

NO. 6: WHY PEER-OPERATED? AN ESSENTIAL INGREDIENT TO INNOVATIVE CRISIS ALTERNATIVES

Partnering with consumer- and peer-operated services programs provides a unique opportunity for states to honor and uphold the role of peer support in crisis alternatives as a complement to clinical services.

Background

Peer support occurs naturally in communities throughout the world. Every person who has received support from someone else with shared experience can understand the power of peer-to-peer relationships. When facing challenges, a connection with someone who can offer wisdom, “lessons learned,” and non-judgmental support can be affirming – helping to make the experience more hopeful and less lonely. Many states are examining ways to leverage peer support services to broaden the array of trauma-informed and person-directed care within their behavioral health crisis continuum. A first step is to ensure a comprehensive understanding of the values, roles, and expectations of peer support, including what makes it distinct from any other service or setting in behavioral health. Partnering with consumer- and peer-operated services programs (COSPs) provides a unique opportunity for states to honor and uphold the role of peer support in crisis alternatives as a complement to clinical services.

Models/Structures for Peer Support Services

There are three structures to the organizations that typically provide peer support services:

PEER STAFFED/ INTEGRATED	PEER-RUN PROGRAMS	PEER-OPERATED ORGANIZATIONS (Consumer-Operated Services Programs)
<ul style="list-style-type: none"> Behavioral health agencies employing peer support specialists All leadership, authority, and finances lie within the clinical agency. 	<ul style="list-style-type: none"> Programs operated under or through a behavioral health organization. Program directors and staff are peer supporters Directors have some decision-making authority but finances and ultimate decisions lie within the clinical agency. 	<ul style="list-style-type: none"> Ensure individualized crisis plans and utilize <u>WRAP</u> to enhance support, promote wellness, and mitigate crisis. Peer-run organizations that are independent of clinical agencies Staff, leadership and boards are primarily persons with lived behavioral health experience All decisions and finances are made by staff and board with lived experience Operate through peer support values and often utilize the Fidelity Assessment Common Ingredients Tool (FACIT) fidelity tool



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While there are benefits and challenges in each of these structures, there are distinct advantages to states in supporting standalone peer-operated organizations. For instance:

- Peer-operated agencies operate with authenticity to peer support and place intentional value on mutuality, low or no barriers to access, minimal power imbalances, and support for personal determination and voice. These programs are designed to advance recovery and promote healing from trauma.
- Peer-operated agencies are unlikely to co-opt peer supporters into pseudo-clinical roles such as case management, monitoring, or advising people receiving services.
- Peer-operated organizations are highly connected and led by the community. This allows them to view mental health and substance use challenges through a broader lens; to co-design innovative and culturally relevant healing alternatives; and to attract and engage individuals who might not otherwise seek out or receive behavioral health services (e.g., individuals with previous traumatic experiences in the behavioral health system, older adults who use substances, BIPOC, and Veterans experiencing homelessness).

Peer-Operated Innovations for Crisis Prevention, Diversion, and Alternative Responses

Peer support provides the healing power of connection and supports recovery and wellness that can [de-ter the need for clinical intervention](#). There are several examples of peer-operated approaches that have proven to be effective in preventing and diverting individuals from the “traditional” clinical crisis system.

1. **Peer Respite** is an alternative crisis environment centered in healing, wellness, connection, and recovery, and has been shown to increase empowerment, promote recovery and hope, and [reduce rehospitalizations](#). Key features of respite include:
 - An alternative to emergency departments, inpatient admission, and involuntary commitment
 - Voluntary and noncoercive
 - Provided in a safe and homelike environment in a house in the community (not on a unit or at a center)
 - Operates 24/7
 - Provides short-term non-clinical crisis support that is focused on supporting people to find a new understanding of crisis and ways to “heal forward.”
 - Staffed and operated completely by individuals with lived experience of behavioral health conditions, psychiatric histories, trauma, and/or extreme states
2. **Peer Lines/Warmlines** provide crisis prevention and diversion, serving as a non-clinical alternative for individuals experiencing extreme distress or crisis:
 - All calls are answer by trained peer support staff
 - Ideally available 24/7
 - Provides an affirming, validating, and confidential connection for individuals experiencing distress and crisis
 - Accessible through chat, text, and call



Recommendations for States to Support and Enhance Peer Support Services

1. Identify and meet with currently active standalone peer-operated mental health and substance use organizations and recovery community organizations to understand their scope and capacity.
2. Identify gaps in your state's existing Medicaid- and state-funded array.
3. Identify start-up, pilot, and sustainable funding for capacity-building and operations of standalone peer-operated agencies.
4. Invest in capacity-building for peer-operated agencies.
5. Close the equity gap through intentional investment in traditionally under-resourced peer-operated agencies and by investing in leadership development.
6. Ensure collaboration between crisis continuum providers and peer-operated alternatives and take steps to ensure crisis provider networks have an understanding of the role of peer support staff.

NO. 7: EFFECTIVE STRATEGIES FOR COORDINATION WITH HOUSING SYSTEMS AND LAW ENFORCEMENT

Providing an array of responses is an effective way for states to reduce law enforcement encounters for individuals with behavioral health conditions.

Background

The experience of homelessness has the potential to create or exacerbate behavioral health symptoms. Crisis providers often respond to individuals who are experiencing homelessness and also having a behavioral health crisis. States are beginning to reimagine their behavioral health crisis response systems, but in many places – particularly rural and other areas with inadequate resources – law enforcement is still the default responder to these situations. Individuals experiencing homelessness are more likely to have law enforcement called on them, particularly when in crisis. Furthermore, this likelihood can be heightened by bias based on perceived characteristics (e.g., race, gender, and age).

Strategies that promote deflection from unnecessary and potentially traumatizing interactions with law enforcement require cross-sector planning and real-time coordination. Effective coordination between crisis providers, homelessness service providers, and law enforcement is necessary to ensure a comprehensive crisis system that responds to *all* the needs of the individual and facilitates access to services that can address [social determinants of health](#).

Strategies for Cross-Sector Collaboration

1. Center crisis system planning and implementation on lived experience, with the driving goal of creating equitable and trauma-informed systems.
 - ✓ Establish an interagency task force with shared decision-making and with representation from all necessary community partners, including behavioral health (mental health and substance use treatment) providers, government partners, persons with lived experience, community-based organizations and social services agencies, housing and homelessness providers, law enforcement, and community advocates.
2. Provide cross-training to ensure role clarity, smooth partnerships, bidirectional referrals, and shared understanding of resources.
 - ✓ **Crisis providers** can train homeless service providers and law enforcement personnel on available crisis services, signs/symptoms of behavioral health crisis and overdose, and de-escalation techniques.
 - ✓ **Homeless service providers** can train crisis providers on coordinated entry assessment, the Department of Housing and Urban Development (HUD)'s [Continuum of Care \(CoC\)](#) and housing system, and effective engagement strategies for people experiencing homelessness.
 - ✓ **Service providers** (crisis and homeless system) should facilitate specialty trainings for law enforcement on topics such as behavioral health, de-escalation, and homeless resources and engagement.
 - ✓ Service providers can attend law enforcement roll call (shift change) to establish relationships and enhance awareness of programs and resources.



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3. Ensure real-time information-sharing through the following strategies:
 - ✓ Data sharing agreements and informed consent to share information in compliance with [the Homelessness Management Information System \(HMIS\)](#), [HIPAA \(Health Insurance Portability and Accountability Act of 1996\)](#), and [42 CFR Part 2 regulations](#)
 - ✓ Use memorandums of understanding (MOUs) to formalize partnerships and roles between crisis system and Continuum of Care members.
 - ✓ Integrate Homeless Management Information System (HMIS) and electronic health records to streamline intakes and communication between crisis providers and homeless system providers.
 - ✓ Encourage homeless services providers to collaborate with crisis providers on locating and coordinating with individuals who are unsheltered.
 - ✓ Encourage crisis providers to proactively engage homeless providers on the best ways to contact an individual's homeless system provider, in order to garner as much information as possible to support crisis triage and response, and to facilitate a transition back into services once the individual is stabilized.

4. Ensure timely follow-up services, warm handoffs (i.e., transferring an individual from one provider to another in person and with the referring participant present, utilizing a foundation of trust and respect), and smooth communication among services.
 - ✓ Ensure quick hand-offs from law enforcement and warm-handed referrals with crisis providers.
 - ✓ Establish a dedicated call line between crisis providers and law enforcement in order to prioritize timely response and deflect law-enforcement-led responses when appropriate.

5. Consider strategies to improve law enforcement response to behavioral health crises, including co-locating behavioral health professionals in 911 call centers; diversion; co-response; and warm handoffs.
 - ✓ Collaborate to analyze 911 calls that could be served by an alternative response in order to quantify the needs and define services.
 - ✓ Interventions should provide the least restrictive response appropriate for each situation. If the situation does not require law enforcement, then it should not involve law enforcement.

PROGRAM SPOTLIGHT: PROMOTING SYSTEM CHANGE THROUGH COLLABORATION

The Policing Alternatives and Diversion (PAD) Initiative

Providing an array of responses is an effective way for states to reduce law enforcement encounters for individuals with behavioral health conditions. Non-emergency responses can support crisis prevention through connections to upstream services that address social determinants of health. A community in Atlanta, GA worked collaboratively to ensure a continuum of responses. The Policing Alternatives and Diversion (PAD) Initiative utilized a collaborative model to bring together legal partners, city agencies, directly impacted community members, and service providers to plan an alternative response. PAD provides alternative first response dispatched through the city's 311 line for concerns related to mental health, substance use, or extreme poverty, as well as diversion from jail for individuals detained by police. By connecting marginalized residents to community resources, PAD offers a new approach to community safety and wellness that reduces reliance on law enforcement and incarceration.



PAD utilized a collaborative design to engage directly impacted community members through listening sessions, surveying residents about service provision needs and designing protocols with stakeholders. The model focuses on connection and collaboration between community members, social service providers, local government, and specialized responders to take a holistic approach to community wellness. PAD aids in crisis prevention by increasing the accessibility and connection to services and resources with a three-pronged approach:

- **Community First Response:** On-scene outreach to individuals referred through the 311 non-emergency city services line for common quality-of-life concerns
- **Pre-Arrest Diversion:** Warm handoff by law enforcement when an individual has been detained and appears to have needs related to substance use, mental illness, or extreme poverty.
- **Care Navigation:** Direct support for basic needs and long-term case management for people with criminal justice system involvement.

Implementing PAD services required extensive collaboration with justice partners, including:

- An intergovernmental agreement to develop and guide a diversion strategy with equal representation from city, county, and community agencies.
- An operational working group with public safety including law enforcement and service providers to review diverted individuals monthly to resolve legal barriers.
- Coordination with public safety partners to ensure warm-handed referrals for services.
- Coordination with court and hospital systems to create referrals, track progress, and coordinate care for individuals.
- Analysis of 911 calls to determine appropriate call types for deflection, and of arrest data to determine frequent charge types that should be targeted for diversion.

Policy Recommendations for State Behavioral Health Authorities

- Use data on local jail bookings and 911 calls for services to inform the design of interventions that will reduce incarceration for people with behavioral health needs.
- Make sure officers are aware of and engaging with crisis and non-crisis behavioral health resources, including any diversion strategies; provide training on engagement strategies.
- Identify and invest in a continuum of behavioral health responders who can provide emergency and non-emergency response for concerns related to behavioral health conditions.
- Invest in a public infrastructure that proactively meets people's basic needs and addresses social determinants of health.
- Ensure safe, supportive, low-barrier, non-congregate shelter, and increase investments in housing solutions.
- Leverage state, federal, and private investments to enhance crisis services, mental health care, substance use treatment, and harm reduction programs.

