialists with histories of mental illness and/or co-occurring substance abuse and criminal justice charges in work with people with similar histories and experiences."[12] They note that this work requires awareness of the impact of the culture of incarceration on behavior, and recognition of trauma and posttraumatic stress disorders in this population. Some studies found that forensic peer support programs are effective in assisting individuals in re-integrating into community life and in reducing rates of re-incarceration.[13-15] However, there is relatively little peer-reviewed literature on this type of program.

Some states have made major investments in forensic programs. For example, between 2011 and 2015, Pennsylvania established an innovative forensic peer support program by training some 500 prisoners with lived experience with mental illness in six state prisons to serve as certified and employed peer support specialists.[16-18]

Background and Policy Framework

Peer support grew out of the mental health advocacy movements of the 1970s and '80s and the self-help tradition of the addiction recovery movement, culminating in an infrastructure of organizations providing consumer-directed recovery services delivered by persons with lived experience with mental illness and/or substance use disorders (SUDs). This emerging recovery-oriented model of care contrasts with traditional treatment model in that it focuses on empowering the individual who has experienced mental illness and/or substance use to manage their symptoms and re-establish a healthy and satisfying life beyond the stage of crisis, diagnosis, and treatment. As activists advocated for the inclusion of consumer perspectives in mental health and SUD treatment, peer support and the philosophy of recovery moved beyond the self-help networks and became increasingly infused into traditional medical models of care, placing peer providers in teams with clinicians and other licensed staff. Until 2007, funding for these new, non-clinical positions was largely provided by grants.

In 2007, the Centers for Medicare & Medicaid Services (CMS) issued a letter to State Medicaid Directors authorizing them to bill Medicaid for mental health (MH) and SUD peer support services under particular conditions of supervision, care coordination, training, and credentialing.[19] The CMS rationale for this authorization was a number of studies that established peer support as "an evidence-based mental health model of care." [19] The ability to bill Medicaid for peer support, along with Medicaid expansion under the Affordable Care Act in the states that took advantage of that option, provided service organizations with a sustainable funding stream for peer support services. In the authors' prior research on peer provider roles in four states, key informants reported that this funding allowed for job growth in the field.[20]

As of 2016, 41 states and the District of Columbia had established statewide training and certification for peer support programs, one of the criteria for billing Medicaid for peer support services.[21] Only 11 states have provisions for Medicaid billing for SUD peer support.[22] California is one of the few states in the US that does not have statewide certification and standardized training for peer providers, one of the prerequisites for Medicaid billing.[23]

Peer Providers in California

California has a long history of mental health activism and advocacy and an estimated 6,000 peer providers according to the California Association of Mental Health Peer-Run Organizations (CAMHPRO). California has developed a service provision model over time that has moved away from state-based provision of mental health services prior to 1960 to a more county-based system with gradual re-allocation of funding to county mental health departments.[24]

In 2004, California passed landmark funding legislation, the Mental Health Services Act (MHSA), also known as Proposition 63. The MHSA imposes a 1% income tax on personal income over one million dollars to aid county mental health programs. The MHSA called for "significant increases in the level of participation and involvement of clients and families in all aspects of the public mental health system," including service delivery. It also called for an increase in consumer peer provided services.[25]

The Mental Health Services Act is probably the most significant California source of funding for peer support and other mental health programs. The MHSA provides millions of dollars to county mental health programs. MHSA funds can be used for grants to counties to support various categories of activity, including community service and supports, prevention and early intervention, capital facilities/technology needs, innovation, and workforce education and training, which could include peer and family employment training. MHSA funding has reportedly increased the number of peers employed in public mental health.[26]

A major funding initiative of the MHSA is the Full-Service Partnership (FSP) funding provided to California counties. FSPs are based on the "Housing First" model of addressing chronic homelessness and mental illness. Full-Service Partnerships use a team approach to provide comprehensive, 24-hour community-based psychiatric treatment and rehabilitation services to underserved individuals.[27] Peer support is often an integral part of FSPs, along with other services to meet individual recovery goals.[28]

A number of innovative projects utilizing peer providers started out as MHSA short-term innovation (INN) grants, which, if successful, can obtain more long-term funding through one of the other categories.[29] For example, an evaluation of Alameda County's Mentor on Discharge Innovation pilot program found the program to be effective in reducing the rate of re-hospitalization by 70% and extending the length of time between hospitalizations. The County of Alameda used various sources of funding to continue this project, including MHSA Prevention and Early Intervention funds (PEI). Similarly, the NAMI Next Steps program in San Diego also started as an MHSA Innovation grant and now receives funding from the County of San Diego. Further details on these programs are included in the section Peer Employment Settings, and in Appendix A.

The Investment in Mental Health Wellness Act of 2013, SB82, was a competitive grant program providing funding to California counties and their contractors to develop mental health crisis support programs. Some of the funding in this grant originated in the MHSA. This source has finished its last round of funding as of 2016. Most programs reportedly hired peer providers.[30]

The Public Safety Realignment Act (AB 109) is the most important funding source for forensic peer provider programs. This bill, passed in 2011, provides a dedicated and permanent revenue stream for counties through the Vehicle License Fees and a portion of the state sales tax. Under realignment, low-level offenders without current or prior serious violent offenses remain in county jails to serve their sentences, rather than continuing to prison. This bill provides funding for supervision and rehabilitative services for adult felony offenders subject to probation, and can be used for evidence-based rehabilitation programs including drug and alcohol treatment and mental health treatment.[31] A number of AB109 programs using peer-support were included in this study.

Another important new source of grant funding launched in 2016 is the Whole Person Care (WPC) Pilot program funding. This funding was authorized through California's 1115 waiver. The program has up to $3 billion in funding, half from federal Medicaid matching funds for counties and other entities. The goal of this funding is to coordinate health, behavioral health, and social services for high utilizers, including the homeless, those with mental health or SUDs, and those who have recently been released from institutions. As they prepared for WPC in 2017, Los Angeles County planned to hire hundreds of peer providers, and other counties have also included peer providers in their plans.

Statewide Certification and Medicaid Billing in California

Despite a fair amount of innovation around mental health services and funding streams, California does not have statewide certification and standardized training requirements for peer providers. Thus, organizations cannot bill Medicaid for peer providers as individual providers. Attempts to institute statewide certification in California have been ongoing since 2011. In that year, a number of California organizations formed a statewide collaborative technical assistance organization, Working Well Together (WWT), to undertake a multi-year process to conduct research and ultimately develop recommendations to the state about peer provider certification. This collaborative included United Advocates for Children and Families (UACF), the California Association of Mental Health Peer Run Organizations (CAMHPRO), and the California Institute for Behavioral Health Services (CIBHS). Working Well Together drew together stakeholders from across the state in a series of meetings to discuss their

initial research findings on peer providers in the US and gather information with which to develop recommendations. The group then convened a summit in 2013, which resulted in a consensus set of 17 recommendations on peer support certification. Finally, Working Well Together solicited input from state agencies on these recommendations.[32]

The resulting bill proposed in 2015, SB 614, would have required the State Department of Health Care Services to establish a statewide certification program for peer support specialists in mental health and substance use disorders and to recognize peer support specialists as providers in the Medi-Cal program.[33] The legislation proposed four levels of certification, including adult, child, family, and parent peer support specialists. The proposed legislation would have created a distinct class of provider and service type and allowed billing for ongoing services that are not currently billable.[34,35]

The California Behavioral Health Directors Association (CBHDA) was the bill's sponsor. The California Consortium of Addiction Professionals opposed the bill because the consortium claimed the regulatory framework presented in the bill lacked standards of education, a defined scope of practice and code of ethics, and concerns about the ability of the Department of Health Care Services to manage licensing.

In 2016, DHCS proposed technical amendments to the bill leading supporters to withdraw support for the bill.[36] However, interest from various stakeholder groups in peer provider employment and certification remains high in California. In January of 2018, Senator Jim Beall (D-San Jose) introduced SB 906, a new bill proposing statewide training and certification for peer support specialists in mental health and addictions recovery.[37]

Despite the lack of a statewide certification and training, the current California State Plan allows billing for rehabilitation, targeted case management, and collaterals under "Other Qualified Providers," which includes peer providers. However, only a few California counties currently bill using those codes.[38] According to one interviewee, this may be due to a disinclination to accept peer providers as valid practitioners and/or concern that peer providers will make costly mistakes in documentation that could result in disallowed claims. In addition, there is confusion over of the current regulations and which existing codes to use to bill for peer support.

Methods

The purpose of this study was to explore care models and policies that enhance the utilization of peer providers in California. The focus was on was on best practices in programs that employed peer providers to help individuals transition out of incarceration and hospitalization.

We utilized a case study approach to address the study objectives. We used a snowball sampling method and website searches to locate likely sites. Eligible sites were those that were currently employing at least three paid peer providers in roles intended to assist individuals with mental illness or substance use disorders in transitioning from hospitalization or incarceration.

We asked for referrals from organizations knowledgeable about peer provider programs, called state prisons and hospitals, and scanned the National Alliance on Mental Illness (NAMI) directory, "2016 MHSA County Programs: Services that Change Lives," for programs that employed peer providers. We contacted over 20 likely sites for an initial telephone interview.

In selecting sites, we looked for geographic diversity, with a goal of visiting programs in different locations across the state, including northern California, southern California, and the Sacramento Valley.

In total, we visited eight sites for this study. Visits took place from May to October of 2017. Three sites focused on transitions from inpatient hospitalization and three sites focused on transitions from incarceration. One large site included several programs in both hospitalization and incarceration transitions. Another site had a single program that included both transition from hospitalization and transition from short-term jail stays. At each site, we interviewed program staff, including program directors, supervisors of peer providers, human resources representatives, clinicians, peer providers, and other staff involved in the programs. Interviews were conducted by two to three researchers who took notes by hand or on a laptop computer. Interviews were approximately 45 minutes in length. Forty-eight interviews were conducted. Interview notes were uploaded into a qualitative analysis software program, Atlas.ti, coded, and analyzed by the research team for key themes.

Program	County
Incarceration	
Mentoring and Peer Support (MAPS)	San Francisco
San Mateo County Service Connect	San Mateo
Santa Clara County Reentry Services	Santa Clara
Hospitalization	
Mentor on Discharge/NAMI Alameda County	Alameda
Next Steps/NAMI San Diego	San Diego
Los Angeles County Behavioral Health: a) Intensive Services Recipient b) Kin through Peer	Los Angeles
Combination	
TLCS, Inc.	Sacramento
Riverside University Health System – Behavioral Health a) AB 109 New Life b) Peer Navigation Center	Riverside

Findings

In the following section, we present a summary of the types of programs we visited. We then present findings and discussion about the key themes that emerged from the interviews, such as peer employment settings and characteristics, peer provider roles and acceptance, peer employment, training and certification, career development, funding sources, challenges, facilitators, and outcomes of peer provider programs. The programs visited are described in greater detail in Appendix A. Appendix A includes information on program location, funding source, number of peer providers, training, population served, services delivered, and available data on program outcomes.

Peer Employment Settings

Programs that help individuals transition out of incarceration and hospitalization share some features, but differ in setting, population served, funding, and in specific outcome goals. One important characteristic that these programs shared is the need to collaborate with one or more outside organizations or county facilities in order to obtain access to program participants.

Hospital Discharge Programs

In California, we could not find programs within the state mental health hospital system that were similar to those we visited during our prior research in other states. For example, for our 2015 SAMHSA-funded study on peer providers in four states, we visited a state mental health hospital that directly employed a large number of peers.[17] In California, we found a number of programs where peer providers are employed to work with those transitioning from short-term holds in county hospitals and a few small-scale programs working with individuals in long-term conservatorships in Institutes of Mental Diseases (IMDs).

We visited five programs that assist individuals in transition out of hospitalization:

- Riverside University Health System – Behavioral Health Peer Navigation Center
- San Diego NAMI Next Steps
- Alameda County South Mentor on Discharge
- TLCS (Transforming Lives, Cultivating Success) Triage Navigator (Sacramento)
- Los Angeles County Intensive Service Recipient and Kin through Peer

In these programs, peer providers primarily assist individuals coming out of short-term (72-hour) involuntary holds at county hospitals under section 5150 of the California Welfare and Institutions Code. Individuals are placed into longer holds if they are still considered a danger to themselves or others after the initial 72 hours under section 5250 (14 days) or section 5270 (30 days).

Two of the programs are county-run (Riverside and Los Angeles). Three of the programs are run by non-profit organizations (Next Steps, Mentor on Discharge, and TLCS Triage Navigator). Mentor on Discharge (NAMI Alameda County South) and Next Steps (NAMI San Diego) are local NAMI (National Alliance for the Mentally Ill) affiliates. All of the non-profit organizations are operating under a contract with their county.

Peer providers in hospital transition programs generally work with a team that includes clinicians, social workers, office staff, and supervisors, as well as other peer providers, although one program has no clinical staff.

Two of the programs are co-located with their hospital sites. Of these two programs, one has peer providers in the emergency room and in the inpatient ward full-time. In another program, both the peer program and the hospitals are part of the same county system, facilitating access to participants. In the fourth program, peer providers can enter the hospital to meet with patients as visitors. In the fifth program, peer providers are only able to meet with patients in the community post-discharge.

In all five programs, potential participants are screened and referred by a social worker or other non-peer staff.

Forensic Programs

We did not find programs with employed peer support providers in California's state prisons such as we encountered in prior research in other states. For example, for our SAMHSA-funded 2015 study on peer providers in four states, we visited a peer provider program in Pennsylvania, Peerstar LLC, which provided contracted mental health peer support in state prisons and jails.[20] Pennsylvania state officials described large-scale initiatives to train current prisoners for paid mental health peer support positions in state prisons.[17] In California state prisons, we found the peer models were more self-help and volunteer peer support.

In California we found small-scale, forensic peer provider programs working with ex-offenders through county programs focused in the county jails. Most of these programs are the result of AB109 Public Safety Realignment.

We visited five programs that assist individuals with lived experience of mental illness to transition out of incarceration:

- Riverside University Health System – Behavioral Health AB109 New Life
- San Mateo County Service Connect
- TLCS (Transforming Lives, Cultivating Success) Triage Navigator (Sacramento)
- Santa Clara Reentry Resource Center and Faith-based Collaborative
- San Francisco Mentoring and Peer Support (MAPS)

Riverside, San Mateo, and Santa Clara are county-run AB109 programs. MAPS was initially funded by a SAMHSA grant and run through a non-profit financial intermediary. TLCS Triage Navigator is part of a hospital discharge program funded by SB 82, which serves four hospital sites as well as the county jail and a homeless shelter.

Transitions Clinic Network: A related program has been in operation for a decade and has significant positive participant outcomes. The Transitions Clinic Network (TCN) is a consortium of primary care clinics that aims to increase access to health care services, improve health, and reduce recidivism among high-risk, chronically ill people recently released from prison. It operates 17 clinics in eight states and Puerto Rico. The program uses specially trained community health workers (CHWs) with a history of incarceration. Like peer providers, the unique attribute of lived experience allows the CHWs in TCN to fully address the physical and behavioral health needs, as well as the social determinants of health, of this specific population.

Source: Chapman S, Schindel J, Miller J. Supporting the Integration of Community Health Workers into Health Care Teams in California. Healthforce Center at UCSF. June 2017.

Like the hospital discharge programs, the forensic programs require partnerships, although these are more frequently interagency partnerships between different county departments rather than between

entirely different organizations. For example, programs often entail partnerships between behavioral health departments, probation, social services, Veteran's Affairs, the courts, and health services departments. However, MAPS and TLCS Triage Navigator programs are run by contracted non-profit organizations, and Santa Clara County's program entails substantial collaboration between the county and faith-based service providers.

Riverside, San Mateo, and Santa Clara employ peer providers at reentry resource or day reporting centers providing "one-stop shop" services to clients. Riverside also employs peer providers at clinics serving AB109 participants. MAPS and TLCS' Triage Navigator have peer providers situated at county jails and provide intensive follow-up in the community post-release. Santa Clara County's Faith Based Collaborative program is unique in that it employs two county staff, including a peer provider, who helps administer county-funded centers at four local faith-based institutions.

Peer providers in forensic programs typically work with teams that include staff from multiple programs, as noted above. Teams could include clinical and administrative staff as well as law enforcement, vocational education specialists, judges and attorneys, and others.

Peer providers in three of the five programs usually meet with participants in the community or at the program centers. However, at San Francisco MAPS and Santa Clara's Reentry Resource Center, most or all of the peer provider staff have been able to obtain jail clearance and can meet with participants in the jails prior to release.

Peer Provider Roles and Responsibilities

Peer provider titles vary across the organizations and include peer specialist, peer mentor, peer navigator, health navigator, and community worker. Peer roles are similar across most organizations, encompassing some aspects of case coordination. At most sites, peer providers meet with program participants pre- and/or post-discharge and assist them with linkages to housing, health care, SUD and MH resources, benefits, and bus passes. In some instances, peer providers are expected to use motivational interviewing to assist participants in developing and setting their own goals for recovery without being directive. Peer providers are also expected to provide emotional support, from listening and empathizing, to facilitating wellness recovery action plans (WRAP) classes. In many but not all roles, peer providers spend much of their time meeting with participants in the community. Peer providers often accompany participants to medical, benefits application, and court appointments. They transport participants in either their own vehicle or one provided by the employer. Peers reported spending recreational time with participants to help them re-integrate into community activities. For example, one peer provider described taking participants to movies and helping them develop a budget for shopping in order to assist the participant in finding satisfying activities that were not drug and/or alcohol-related.

One role that differs somewhat is that of health navigator at San Diego's Next Steps program. Health navigators are expected to link clients to medical services and help them become comfortable managing their health care needs. This is similar to the developing CHW role in other programs such as the Whole Person Care pilots.

Post-discharge follow-up time with peers varies by program, from 60 days to one year in hospital programs, and from 60 days to 3 years in the forensic programs. In all of the hospital programs and three of the five forensic programs, peer providers have a caseload that they continue to follow in the community. Peer providers reported calling and/or meeting with participants as often as multiple times per week. However, forensic peer support services at the Day Reporting Centers in Riverside and the Reentry Resource Center in Santa Clara are on a drop-in basis and do not entail tracking and follow-up.

Impact of Peer Provider Roles on Clients

Peer providers and other interviewees were asked to reflect on the impact of peer provider support on their clients and the benefits peer providers bring to the workplace. Common factors included the following:

- Peer providers serve as role models and symbols of hope.
- Peer providers establish rapport in a way that professionals cannot, partially because they are not intimidating and partially because they have an intimate knowledge of what participants are going through from their lived experience.
- Peer providers can spend time with participants and help relieve their anxiety.
- Peer providers can relieve the burden on clinical staff and social work staff by working with participants to set goals and obtain resources.

One supervisor described the impact of peers in this way:

"I had a peer on my team and he could go there and talk to the client on that level and he could connect in ways that I couldn't. It was like, "I walked where you walk; I understand and I get it." A guy who had been chronically homeless for a while turned and said, "I want to be just like (him)!" And I said, "We can do that; you can totally do that." They are living examples of where we want people to go."

Interviewees noted that in forensic programs, in particular, participants were very leery of law enforcement and distrustful of authority figures. Peer providers could often break down that distrust.

Peer providers are also impacted by their work. As one peer provider noted,

"I like being in these people's lives as hard as it is. It comes from the heart. They don't have anybody. There is healing and celebration there. The relief that comes after engaging with my guys after they have had a tough week: you feel their spirit come back to them. You do not have to do it alone. It is a joy to see them when they are doing good."

Acceptance of Peer Provider Roles

A key aspect of transitional programs is the need to form partnerships with jails, courts, prisons, and hospitals. However, when peer providers are dispatched to sites that are not their employer sites, they may face stigma and lack of acceptance from those less familiar with their role. In some instances, the peer programs have made inroads into host facilities and some are co-located; in others, gaining a foothold in the facility has been challenging and led to compromises in order to gain access and build trust. For example, one organization had to split the peer role into onsite and offsite teams and assign staff who were not designated as having "lived experience" to onsite roles in partner sites due to partner organizations' concerns.

However, many peer provider and other interviewees noted that acceptance changed over time as their worksite, or host site, grew to understand their role and value:

"Things have changed in a good way. I am watching this evolve. I do feel like the people we serve are reflected in the office setting…That speaks volumes about what your agency represents."

"Professionals accept me. Doctors want to help more because peers are a sign the client is working to get better. Doctors see a lot of people who don't recover."

"Court staff were pretty skeptical but a lot have been won over now…it is remarkable how much they value this program now."

Peer Employment

Peer providers are employees at all of the sites visited. At three sites, they are county employees with permanent positions. At two county-run programs, at least some peer providers are contractors hired from registries or temporary employment agencies with the potential of becoming full county employees. At four sites, peer providers are the employees of non-profit agencies contracted by the county.

Full Time/Part Time Status

Peer providers work full-time schedules in six programs. In Mentor on Discharge and MAPS, all positions are part-time. At both of the latter sites, supervisors noted that peer providers had other jobs or commitments such as school or work on personal recovery that did not allow for full-time employment. At one site with full-time peer providers, a supervisor observed that it would be better if peer providers had the option of part-time work if they could not manage full-time hours.

Wages and Benefits

Wages for peer support staff at study sites range from $13.87 -$16.00 at entry level and from $17.00-$23.00 for more senior or advanced peer support staff. There is variation in wages across geographic setting that could reflect differences in the cost of living as well as employer type. County staff appear to have more extensive employee benefits and are unionized at two sites. Peer providers from registries or temporary employment agencies usually do not receive employee benefits, which one peer provider noted was ironic considering how much training time was devoted to helping clients access health insurance.

Accommodation and Support for Peer Recovery

Administrators were asked how they accommodate peer providers' ongoing recovery needs. Most employers reported making work accommodations such as time off or unpaid leave for peer support staff, although others said that peer providers require no more accommodation than other staff.

Peer provider absenteeism was reported as an issue at two sites. Supervisors said that physical and emotional problems are some of the reasons that staff miss work. Managers reported that it is also problematic if peer providers feel pressured to show up to work when they are not feeling well. As one supervisor noted, "The lived experience means they are still living that experience. People are vulnerable to relapse." Supervisors and peer providers spoke of peer staff occasionally being triggered by entering certain situations (jails, hospitals), interacting with difficult clients, or stigma from unsympathetic non-peer staff towards themselves or clients.

Several supervisors noted an "open door" policy that encouraged staff to come and process with supervisors when they had concerns and most had one-on-one supervision. A supervisor observed, "We talk consistently about conflict of interest or if they are not comfortable working with a certain client and need to be assigned elsewhere. We make sure they take time off." Another said, "The culture here is that if you feel like you are having a crisis and you cannot handle it, you should take some paid time off. If you

need a day, take a day." Peer providers also commented on how helpful supervisors pay attention to need for continuing recovery.

"I was impressed that supervisors wanted me to take leave and were open to me coming back. They asked if I was okay or needed any additional help when I came back. I have never worked anywhere that this where this was okay. They walk the walk and talk the talk. Advocate not only for clients, but also their employees. Management is humble and pays credit to their workers in the field."

In addition to supervision, some sites like Riverside and San Mateo encourage peer support staff to meet together to discuss issues they are facing on the job and to celebrate successes.

Training and Certification

Sites vary in the amount and type of pre-employment training they expect peer providers to have. Two sites require no preliminary peer provider training, three sites require at least some preliminary training, and three sites prefer staff to be or become certified by a recognized training program.

Core training programs used include:

- RI International's 76-hour Peer Employment Training, certificate (Riverside County, NAMI Next Steps)
- Pacific Clinics Training Institute's 40-hour Peer Advocacy Certification Program and health navigator training (LA County Kin Through Peer; some staff at NAMI Next Steps)
- Worker Education & Resource Center (WERC) 72-hour Community Health Worker training (LA County Intensive Service Recipient)
- Several courses through the Workforce Integration Support and Education (WISE), a program of NorCal MHA funded by the Office of Statewide Health Planning and Development (OSHPD) (TLCS, Inc.)
- Richmond Area Multi-Services 96-hour 12-week Peer Specialist Mental Health Certificate Program with a job-shadowing component (MAPS)
- Steven Pocklington's week-long Art of Facilitating Self-Determination (Mentor on Discharge)

Post-employment, nearly all organizations provide additional training in motivational interviewing, and all have ongoing specialized training for peer providers on topics such as suicide prevention, harm reduction, co-occurring disorders, conflict de-escalation, HIPAA rules and regulations, documentation, and facilitator training for WRAP. Documentation training is especially important at Riverside because the program bills Medi-Cal for peer support.

Santa Clara County's Reentry Resource Center is currently working in conjunction with San Jose City College Alcohol and Drug Program to implement a new peer mentor certificate program that will be held at the Reentry Resource Center. Administrators hope to provide job training for clients and potentially fill job openings in the system with some of the graduates. The increased emphasis on training and certification may allow the program to bill Medi-Cal for peer support in the future under case management.

Interviewee Perspectives on Statewide Certification

When asked, interviewees expressed mixed feelings about statewide, or even national, certification. Most peers lamented the fact that California was behind other states in adopting statewide training and certification.

As one peer provider said:

"Certification? Bring it! We do valuable work. We reach community members a clinician cannot reach, but they get paid more. We can make changes. Certification would bring better pay and more recognition as being a valuable member of the team. Credentials would give us leverage; it levels the playing field."

However, some peer providers were concerned that certification would create a barrier of professionalism between themselves and their clients. The certification might mean that the peer providers have to "abide by rules rather than the goal being the human connection."

"Some think that for us to be valid we have to have a certification and a license—but the benefit of our roles is that we are just like the people we serve. This keeps us at a level with them. Personal experience is not a document that says, "I'm qualified." We all have our experiences, let's bring them together."

There was also concern that increased Medicaid billing made possible by certification would further drive a wedge between peer provider and participant(s) by increasing the amount of paperwork and documentation. Finally, one person supported formal training and credentialing at the county level, but felt that codifying this through the state Board of Consumer Affairs might prohibit some from entering the field.

A supervisor voiced ambivalence about certification:

"There are upsides and risks to certification. We have people with amazing potential. If we can use certification to chart a path of standard training and career advancement so people can be recognized and compensated for their work so they can continue to live in this county, it would provide a structure and guidelines for supervisors, managers, and peer providers in the workplace. Right now most of the stuff happens due to strength of person in the position rather than the structures that were put in place. Any structure can be used to exclude, that is the risk."

The majority of respondents agreed with certification as a strategy to enhance the status of the peer provider. A couple thought that there should be mandatory training of peer provider supervisors on how to manage peer staff, and one felt the peer supervisor should also be a person with lived experience who could advocate on their behalf. One observed that there is a need for more peer training programs, as there were few vacancies in existing programs and that these programs needed to incorporate both didactic and fieldwork. Another felt that it would be important to include both substance use disorders and mental health/illness in any trainings, with a specialization in criminal justice issues for forensic peers.

Career Development

While all sites try to provide or encourage additional training for peer providers, few are able to offer a career ladder within the job classification for a variety of reasons. Several of the programs only have a few peer providers on staff (3-5), and therefore no real career steps within that role. Others are non-profit programs on county contracts that enumerate the number of positions for the program and provide a set amount of funding, which makes it difficult to provide advancement opportunities. Positions within county

programs that could provide a step up usually require a professional license or degree such as counseling or social work, a challenge for some peer providers to achieve.

Several programs provide additional training along with encouragement to obtain professional degrees to advance. San Francisco's MAPS program has as an explicit goal of "offering opportunities for participating peer mentors to receive job experience and training and to move on to successful careers following the conclusion of the program." Indeed, many peer providers we spoke with across the state recognized that there was no career ladder for them within peer support programs and were pursuing education to become drug and alcohol counselors or enter other human services careers.

Only two sites had distinct career ladders at the time of this study: Los Angeles County, which was, at the time of our visit, in the process of hiring a large number of peer providers (community workers) for its Whole Person Care initiatives, and Riverside University Health System – Behavioral Health, which has a large and established peer provider program.

Los Angeles County has an entry-level position with the title of mental health advocate. After six months of work as a mental health advocate, an individual is eligible to apply for any open positions under the job title community worker, which entails a promotion and a pay increase. These community workers are different than Community Health Workers. At the time of our visit, there were a limited number of senior community worker positions available and an open position for a new division chief of peer services.

Riverside University Health System – Behavioral Health has a large number of peer providers on staff (133 employed peers) and multiple program types. The peer program has a large site for consumer affairs and affiliated staff. A distinguishing factor at Riverside is that the county bills Medi-Cal for peer support under the Medicaid rehabilitation services option, which has created a dedicated funding stream for peer providers and allowed for the growth in the number of peer support staff.

Potential peer providers are encouraged to enter the Riverside system through structured volunteer internships as peer support specialists, family advocates, or parent partners. Successful completion of an internship enhances an individual's chances of hire. Those hired continue employment as a trainee, and then move to the journeyman phase. They can apply for supervisory positions as senior peer support specialists, family advocates, or parent partners. From there, they can progress to management positions (peer policy & planning specialists).

Funding for Peer Provider Services

The programs we visited depend on a variety of sources to cover peer support. Riverside is the only program that bills Medicaid for most of its peer support services. Other hospitalization programs depend on state grant funding and county general funds to pay for the peer provider positions. There are pros and cons to each source of funding. Grant funding alone does not allow for sustainable programs and creates a sense of uncertainty for staff about the sustainability of their jobs. Interviewees reported that grant funding was sometimes extremely prescriptive and did not allow for promotions or the development of a career ladder. However, some administrators reported preferring the grant funding because it did not require the level of documentation and scrutiny that billing Medicaid might require.

Grant Funding

Most of the grant funding for programs in this study originated in the California Mental Health Services Act (MHSA).

- The TLCS, Inc. Triage Navigator Program in Sacramento is funded by the Investment in Mental Health Wellness Act of 2013, or SB82, which distributes some funds from the MHSA in conjunction with other funds.

- The NAMI Alameda County South's Mentor on Discharge Program and the San Diego NAMI Next Steps program received their initial funding from MHSA Innovation grants. The MHSA INN program is intended to foster new and innovative approaches in county mental health systems.

- Federal grants were also an important source of support:

- The California Whole Person Care Pilot program funding, launched in 2016, will provide a total of up to $3 billion in funding, half from federal Medicaid matching funds for counties and other entities. This 5-year state program funds the LA County's Intensive Service Recipient Program and Kin through Peer Program.

- The Behavioral Health Treatment Court Collaboratives program (BHTCC) is a grant intended to address the behavioral health needs of adults in the criminal justice system by developing a coordinated effort between criminal justice agencies, community-based service providers, and the courts. These courts include drug courts, DUI/DWI courts, mental and behavioral health courts, Veterans Administration treatment courts, and tribal courts. This 4-year federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) is the source of funding for San Francisco's Mentorship and Peer Support Program.

Other funding sources

- NAMI Alameda County South's Mentor on Discharge Program was very successful as a pilot program under the MHSA Innovation grant program. After the grant term, the program reconfigured and is now funded by Alameda County Behavioral Health Care Services (BHCS) through MHSA Prevention and Early Intervention funds (PEI) and supplemented by funding from Kaiser Permanente's Community Benefit Program. The program administrators are developing means to replicate this program in more broadly and exploring "Pay for Success" as a future funding source.[39]

- NAMI Next Steps in San Diego County started out as MHSA Innovation grants, and is now funded by Behavioral Health Services and the Health and Human Services Agency of San Diego County.

- AB109, or Public Safety Realignment, is an important funding source for forensic programs. This is a major source of funding for San Mateo County's Service Connect program, which also receives support from county general funds. It is also the main source of funding for Riverside County's AB109 New Life program and Santa Clara County's Reentry Resource Center.[31]

- Riverside's peer provider programs receive funding from a number of sources, including AB109 for some of its forensic programs, and Medicaid billing.

Challenges

Interviewees were asked to identify challenges in their programs. The nature of work in transitional programs was reported to be a major challenge. Many of these programs entail partnerships between an agency or department that provides peer support within a jail or hospital. While the employing agency or department might be very accepting, the staff at the host site might not be similarly well educated about the peer provider role. In addition, federal privacy rules and risk management or jail protocols make it difficult for peer providers to access the site and clients in a timely fashion. One program is staffed by a

consortium of service providers, which introduces additional complexity in managing staff from multiple agencies with different employment policies and training protocols.

Challenges Specific to Hospital Discharge Programs

Hospital Access

Peer provider direct access to hospital sites and patients is a major issue for hospital discharge programs. Interviewees noted that making contact with participants prior to release to start discharge planning and/or goal setting is vital to establishing rapport and successful follow-up in the community. Five of the programs we visited work with patients being discharged from short-term hospitalization. While peer providers at three sites could enter the hospital relatively freely, hospital protocols and concerns about risk management make it more difficult to bring peer providers onsite without special permission. In two sites, peer providers could only meet with participants post-discharge.

Discharge Schedule

The unpredictable discharge schedules at the hospitals also provide a challenge to peer provider programs. Two sites reported that the up-to-72-hour hold for patients did not allow a peer provider to establish a relationship prior to discharge even if they were able to access the hospital. Additionally, it proved difficult to know when the patient might be released. This makes follow up and connecting the patient with community-based peer support and other resources difficult. Even one of the programs with an office onsite has different peer providers based in the hospital than those who followed up in the community due to scheduling complexities.

Challenges Specific to Forensic (Jail) Discharge Programs

Jail-based programs face their own challenges. Peer providers with a history of criminal justice involvement are particularly effective at reaching individuals who are being released from jails and prisons with mental health and substance use issues. However, interviewees reported that counties have rules that may prevent peers with a criminal justice record from entering jails, thus making it difficult to establish peer provider programs that work with prisoners prior to discharge. In addition, some counties will not even hire individuals with a criminal record, even if they were to work solely in community-based programs. At one program, interviewees noted that their sheriff's department refused to work with peer providers because there was an assumption that the peers would not pass a background check. Only two of the four programs we visited had jail clearance for all of their peer providers, allowing them to meet with prisoners in the county jail.

Stigma Associated with Criminal Justice Involvement

In addition to the stigma of mental illness, interviewees reported prejudice in the community towards Proposition 47, the California ballot initiative that reduces some drug possession felonies to misdemeanors and requires misdemeanor sentencing for petty theft, receiving stolen property and forging bad checks below a certain dollar amount. This has become conflated in some people's minds with AB109 programs. One peer provider noted that many people feel that this is about "going soft on crime."

Other Challenges

Lack of Resources for Clients

A number of interviewees in both types of programs expressed frustration at their inability to provide clients with the services they need. They indicated that the housing problem for this population is only

exacerbated by California's housing crisis. Many individuals were reported to be released or discharged into homelessness. Peer providers reported that a percentage of the participants they were assigned disappeared after release and could not be located.

Stigma

Several interviewees in both types of programs reported a lack of acceptance of peer providers by certified or licensed co-workers as a challenge. While many mentioned this as a problem that had diminished over time, especially at their employer site, they still felt this was an impediment to their work, especially at partner organizations and agencies.

Peer Provider Self-care and Maintaining Boundaries

Maintaining professional boundaries was reported to be essential for peer providers to maintain their own health and foster healthy independence on the part of their clients. This can be challenging for peers pursuing their own recovery. While the lived experience is a benefit in terms of forging connections, it can also lead to over-identification with clients and a blurring of boundaries. In interviews, peer providers recognized the precarious situation in which many of their clients found themselves, and a number reported that they intentionally worked beyond their scheduled hours, used their own funds, and otherwise "went the extra mile" for clients.

"You have to go the extra mile to help them, but then it is hard to keep boundaries. Last week I was going from bridge to bridge trying to find one of the clients. Self-care and burnout are big issues."

Over-identification with clients could jeopardize peer providers' own recovery. "You are not supposed to work harder than the client," one peer provider observed, although she said she put in extra effort for those who had just had their first occurrence of mental illness because she hoped that might prevent further hospitalizations.

"You can get really involved in someone's story, and you can end up caught up and not letting them do [it] for themselves; you can over-identify. You need to keep boundaries, clear cut boundaries."

Staff at several sites noted that they worked in an overall culture of support. Peer providers reported that peer support staff and sometimes supervisors could be consulted for logistical and emotional support. Some sites try to institute activities such as mindfulness classes, art therapy, and other activities for self-care onsite. One program has a regularly scheduled support group for peer providers. Those that report the most difficulty are those that were stationed in remote sites where they have little interaction with other peer support staff. Peer providers are also encouraged to seek outside support via their own therapists, support groups, or peer-run warmlines (peer-staffed telephone support programs).

Documentation in Health Records

Peer providers and supervisors alike reported that documentation is a challenge. One program director noted that the county requires staff to use an electronic health record system, which is not user-friendly and is difficult for some peer providers who have limited computer skills. While only one program bills Medicaid, all are required to keep records of some sort. Some peer providers do not see documentation as a challenge, yet others feel it prevents them from spending needed time with clients.

"It doesn't make a lot of sense, when need outweighs the supply and we are supposed to document—you sacrifice one or the other. For purposes of job security, could sacrifice the needs of the clients, but if I go to the other side, then I fear losing my job."

"It can feel like you meet with someone for 15 minutes and you have 20 minutes of paperwork. Part of our documentation is quantifying what we helped people with to justify our funding. It is possible and plausible that I have a 5-minute interaction and then that translates into lengthy documentation. That leads to a time management challenge."

Recruitment and Retention

Recruitment and retention are problems for three sites with rapidly expanding programs. In general, the peer provider role is challenging and the pay is relatively low; however, one site indicated that the work schedule is the problem. Employers at this site have to find people with lived experience who are far along enough in their recovery to handle the work and share their story judiciously. In addition, one county site reported difficulty hiring in a timely fashion because of county bureaucracy and rapid expansion due to grant requirements. In an attempt to expedite hiring, staff were recruited through a temporary employment agency, which then introduced its own problems since staff were not eligible for any benefits in the temporary jobs.

None of the sites mentioned problems with peer provider turnover. However, it was noted that there was turnover of other project site staff, particularly the clinicians.

Facilitators

Leadership and Organizational Support

Leadership and organizational support were cited as important facilitators for peer provider programs to thrive. Most of the programs pointed to this factor as part of their success. This is particularly important for transitional programs that are reliant upon host sites that were part a different organization or department.

For example, Alameda County's Mentor on Discharge program was championed by the former chief administrative officer at John George Community Hospital, who was approached by NAMI with an innovative idea about a peer mentor program. This partnership led to a proposal for a Mental Health Services Act (MHSA) peer mentor program at John George Psychiatric Hospital, which became the Mentor on Discharge program.

San Diego County NAMI Next Step interviewees also pointed to an innovative director at their county hospital who was instrumental in helping them gain access and support for their hospital transition program. Sacramento, TLCS, Inc., a non-profit organization, has always had a large number of employees with lived experience. However, their Triage Navigator program requires collaborating with four hospital systems, the county jail, and a homeless center. The program leaders identified and built relationships with administrators at each site in order to place a triage navigator at each.

On a broader level, top leadership support could inspire the integration of peer support into an entire system of care. As of 2017, Los Angeles was experiencing a resurgence of interest in peer support, partially because of the county's receipt of Whole Person Care funding. In addition, the county hired a new mental health director who is a champion of peer support programs and responsible for the recent opening of the county's first peer-run resource center in the County Mental Health building. The peer support champion came from a long career with the Department of Veteran Affairs, which has a robust peer support program.

Riverside University Health System- Behavioral Health instituted the largest peer support program in the state, largely as a result of peer support and family peer advocates rising through the ranks in the organization and strong and committed leadership. Riverside's strong leadership and advocacy for peer providers has led them to be consulted by other programs across the state to advise on implementation issues.

One administrator noted the importance of those advocating for peer support programs being attuned to relationship building within the organization and beyond. Careful recruitment and training of peer support staff and development of evidence-based programs helps to make the case that peer support is advantageous to the organization.

Ongoing Supervision

Interviewees noted that consistent and supportive supervision is important to maximizing peer providers' potential while providing a safe and healthy environment for them to work in the program. Beyond day-to-day logistics, supervisors, many with lived experience, serve as a sounding board for staff. Supervisors are often their supervisees' advocates, help them keep healthy boundaries, and attend to their own recovery. Supervisors also advocate for staff interfacing with staff at outside programs and departments.

Outcomes

The outcomes measured by each site vary depending upon reporting requirements by funders or the county organizations. All programs collect data and have evaluation plans. Common outcome goals include reducing jail/prison recidivism and reducing re-hospitalization rates. Other intermediate term outcome goals include success in being housed, finding a job, signing up for benefits such as health insurance and disability, and connecting participants with a primary care physician and outpatient services. Some programs have extensive documented outcomes and reports while others are in the process of collecting and evaluating their data. Evaluation of those detailed outcome reports from each site was not within the scope of this study.

Discussion of Key Findings

In summary, the size and scope of the programs that we visited varies greatly. The transitional peer provider programs we identified employ only a few peer providers, except in the cases of Riverside County and Los Angeles County. The lack of large numbers of peer providers employed in these roles may be due to the lack of available and sustainable funding and to the lack of state development of peer roles in these types of programs. In several instances, legislation or new funding requiring the involvement of peers led to the development of these unique, transitional roles.

Hospital transition programs are funded primarily through state and federal grants. The lack of dedicated funding makes many peer support programs unsustainable over the long-term, although some successful programs were able to transition to county general funds. Forensic program support is provided primarily by AB109 and realignment funding, which may be a sustainable source of funding for programs across the state. However, two innovative jail-based programs we studied are grant-based and in danger of being discontinued if not re-funded or continued with another source of funding. Only one program bills Medicaid for peer support services, and that funding has allowed that program to grow and innovate.

As stated previously, California does not mandate peer provider training. While nearly all interviewees agreed that training peer providers is important, training at the study sites ranged from minimal to extensive, with no standardized curriculum or number of training hours. At least two organizations require that peer providers be trained and certified by a recognized training organization such as RI International or Richmond Area Multi-Services (RAMS) in San Francisco before working with clients. Another program

is expanding its own training capacity to increase the skill level of potential applicants to meet growing demands for skilled peer providers.

Certification of peer providers is an area where California lags behind other states in the country. We heard opinions both for and against statewide certification from our interviewees. The benefit of statewide certification is that it may lead to enhancement of the status and employability of peer providers in the state and may provide employers with assurance as to the minimum level and type of training achieved by new peer provider employees. Another argument for standardized training and certification is that peer providers are working with vulnerable populations and are themselves vulnerable to relapses due to their lived experience. Training in professional boundaries is emphasized in peer provider training programs. Standardized training and certification would facilitate the ability of programs to bill Medicaid for peer support and might enhance the long-term stability and sustainability of programs currently reliant on grant funding.

In transitional peer provider programs, the peer providers' ability to reach the target population prior to or during transition to the community was reported to be a critical component of all the programs. Because jails and hospitals are often part of another department or agency than the one that employs the peer provider, peer providers may have difficulty obtaining permission to access these sites to meet with program participants. While individuals with lived experience with incarceration are vital to forensic peer provider programs, the lived experience of peer providers may make it difficult for those a with conviction history to obtain jail clearance. However, this is a resolvable issue considering that interviewees reported that access to jails was a county-level decision, and that several programs had gained clearance for peer providers to visit potential clients in the jails.

Policy Recommendations

A number of policy actions may facilitate increasing the utilization of peer providers in California. The state lags other states in the US in the development of standardized training and certification. While employment of peer providers is found throughout California, sustainable employment and peer status and recognition are ongoing challenges. While there are both pros and cons to standardization of the role, there are potential benefits that should be considered. Below are several high-level policy recommendations that are based on finding from this study.

- Statewide certification and training for peer providers may ensure high quality training and competency standards in peer support. Establishing statewide certification and training standards may enhance the visibility and legitimacy of peer providers.
- Defined state requirements for training and certification would help meet the requirement for billing Medicaid for peer support and could lead to more sustainable funding for peer provider employment.
- With the launch of several new, state level and local initiatives that have the option for peer support components, it may be useful to establish a learning collaborative for training and resource-sharing to prepare organizations for implementation of successful peer support programs.
    - This type of program would become even more vital if statewide training and certification is established.
    - A forum for peer provider programs in forensic and hospital discharge programs to share best practices to be shared across sites could be useful to assist and build new programs.

- Peer provider programs in transitional settings show considerable promise in reducing re-hospitalization and recidivism. However, they may be more effective if greater direct access to hospital and jail/prison populations is possible prior to release.
- Additional research on the efficacy of these types of transitional programs is needed to establish what models and elements of these models are most effective in reducing re-hospitalization and re-incarceration.

Conclusion

Transitional peer provider programs such as hospital discharge and forensic programs are similar in the services provided and the role of peer providers. Peer providers can play an important role in transitional programs because of the rapport they establish with consumers and because they can provide linkage to services and support after discharge.

Some research suggests that these programs may have the potential to reduce recidivism and hospitalization rates in California. However, there is relatively little peer-reviewed research on the outcomes of transitional programs. While there are more studies on peers in transitional programs from inpatient hospitalization than from jail settings, outcome findings from the studies are often inconclusive. To be successful, transitional peer provider programs require considerable collaboration between the programs employing the peer providers and hospital and correctional facilities.

Greater recognition and legitimization of the peer provider role could enhance program success by increasing peer provider access to work with participants at host sites (hospitals and jails). Peer providers have the potential to become an important part of the California behavioral health care workforce and could help alleviate current and future workforce shortages in public behavioral health.

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Appendix A

Program Descriptions

Service Connect, San Mateo County

Program:	Service Connect
Location:	San Mateo
Program Type:	Incarceration
Organization:	San Mateo Human Services Agency, San Mateo Behavioral Health and Recovery Service; San Mateo County Sheriff's Office, San Mateo Correctional Health, and San Mateo County Probation Department
Funding Source:	AB 109, County General Fund
Number of Consumer Peer Providers:	3: one peer mentor coordinator, one peer mentor, one peer support worker
Number of Family Peer Providers:	0
Caseload:	20
Employment Status:	2 consumer peers are county employees; 1 consumer peer is contracted
Time Base:	Full-time
Worksite:	County office and in the field
Training:	"Home-grown" curriculum, including motivational interviewing, boundary-setting, and other topics
Population:	Individuals who live or plan to live in San Mateo County, and who are enrolled in Post-Release Community Supervision (PRCS) or who served their sentence in county jails under the 1170h program, as well as those who served a sentence in county jails identified at moderate or high risk of recidivism
Services:	Medical referrals; benefits screening; mental health services; substance use recovery, peer support, vocational counseling, job training and linkages, family support
Follow-Up Period	12 to 36 months
Outcome Measures:	Employment placement, reduced recidivism
URL	http://hsa.smcgov.org/service-connect

Service Connect is a "one-stop shop" for formerly incarcerated individuals to help them reintegrate into the community. This is an interagency partnership within San Mateo County and includes non-profit partners. Service Connect provides case management; employment services; behavioral and physical health services, including dental care; moral reconation therapy; and assistance with accessing temporary emergency shelter, emergency food, clothing and transportation vouchers, personal hygiene kits, and assistance obtaining California identification documents.

Goal: To work in collaboration with partner agencies to promote self-sufficiency and reduce recidivism.

Peer Roles/Tasks: There are currently three consumer peer providers working in this program. Two are employed by HSA, and one is employed by BHRS. A bilingual family peer provider shares time from another program to work with the families of incarcerated individuals to understand better mental illness and the jail and court system.

Peer mentors work in teams with other staff such as LCSWs, benefits analysts, and vocational rehabilitation counselors on the Health Services Agency side as well as with case managers, LCSWs, LMFTs, psychiatrists, and others on the Behavioral Health Side. While the HSA team focuses on referral and linkage to basic needs, housing, and employment services, the BHRS team focuses more on mental health and substance recovery issues. Consumer peer mentors work closely with their teams and across teams. Peer mentors can meet with referred participants two weeks prior to release to help plan for needs post-discharge. They can assist in transporting participants to appointments, including court, medical, and benefits and stay with participants through these appointments. They may facilitate wellness and support groups and administer screening to make referrals to further alcohol and drug and mental health assessments. They also provide peer 1:1 support by listening to and acknowledging participant concerns.

Triage Navigator Program, TLCS Inc., Sacramento

Program:	Triage Navigator Program
Location:	Sacramento
Program Type:	Hospitalization, short-term incarceration, homeless center
Organization:	TLCS (Transforming Lives, Cultivating Success), Inc.
Funding Source:	SB82 / MHSA grant
Number of Peer Providers:	8 peer navigators, 8 triage navigators
Caseload:	Up to 50
Employment Status:	Community based organization (CBO) employees
Time Base:	Full-time
Worksite:	Triage navigators: 4 hospital systems, county jail, homeless center. Peer navigators: main office and in the community.
Training:	WISE (Workforce Integration Support and Education), Motivational Interviewing; Pro-ACT de-escalation, ASSIST Suicide Prevention Training.
Population:	People transitioning from short-term hospitalization, short term jail (24 hours or less), and homelessness
Services:	Crisis intervention and safety planning, help accessing mental health services, primary care, employment services, alcohol or substance abuse services, financial assistance services, and other social services as needed; peer support, wellness education
Follow-up period	60 days
Outcome Measures	Improve client experience, reduce unnecessary inpatient and incarcerations, mitigate unnecessary expenses, and grow collaborations
URL	http://tlcssac.org/services

The Triage Navigator program is a collaboration between the Sacramento County Department of Behavioral Health Services and TLCS, Inc., a non-profit mental health and housing services organization. While TLCS has housing facilities, TLCS does not provide housing through the Triage Navigator program. Peer navigators help participants find housing resources and listings in the community.

Program Goals:

- To improve client experience for those experiencing a mental health crisis
- Reduce unnecessary inpatient hospitalizations
- Reduce unnecessary incarcerations
- Mitigate unnecessary expenditures of law enforcement
- Increase the number of community agencies collaborating to support individuals

Peer Support Roles/Tasks: The Triage Navigator program employs triage navigators, who may or may not have lived experience, work onsite at hospitals, the county jail, and the homeless center. They do intake and assessment of potential program participants, and can spend time with participants. The triage navigator can connect the participant with resources and a peer navigator. The peer navigator works in the community with participants to help them access resources and transition back into the community. The peer navigator requires lived experience and access to a personal car to meet with and transport participants. Peer navigators call potential participants and develop a plan with them so they can achieve their goals. The peer navigator meets with the participant at least once a week for 60 days to help them with mental health and substance use linkages as well as helping them find resources to meet their basic needs such as food, housing, transportation, phones, and benefits.

Mentor on Discharge®, NAMI Alameda County South

Program:	Mentor on Discharge
Location:	Alameda County
Program Type:	Hospitalization
Organization:	National Alliance on Mental Illness (NAMI) Alameda County South
Funding Source:	MHSA (Mental Health Services Act (CA Prop 63)) funded contract with Alameda Health System for uninsured and publicly insured patients. Additionally, funded by a Kaiser Permanente Community Benefit grant for privately insured patients.
Number of Peer Providers:	12 peer mentors
Caseload:	4-8
Employment Status:	Community based organization (CBO) employees
Time Base:	Part-time
Worksite:	Primarily in the community, but early meetings in John George Hospital (and Telecare Heritage Hospital) facilitate seamless transition back into to the community
Training:	Steven Pocklington: The Art of Facilitating Self-Determination (40 hours)
Population:	Hospitalized two times in the prior 12-month period
Services:	Mentoring, coaching for empowerment, assistance with community linkages such as housing, obtaining a phone, WRAP classes, and other support groups.
Follow-up period	6 months
Outcome measures	Reduced rate of re-hospitalization
URL	http://www.namiacs.org/mod.html

The Mentor on Discharge® program is facilitated by NAMI Alameda County South, subcontracted by Alameda Health System with funds from the Mental Health Services Act (Prop 63) through Alameda County Behavioral Health Care Services.

An earlier Innovation and evaluation program found this program to be effective in reducing the rate of re-hospitalizations by over 70% and extended the amount of time for the remaining cohorts from an average of two to six months between hospitalizations. Other program administrators are also piloting this model in other bay area counties; they are evaluating it in order to replicate the program more broadly.

Goal: To reduce the rate of hospitalization among the participant by facilitating the participant being more critical in his or her thinking; and by inspiring the participant to actively seek recovery resources.

Peer Support Roles/Tasks: The mentor role is different from the peer provider role in that the mentor's role is not primarily to link the individual to services, but to listen and offer support to the participant so that the participant can become more self-directed. The peer mentor works with the participant to access resources and services in the community, but this is a less central task than in peer navigator programs. A social worker in the hospital screens patients and makes referrals for those they determine could best benefit from being connected with a peer mentor. The peer mentor meets with the participant in the hospital as the participant prepares for discharge, and then further develops the relationship with the participant in the community for up to six months or longer, if needed.

Next Steps, NAMI San Diego

Program:	Next Steps
Location:	San Diego
Program Type:	Hospitalization
Organization:	National Alliance on Mental Illness (NAMI) San Diego (lead), in conjunction with Family Health Centers of San Diego, Mental Health Systems Inc., and Union of Pan Asian Communities of San Diego
Funding Source:	Initially an MHSA Innovation grant; now County of San Diego, Health and Human Services Agency, Behavioral Health and the Mental Health Services Act
Number of Peer Providers:	14 consumer peer specialists and 3 health navigators. There are also 5 family peers.
Caseload:	Peers working in the hospital have no caseload; community peers and health navigators: 8-15 depending on client level of need
Employment Status:	Community based organization (CBO) employees
Time Base:	Most are full-time (30-40 hours)
Worksite:	Offices co-located with County Hospital. Hospital peers work in the emergency room and in the inpatient unit; community-based peers work primarily out in the community; family peers work in the emergency room and in the inpatient unit. .
Training:	Peer Employment Training (PET), RI International; Pacific Clinics Training Institute for health navigation (72 hours)
Population:	Adults experiencing short-term hospitalization in the San Diego County Hospital and their families. Adults referred from county-operated outpatient clinics, DUI programs, and an AOD, and walk-ins.
Services:	Recovery-oriented services including information on community resources, linkages to mental health, physical health and substance abuse services, assistance in obtaining benefits, health navigation, coaching / mentoring, peer and family member support.
Follow-up period	90 days
Outcome measures	Program tracks services provided including those discussed, referred, linked, and, connected (client-accessed service.) Categories include physical, mental and social health; substance abuse, housing, occupation/education, financial assistance/benefits, transportation, identification, and basic needs. Additional evaluation work is underway.
URL	https://namisandiego.org/services/next-steps/

NAMI Next Steps is a collaborative partnership between NAMI San Diego as the lead agency and Family Health Centers of San Diego, Mental Health Systems, Inc., and Union of Pan Asian Communities of San Diego. The program has offices on the San Diego County Psychiatric Hospital campus and in the hospital ward.

Goal: to support and educate participants to successfully navigate the behavioral and physical health care systems as they reintegrate into the community.

Peer Support Roles/Tasks: Peer specialists work in the hospital emergency room, in inpatient units, and in the community to engage participants and help them plan for discharge. Pre-discharge, family peers will meet with the patient's family in the lobby, if there is family involvement, to try to get the family involved in support networks. If a person is brought into the emergency department but not admitted, the hospital peer specialist will meet with them and try to connect them to the program and resources. Those patients who are admitted may work with hospital peer specialists in the hospital. Post-discharge, community peer providers help participants integrate back into the community with 90 days of follow-up. Health navigators with lived experience help participants navigate the health care system, make linkages to primary care providers and specialists, and advocate for patients. Family peers support family members and help them understand the mental health system and how to work with their family member on discharge.

Intensive Service Recipient, Kin through Peer, Los Angeles County

Program:	Intensive Service Recipient (ISR) and Kin through Peer (KTP)
Location:	Los Angeles
Program Type:	Hospitalization
Organization:	Los Angeles County Department of Mental Health and Los Angeles County Department of Health Services
Funding Source:	Two Whole Person Care Grants
Number of Peer Providers:	40
Caseload:	ISR=29:1 KTP = 10:1
Employment Status:	County employers and registry staff (transitional)
Time Base:	Fulltime
Worksite:	Some office; most in the field
Training:	ISR: Training from The Worker Education & Resource Center (WERC); other extensive internal training including motivational interviewing; KTP: The Depression and Bipolar Support Alliance
Population:	ISR: On a DMH-generated list, or serious mental illness; at least 4 inpatient psychiatric admissions in the past 12 months. KTP: Adults 18 + with Serious Persistent Mental Illness (SPMI), including co-occurring substance use disorders who have had at least 4 psychiatric in-patient hospitalizations within the last 12 months. Lack of healthy family relations or significant social isolation
Services:	ISR: "ongoing monitoring and follow-up, including home visits; Accompaniment to appointments with physical and mental health and SUD providers; Crisis support services; Transportation; Benefits establishment; Assistance with life skills; Assistance with emergency food, clothing and other basic goods; educational and vocational support; requests for legal documents and legal assistance; navigation to permanent housing; and hand-off to FSP program after 90 days."
Follow-up period	ISR: 90 days; KTP: 1 year
Outcome measures	Reduce hospitalization and enroll 50% of participants into a Full-Service Partnership (FSP) by end of program
URL	https://dhs.lacounty.gov/wps/portal/dhs/wpc

Intensive Service Recipient (ISR) and Kin through Peer are very new pilot programs funded through the statewide Whole Person Care initiative. Los Angeles County has several WPC grants, but for the purposes of this study, we focus on these two programs that are administered by the Department of Mental Health.

Goals: The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. A specific goal is to reduce inappropriate emergency department and inpatient utilization. Kin through Peer focuses on providing supportive relationship to those who have no family or social support.

Peer Support Roles/Tasks: Peer providers meet with their teams every morning in the office and prepare for their day in the field. Teams are provided with cars with which they can meet with participants in the community. The peer provider can help participants reinstate their insurance and benefits, make medical appointments, access food, procure a new ID at the DMV, and transport participants from the hospital and to appointments and resources. They can stay with the participant through various appointments and help the participant reconnect to community by taking the participant to a café, the movies, or on a walk—particularly in the Kin through Peer program.

Mentoring and Peer Support (MAPS), San Francisco County

Program:	Mentoring and Peer Support (MAPS)
Location:	San Francisco
Program Type:	Incarceration
Organization:	San Francisco Collaborative Courts system; San Francisco Department of Public Health (SFDPH). Healthright 360 is the fiscal sponsor.
Funding Source:	SAMHSA BHTCC grant
Number of Consumer Peer Providers:	6: one lead peer mentor supervisor, 5 peer mentors
Caseload:	10-14
Employment Status:	Contracted
Time Base:	Half-time
Worksite:	In the field
Training:	Primarily Richmond Area Multi-Services (RAMS)
Population:	Client of the San Francisco Collaborative Courts, non-violent, dually diagnosed.
Services:	Assistance with navigating community resources including transportation, mobility, housing, decision-making, assistive technology, language, government programs, cultural adjustment, immigration services, food assistance, legal assistance, women's services, medical assistance, mental health services, vocational services, volunteerism, and education programs, etc.
Follow-Up Period	6 months
Outcome Measures:	Reduce recidivism, demonstrate client and staff satisfaction
URL	(none)

MAPS is a project the serving clients of the San Francisco Collaborative Courts System, which includes the Behavioral Health Court; the Drug Court; and the Veterans Justice Court.

Goal: "The overarching goal of the program is to significantly enhance client outcomes in regard to substance use, mental health issues, employment, housing, and criminal justice recidivism, while offering opportunities for participating peer mentors to receive job experience and training and to move on to successful careers following the conclusion of the program."

Peer Roles/Tasks: There are currently six consumer peer providers working in this program. One is a lead peer mentor supervisor, and the others are peer mentors.

Peer mentors work out of a small office located in the San Francisco County Jail. They meet daily to review caseloads and discuss plans for their participants. They follow up with participants by phone and in-person, meeting with them up to several times a week. This program is unusual in that all of the peer mentors have jail clearance and can meet with participants prior to discharge to plan for reentry. They can help mentees access housing, benefits, transportation, and recovery services, as well as provide emotional support and social activities. They can accompany participants to court, medical, and benefits appointments.

New Life AB109 and Peer Navigation Center, Riverside University Health System – Behavioral Health

Program:	1. New Life AB109 (4 outpatient clinics, 2 crisis residential treatment centers, and 2. Day Reporting Center); Peer Navigation Center
Location:	Riverside County
Program Type:	1. Incarceration 2. Hospitalization
Organization:	Riverside University Health System – Behavioral Health
Funding Source:	1. AB 109; 2. Medicaid
Number of Peer Providers:	1 peer mentor at each of the four clinics, 1 peer mentor at the Day Reporting Center; 6 peer mentors at the Peer Navigation Center (133 consumer peer providers system-wide; in addition, there are 25 parent partners and 28 family advocates)
Caseload:	AB109 clinics: 17-18
Employment Status:	County employees, Union
Time Base:	Full-time
Worksite:	Day Reporting Center, Clinics; Peer Navigation Center
Training:	Initial: RI International Peer Employment Training (72 hours). Additional training through the County.
Population:	Newly released from jail and prison, 3 months to 30 years; Newly discharged from county hospital
Services:	1. Substance Abuse Education, Anger Management, Wellness Recovery Action Plan (WRAP), WELL (Wellness & Empowerment in Life & Living), Criminal and Addictive Thinking, Courage to Change interactive journaling, Parent Support Services, GED, assistance obtaining Cal Fresh, help with child support issues, Workforce Development Center, Interview clothing, kitchen 2. Linkages to MH and SUD resources, wellness tools, assistance with accessing healthcare, budgeting, positive social activities, placement in sober living and temporary housing, search for low-income housing.

The Day Reporting Center is a multi-agency initiative that is part of the organization's New Life AB109 program. The DRC is a collaborative effort between the Probation Department, Riverside County Office of Education, the Department of Mental Health, Veterans Affairs, the Department of Public Social Services, and other agencies. This program also has four associated clinics for AB109 participants in Riverside County, each with two peer providers.

Goal: The program is designed to reduce recidivism and build self-sufficiency among participants by addressing the root causes that lead to re-offending.

Peer Roles/Tasks: The peer provider at the DRC engages participants by greeting them in the communal areas of the center. The peer provider facilitates WRAP groups and helps participants access other wellness tools and community resources, including provider networks and health care, substance use and mental health resources, housing, and sober living facilities. The peer provider can also assist with filling out forms, budgeting, and locating positive extracurricular activities.

At the clinic sites, the peer providers work with individuals to build skills for self-sufficiency. They can provide transportation and accompany participants to appointments and mental health court.

The Peer Navigation Center is located on the grounds of the Riverside Community Hospital. The Peer Navigation Center is a relatively new program intended to establish rapport with consumers prior to discharge and provide them with support for physical and mental health and substance use services post-discharge.

Goals: Get the participant to follow-through with a medical appointment with a physician within seven days of discharge, establish connection with primary care service agency/clinic, and peer support at that site within 60 days with 90 days of total follow up.

Peer Roles/Tasks: Peer providers review the hospital census, meet with clinical teams, and follow-up with patients onsite prior to discharge when possible. Peer coaches can accompany/transport participants to the pharmacy and medical appointments and coach them for their visits. They can phone participants for check-ins and reminders. Once the participant is established with a new clinic and peer provider at that clinic, there will be joint sessions for a period of time before the participant is left with their new site.

Santa Clara County Reentry Center and Faith Based Collaborative

Program:	Santa Clara Reentry Program (Behavioral Health) and Faith Based Collaborative
Location:	Santa Clara County
Program Type:	Incarceration
Organization:	Santa Clara County Behavioral Health Services Department
Funding Source:	AB109 and MHSA
Number of Peer Providers:	3 (2 associated with behavioral health; 1 with the Faith Based Program) Does not include others affiliated with probation and contractor groups.
Caseload:	N/A
Employment Status:	County employees, Union
Time Base:	Fulltime
Worksite:	Reentry Resource Center; some offsite
Training:	Lived experience, internal post-employment training
Population:	Released from jail or prison in the last 12 months and a resident of Santa Clara County or eligible for services in the county
Services:	Intake and assessment (AB109), intensive case management for parolees, one-touch service, alternative custody programs, housing referrals and deposit assistance; referrals to SUD and mental health treatment, employment, vocational training, education, and legal aid; assistance with obtaining an ID, bus passes, clothes closet, food pantry, computer literacy lab, expungement services, transitional case management, general assistance benefits; onsite mobile primary care clinic, family support, connection to faith community.

The Reentry Resource Center is a Collaborative, multi-agency initiative that is part of the organization's AB109 program. This program includes the Office of the County Executive, the Office of the Sheriff/Department of Correction, Behavioral Health Services Department, Custody Health, Ambulatory Care, Social Services Agency, and Probation, along with a number of faith-based organizations. The Faith Reentry Collaborative can connect participants with additional resources not available through the Behavioral Health Services Department. The four Faith Based Centers can serve anyone regardless of religious orientation. Because these contracted programs have more flexible funding, they can often target individual participants' needs, such as clothing. An additional benefit of the Faith Based Centers is that they may be more comfortable for some participants who are uncomfortable with the presence of law enforcement officer at the Reentry Resource Center.

Goal: Reduce recidivism by using evidence-based practices in implementing a seamless system of services, supports, and supervision.

Peer Roles/Tasks: The peer mentors with the behavioral health group meet with participants and assess their needs. The peer mentor can help participants access community resources, health care, substance use and mental health resources, housing lists and deposit assistance, procuring identification cards, obtaining benefits, and sometimes food and clothing. The peer mentor in the faith-based program can connect participants with any one of four faith-based reentry resource centers. Faith-based peer mentors can meet with participants pre-discharge and assist with discharge planning.