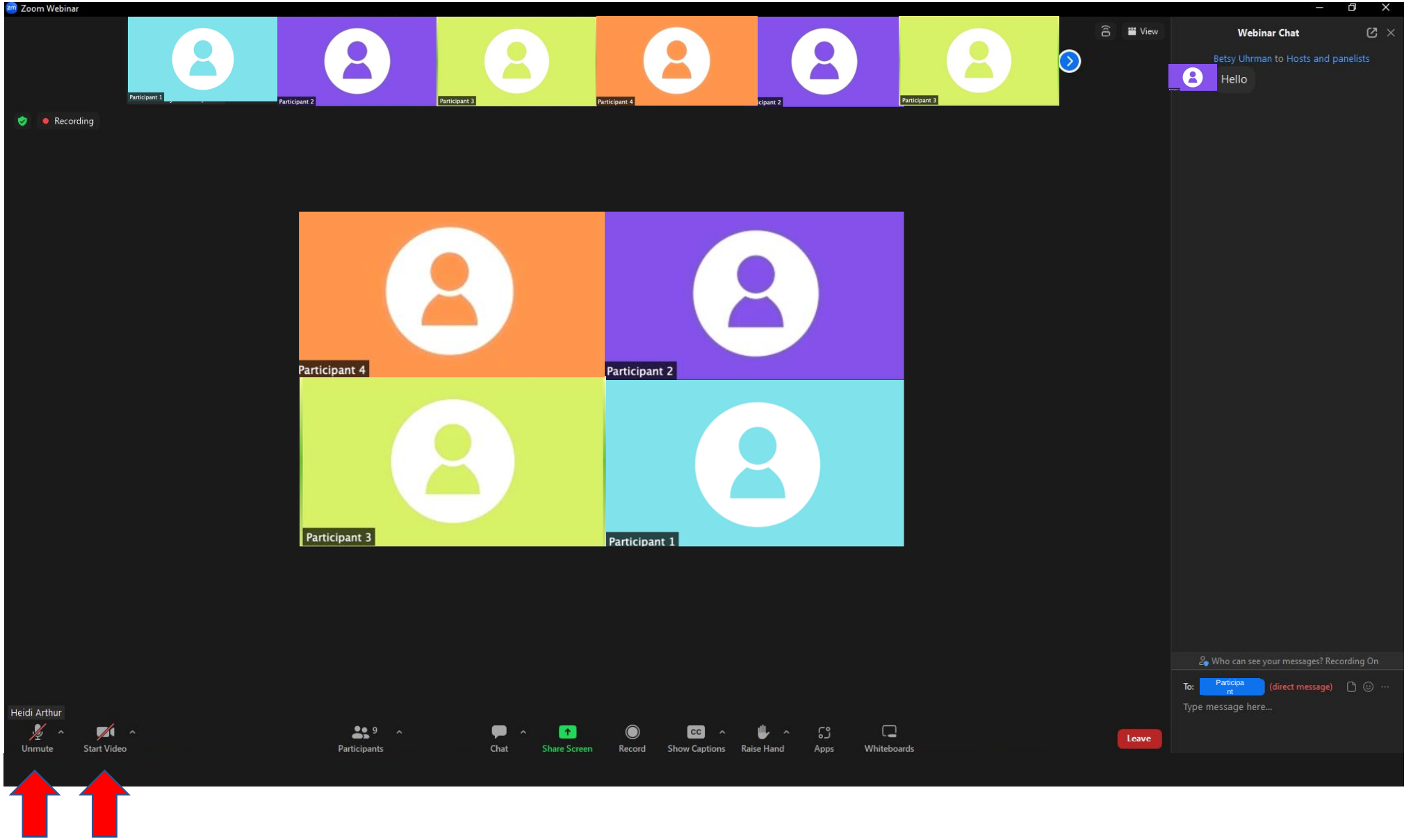
Peer Supporter Workgroup

Meeting 1
June 11, 2024

Webinar: Panelist View



Webinar View: Attendee

- Workgroup members will be able to utilize the chat function throughout the meeting. Chat messages cannot be seen by non-workgroup members, but they will be captured in the public meeting summary.
- Workgroup members will be asked to use the "raise hand" function when you would like to speak.

Agenda

1. Review of Agenda and Session Objectives (5 min)
2. Level Setting on AB988 and Workgroups (10 min)
3. Discussion of Peers Supporters in the Crisis System (60 min)
4. Public Comment Period (10 min)
5. Next Steps (5 min)

Workgroup Members

- **Co-Chair,** Keris Jän Myrick, Inseparable
- **Co-Chair,** Rayshell Chambers, Painted Brain
- Deborah Diaz de Leon, NAMI Orange County
- Gwen Schrank, Schrank's Clubhouse & Peer Connect and Collaborate Coalition
- Jana Spaulding, Setup4Success
- Jason Robinson, SHARE
- Kenna Chic
- Lei Portugal Calloway, Telecare Corporation
- Lori Fischer, Telecare AOT/CARE Act
- Michelle Tanner, Pacific Clinics
- Stephen McNally, Brain Health 247
- Susan Gallagher, Cal Voices
- Tiffany Murphy, Consumers Self Help Center
- Tina Robinson, Owning My Own Truth
- Vanessa Ramos, Disability Rights CA
- Wendy Cabil, Independent Mental Health Care Professional

Public Comment Overview

- **All comments—whether written or spoken—will be shared with the Work Group in the meeting minutes.**
- We will take comments in the order in which we receive sign-ups.
- If you are on Zoom and would like to make a public comment, please raise your hand at any point throughout the discussion. We will then write down your name and call on you to speak during the public comment period.
- Each person will have 2 minute to speak. If you have a condition that may require an accommodation (such as additional speaking time), please notify the project team and we will do our best to provide that accommodation.
- If you would like to make a comment but prefer not to do it in front of a camera or microphone, you may email your written comment to the project email address: AB988Info@chhs.ca.gov.

Code of Conduct

- Presume positive intentions
- Ask from a place of inquiry
- Be present and stay engaged
- Be brief and brilliant
- Be respectful and courteous

Note: Meetings of the Work Group are open to the public and are subject to Bagley-Keene Open Meeting Act requirements

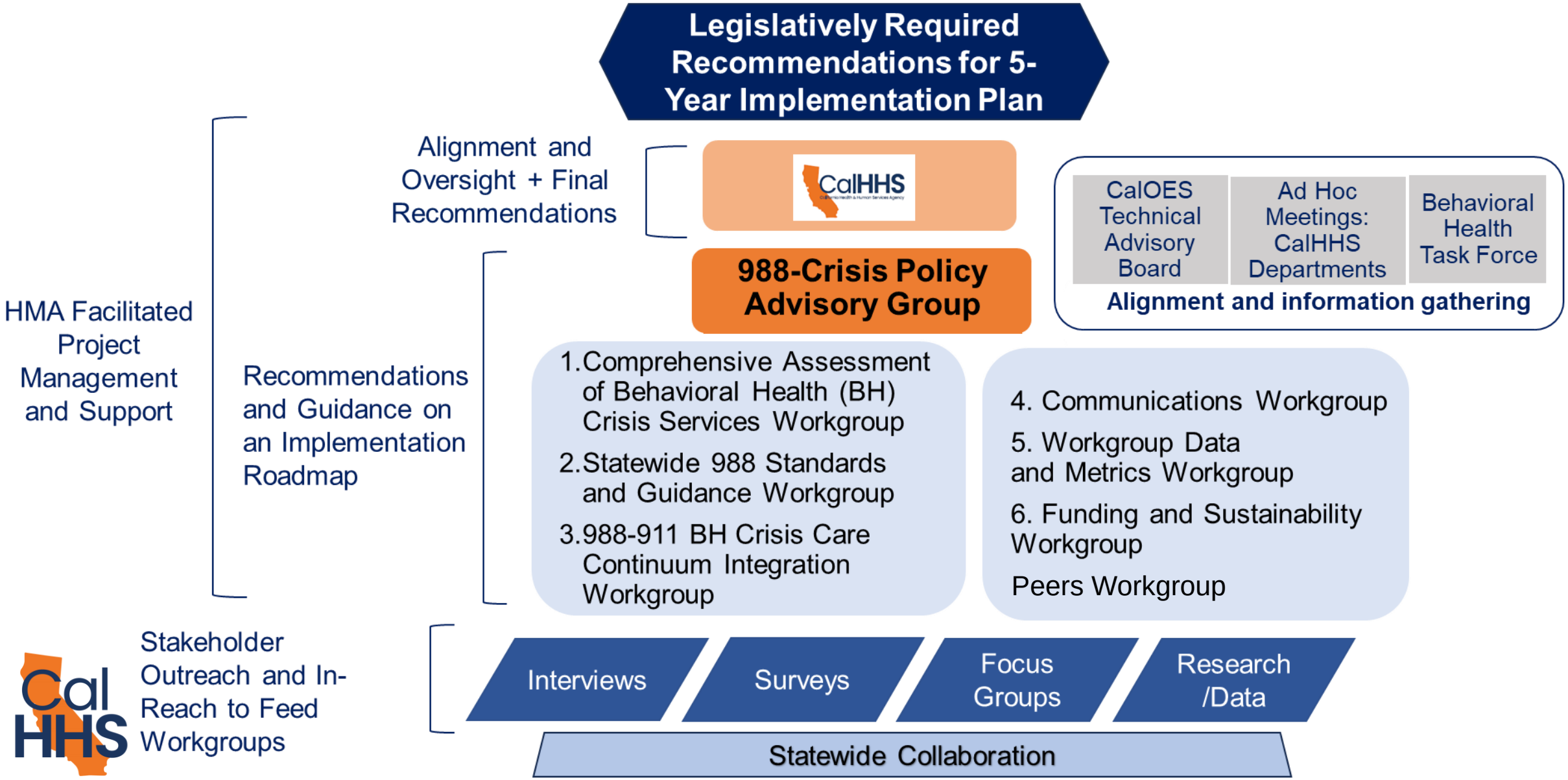
AB 988 Legislation

The Miles Hall Lifeline and Suicide Prevention Act was authored by Assemblymember Bauer-Kahan (AD-16) and enacted in September 2022:

- Creates the 988 State Suicide and Behavioral Health Crisis Services Fund via surcharges on telecom per access line per month
- Requires the California Governor's Office of Emergency Services (CalOES) to convene a state 988 Technical Advisory Board
- Requires CalHHS to convene a state 988 policy advisory group (988-Crisis Policy Advisory Group) to advise on a set of recommendations for the five-year implementation plan for a comprehensive 988 system by December 31, 2024
    - AB 988 underwent further modifications in AB 118, the trailer bill that incorporates the implementing language of the California State Budget.

Source: AB 988, Miles Hall Lifeline and Suicide Prevention Act

AB 988 Organizing Structure



AB 988 Legislation: 14 Requirements

CalHHS and the 988-Crisis Policy Advisory Group must make recommendations on the following:

1: Federal Substance Abuse and Mental Health Services Administration requirements and national best practices guidelines for operational and clinical standards, including training requirements and policies for transferring callers to an appropriate specialized center, or subnetworks, within or external to, the National Suicide Prevention Lifeline network.

2: Maintenance of an active agreement with the administrator of the National Suicide Prevention Lifeline for participation within the network.

3: Compliance with state technology requirements or guidelines for the operation of 988.

4: A state governance structure to support the implementation and administration of behavioral health crisis services accessed through 988.

5: 988 infrastructure, staffing, and training standards that will support statewide access to crisis counselors through telephone call, text, and chat, 24 hours per day, seven days per week.

6: Access to crisis stabilization services and triage and response to warm handoffs from 911 and 988 call centers.

AB 988 Legislation:14 Requirements (continued)

7: Resources and policy changes to address statewide and regional needs in order to meet population needs for behavioral health crisis services.

8: Statewide and regional public communications strategies informed by the National Suicide Prevention Lifeline and the Substance Abuse and Mental Health Services Administration to support public awareness and consistent messaging regarding 988 and behavioral health crisis services.

9: Recommendations to achieve coordination between 988 and the continuum of behavioral health crisis services. Recommendations shall address strategies for verifying that behavioral health crisis services are coordinated for a timely response to clearly articulated suicidal or behavioral health contacts made or routed to 988 services as an alternative to a response from law enforcement, except in high-risk situations that cannot be safely managed without law enforcement response and achieving statewide provision of connection to mobile crisis services, when appropriate, to respond to individuals in crisis in a timely manner.

10: Quantifiable goals for the provision of statewide and regional behavioral health crisis services, which consider factors such as reported rates of suicide attempts and deaths.

11: A process for establishing outcome measures, benchmarks, and improvement targets for 988 centers and the behavioral health crisis services system. This may include recommendations regarding how to measure, the feasibility of measuring 988 system performance, including capacity, wait time, and the ability to meet demand for services for 988 State Suicide and Behavioral Health Crisis Services Fund recipients. This may also include recommendations for how to determine and report the amount billed to and reimbursed by Medi-Cal or other public and private health care service plans or insurers related to 988 services.

AB 988 Legislation: 14 Requirements (continued)

12: Findings from a comprehensive assessment of the behavioral health crisis services system that takes into account infrastructure projects that are planned and funded. These findings shall include an inventory of the infrastructure, capacity, and needs for all of the following:

A: Statewide and regional 988 centers.

B. Mobile crisis team services, including mobile crisis access and dispatch call centers.

C: Other existing behavioral health crisis services and warm lines.

D: Crisis stabilization services.

13: Procedures for determining the annual operating budget for the purposes of establishing the rate of the 988 surcharge and how revenue will be dispersed to fund the 988-system consistent with Section 53123.4 and Section 251a of Title 47 of the United States Code.

14: Strategies to support the behavioral health crisis service system is adequately funded, including mechanisms for reimbursement of behavioral health crisis response pursuant to Sections 1374.72 and 1374.721 of the Health and Safety Code, including, but not limited to:

A: To the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized, seeking to maximize all available federal funding sources for the purposes of behavioral health crisis services and administrative activities related to 988 implementation, including federal Medicaid reimbursement for services; federal Medicaid reimbursement for administrative expenses, including the development and maintenance of information technology; and federal grants.

B: Coordinating with the Department of Insurance and Department of Managed Health Care to verify reimbursement to 988 centers for behavioral health crisis services by health care service plans and disability insurers, pursuant to Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code and consistent with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. Sec. 1185)

Desired Outcomes of the Future CA Crisis System: PAG and Workgroup Input

The Future State… (Adapted from the CCC-P)	Characterized by…
Consistent statewide access	▪ Increased capacity, affordability, and range of services ▪ Connecting people in crisis to immediate and ongoing care
High quality services	▪ An array of essential crisis services across the continuum ▪ A comprehensive strategy for data measurement and quality of care that is inclusive of all populations and geographies
Coordination across and outside the continuum	▪ Offering the least restrictive responses to crisis ▪ Robust formal and informal community-based partnerships
Serves the needs of *all* Californians	▪ Services that are culturally and linguistically responsive ▪ Services that are person- and family-centered ▪ Services are delivered regardless of insurance/payer source

Proposed Components of Future State Crisis Care Continuum

Behavioral health crisis systems strive to serve anyone, anywhere and anytime and fall along a continuum:

Preventing Crisis

Community-based preventive interventions for individuals at risk for suicide or mental health / substance use crises (e.g., Zero Suicide, harm reduction programs, warmlines, peer support, digital-self-help, recovery support services, addressing stigma)

Responding to Crisis

Acute crisis response services, including hotlines, 911 / 988 coordination, mobile crisis teams, social service response, and co-response models

Stabilizing Crisis

Community-based crisis stabilization services, including in-home crisis stabilization, crisis receiving facilities, peer respite, crisis residential services, sobering centers and transitioning individuals to care

California Health and Human Services Agency, “Behavioral Health Crisis Care Continuum Plan” (2023), page 21.

Peer Supporter Workgroup – Areas of Focus

- This Peer Supporter Workgroup was added in recognition of the important roles that the Peer Workforce plays in crisis services, as well as the recommendation of a Policy Advisory Group (PAG) member.
- Workgroup members were identified based on recommendations from PAG members.
- As a Workgroup, we'll explore Peer Workforce-specific implementation considerations across the crisis continuum.

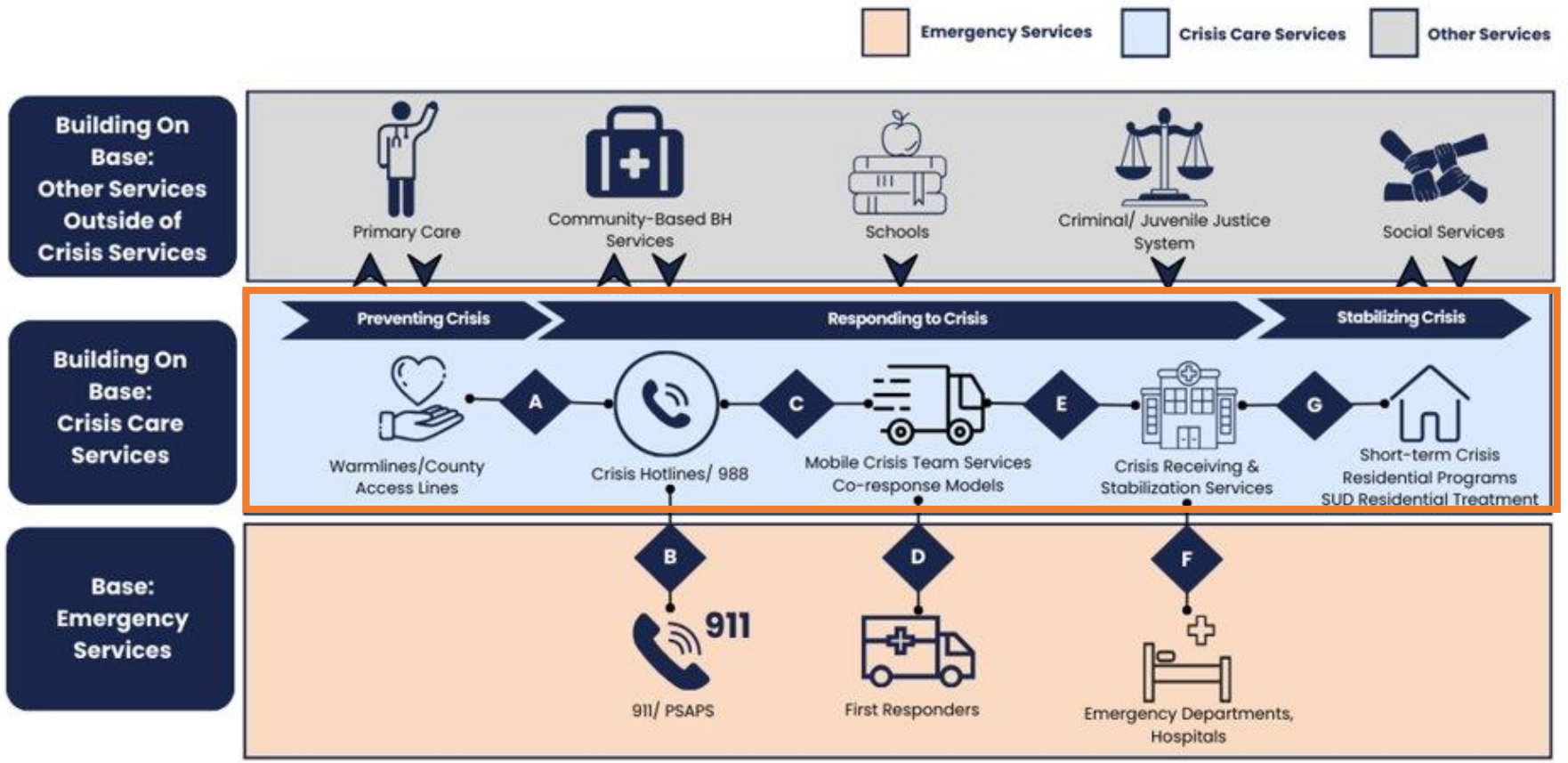
Timing of Implementation

- An outcome of our work – in conjunction with the work of the Policy Advisory Group, other Workgroups, the 988 Project Team, and others – is the creation of a Five-Year Implementation Plan.
- The implementation timeframe reflects an understanding that change does not happen overnight.
- Activities will be sequenced to continue our progress toward a crisis system that meets the needs of *all* Californians, without overwhelming the system during the process.

Definitions & Discussion of the Role of Peer Supporters in Crisis

Definitions & Discussion (1)

Below is a graphic depicting the crisis care continuum. Our discussion today will focus on Peer Supporter roles that exist – or should exist – within this continuum.



Adapted from the California Health and Human Services Agency, "Behavioral Health Crisis Care Continuum Plan" (2023), page 25

Definitions & Discussion (2)

California has instituted the qualification of **“Certified Peer Support Specialist”** (PSS) to enable provider, counties and other entities to bill MediCal for Peer Support Services.

From CalMHSA:

- Certified Medi-Cal Peer Support Specialists provide recovery-oriented, culturally appropriate services that promote engagement, socialization, self-sufficiency, self-advocacy, and natural supports and are trauma-aware.
- Certification is designed for individuals who are 18 years of age or older, who self-identify as having lived experience with the process of recovery from mental illness, substance use disorder, or both, either as a consumer of these services or as the parent or family member of the consumer.
- Peer Support Specialists are an allowable staffing category for Medi-Cal Mobile Crisis Services *(Approved by CMS July 2023)*

Definitions & Discussion (3)

Other Related Roles

- Starting July 1, 2022, the Department of Health Care Services added Community Health Work, Promotores, and Representatives (CHW/P/Rs) as a billable service to Medi-Cal. The CA Department of Health Care Access and Information (HCAI) is also in the process of developing a CHW/P/R Certification.
    - Community Health Workers are also an allowable staffing category for Medi-Cal Mobile Crisis Services *(Approved by CMS July 2023)*
- The Certified Wellness Coach (CWC) role was also created by HCAI as part of the state's Children and Youth Behavioral Health Initiative (CYBHI) to increase California's overall capacity to support the growing behavioral health needs of the state's youth.
    - There are two CWC levels, one for those who have an Associate's Degree and another for those who have a Bachelor's or higher.
    - There are two pathways for certification, either education or prior workforce experience; certification also requires 400-2,000 hours of field experience, depending on the CWC level and certification approach

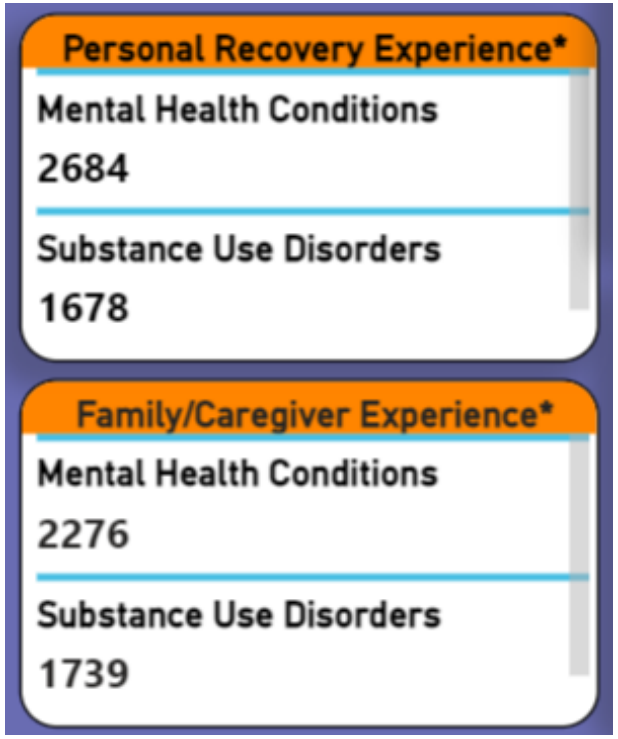
Definitions & Discussion (4)

Distinctions Between Peer Supporters & CHW/P/Rs, CWC, and Other Roles

- Peer Supporters and CHW/P/Rs & CWC roles can be filled by individuals with lived experience, but each has a different scope of practice.
- An individual with lived experience could be certified as both a Peer Support Specialist and CHW, as an example, but can only *practice* as one or the other at a time.

Definitions & Discussion (5)

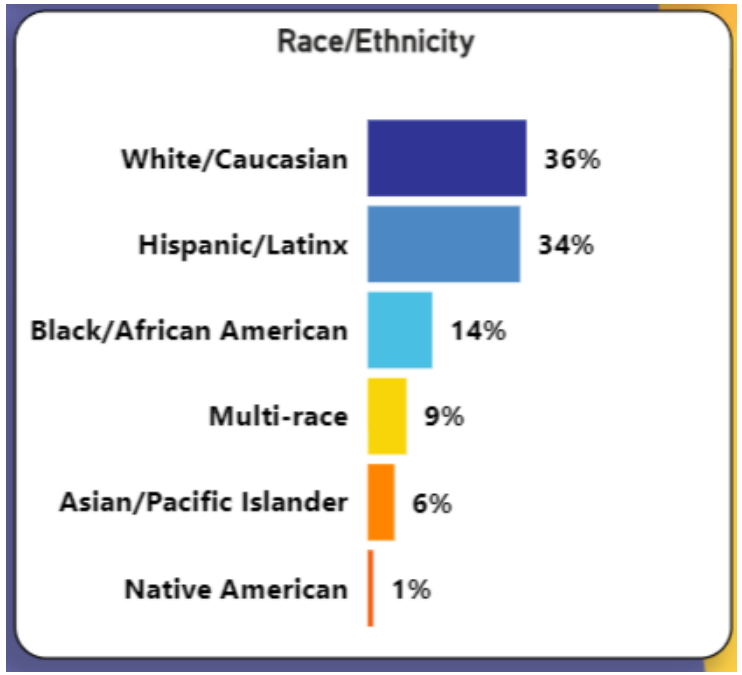
Below are snapshots from the CalMHSA Medi-Cal PSS Certification Data Dashboard**.

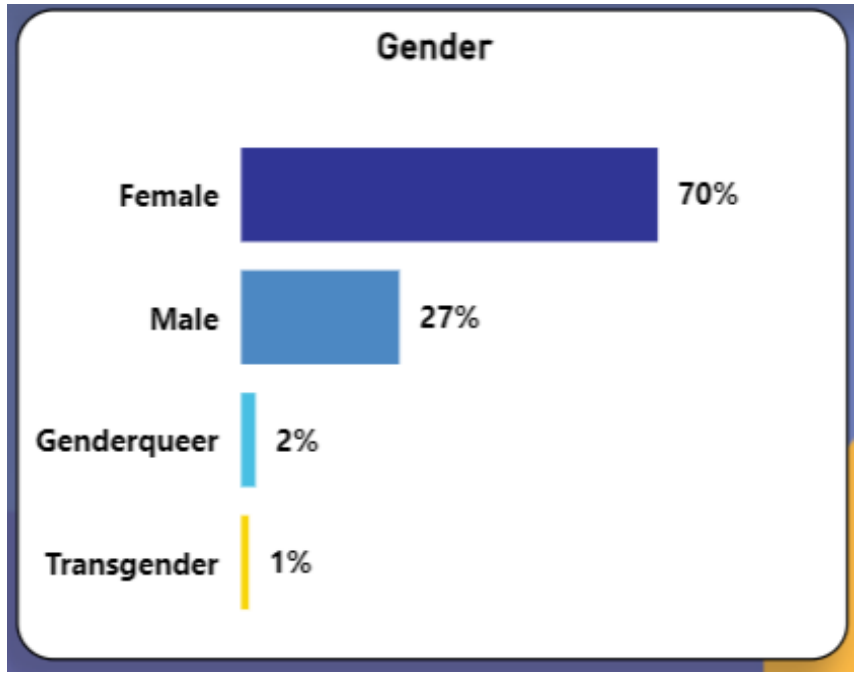


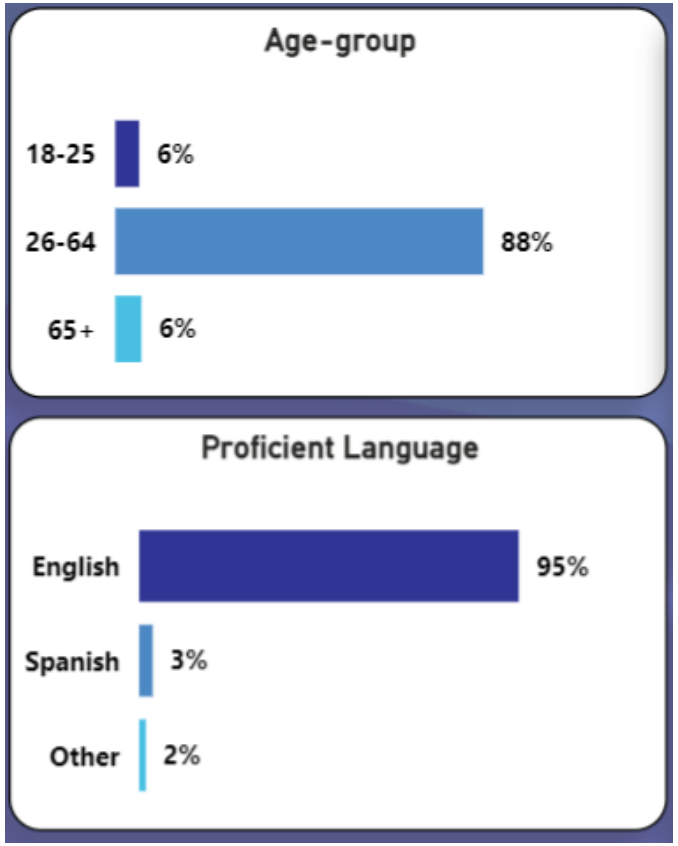
*CPSS may self-identify with multiple lived experience
**Accessed on June 6, 2024
Peer Certification - California Mental Health Services Authority (calmhsa.org)

Definitions & Discussion (6)

Below are snapshots from the CalMHSA Medi-Cal PSS Certification Data Dashboard*.



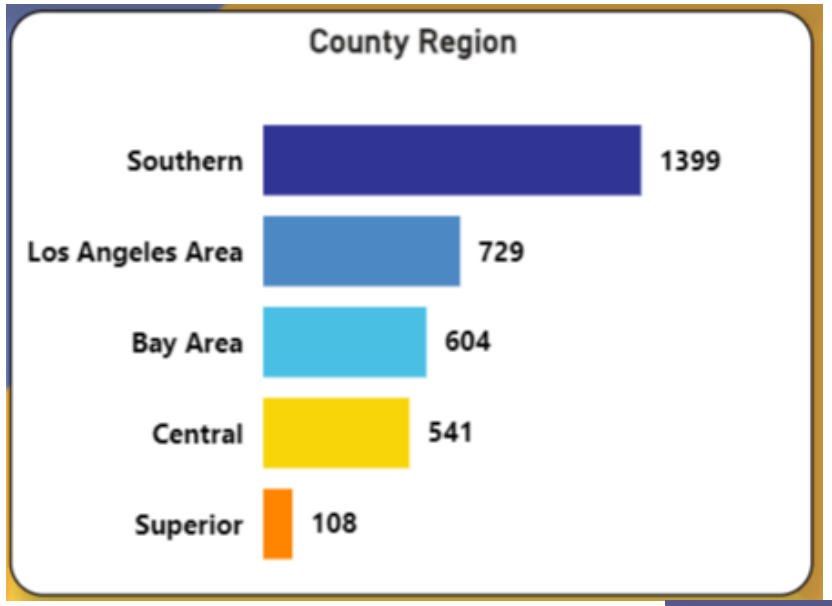


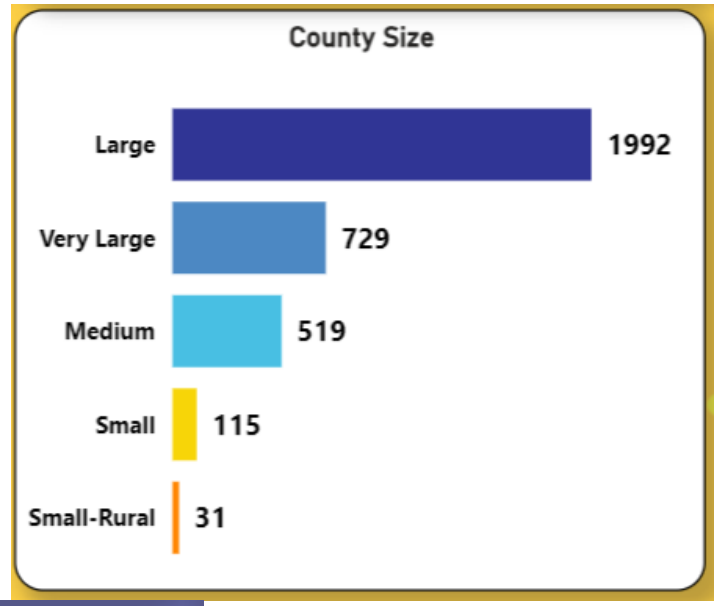


*Accessed on June 6, 2024

Definitions & Discussion (7)

Below are snapshots from the CalMHSA Medi-Cal PSS Certification Data Dashboard*.





*Accessed on June 6, 2024

Definitions & Discussion (8)

SAMHSA released an advisory on Peer Support Services in Crisis Care. We will use their advisory as a starting point to discuss the roles of Peer Supporters in California's Crisis System. Below are the purposes – as defined by SAMHSA – of the different types of care and on the following slides are the Settings for care and Services provided.

CA Categories	Preventing Crisis	Responding to Crisis		Stabilizing Crisis	
SAMHSA Categories	**Pre-Crisis Services**	**Sub-Acute Care**	**Acute Care**	**Stabilization**	**Post-Crisis Care**
Purpose	Services intended to avert a crisis, or, if a crisis occurs, alleviate the need for more acute services.	Services provided to those who experience a mental and/or substance use disorder crisis, but do not require acute care.	Services provided to de-escalate a crisis and/ or when acute behavioral health care is required.	Services designed to assist with symptom stabilization before returning to the community.	Services aimed to support the individual after the crisis has subsided.

Definitions & Discussion (9)

Below are the Settings for Peer Support Services identified by SAMHSA. **Would you suggest any changes to the settings identified? Are there additional settings in California in which Peer Supporters do or should provide services?**

CA Categories	Preventing Crisis	Responding to Crisis		Stabilizing Crisis	
SAMHSA Categories	**Pre-Crisis Services**	**Sub-Acute Care**	**Acute Care**	**Stabilization**	**Post-Crisis Care**
Settings **Note: Peer services need to be more deeply embedded in systems: how peers are utilized to share their lived experience –role, function, and supervision requires further attention**	• Peer-run organizations, such as recovery community organizations and drop-in centers. • Mobile recovery centers. • Outpatient and rehabilitation programs. • Outreach and engagement • Homeless outreach. • FEP • Employer Insured corporations (non-public funded insurers) • First responder teams, departments • Crisis intervention training for hospitals and facilities	• 23-hour stabilization units and beds. • Outpatient BH • Inpatient hospitals and partial hospitalization programs. • Hospital diversion houses. • Wellness Centers • County Access Lines	• Emergency departments. • Psychiatric ED • Mobile crisis teams. • Crisis intervention and response teams. • Police and correctional diversion. • Support for crisis responders • State hospitals •	• Crisis receiving and stabilization units and facilities. • Crisis respite. • Recovery residences. • Living rooms. • County BH Programs • Peer Run Stabilization Centers •	• Peer-run organizations, such as recovery community organizations and drop-in centers. • Recovery Organizations • Assertive community treatment teams. • Other outpatient and rehabilitative support settings. • • •

Definitions & Discussion (10)

Below are the Peer Support Services identified by SAMHSA. **Would you suggest any changes to the services identified? Are there other Peer Support Services that do or should exist in California?**

CA Categories	Preventing Crisis	Responding to Crisis		Stabilizing Crisis	
SAMHSA Categories	**Pre-Crisis Services**	**Sub-Acute Care**	**Acute Care**	**Stabilization**	**Post-Crisis Care**
Services **Integrate attention to roles for: Family/Parent Partners & Youth Peer Support** **Peer Run Recovery Housing needs to be integrated into framework** **Support between visits**	• Outreach and engagement • Warm lines and county warm lines • Crisis planning. • Linkage to resources. • Individual and group digital support. • Harm reduction. • Family support • Parent Support • SUD prevention	• In-patient and partial hospitalization care and advocacy. • Short-term crisis residential services. • Short-term intensive treatment and services. • Linkage to resources. • • •	• Crisis hotlines. • Emergency department care and advocacy. • Intensive treatment and services. • Linkage to resources. • Family Supports for adults, as well as youth, to help them with their own experience—in homes and in other settings • Support between visits • Transitional care •	• Residential stabilization. • Step-down services. • One-on-one support. • Linkage to resources.	• Post-crisis support groups. • Recovery supports. • Social inclusion and structure. • In-home peer companionship. • Self-care supports. • Digital support. • SUD prevention • •

Definitions & Discussion (12)

1. Defining Peers in the Crisis Continuum:

How are Peer support Services in the crisis space different than Peer support Services in other areas, if there is a difference?

- Peer support is not pushing people into the ED if they haven't harmed themselves; may have thoughts of ending their life and peers will contact resources and support them, a youth in schools will get pulled out of class, transported to ED, while a peer will talk it through with student
- There is an assumption that a person is a threat; peers in crisis needs to be trained to identify things that are distressing and threats. Need to be trained to react with empathy in situation when other responders may be escalating
- Peers can just be with the person, share that we can just get through this together…just being there having been in that situation. Let's just talk about how I can support you in the crisis
- peers need to be clear on their role, adrenalin is high from clinicians and other responders. The peer is not the clinician, decider about the facility, etc. Requires more training about the role
- After the crisis, first respnders have protocols to debrief, peers need this supervision structure. Agencies don't always have supervisiors who are peers able to offer this. Vicarious traumatization and planning for debriefing
- Whole team needs training to understand the peer's role and to support the peer in that role

Definitions & Discussion (13)

1. Defining Peers in the Crisis Continuum:

What can be done to protect the Peer Supporter role and effectively integrate them into multi-disciplinary teams?

- clarifying roles
- Supporting training for peers and other team members
- Peer supervision needs to address debriefing related to the peer role in crisis
- Whole team needs clarity of role
- Hierarchy needs to be clear and the whole team needs to be trained; workplace mental health requires attention with commitment from the agency level (perhaps via contract requirement)
- Clarifying the peer role is critical; some accept the role, but effectiveness requires clinician and CM clarity about the role in order to effectively utilize the value of the peer role, peer has to remain the peer (ie support someone in the crisis vs “go look for this person”)
- Show value of peers to the clinical staff –clinical staff may disregard role of peer because they are not clinical---show outcomes, share stories about the peer impact on people’s lives
- peer evidence based is available re: impact of peers on outcomes; when peer is in a crisis situation and peers are seen as important to the outcome; When clinicians are resistant to peers in “higher levels of care” they may need to see it in action, but research findings are an inroad resource
- co-supervision and group supervision is so important, especially for peers who are supervised by

Definitions & Discussion (14)

1. Defining Peers in the Crisis Continuum:

What is the role of Certified Family Peer Specialists in supporting families? How should Family Peer Specialists and Peer Support Specialists collaborate?

- Recommend a statewide peer agency; developed supervision training and pathway toolkit
- Supporting people who have challenges requires different skills than a person who has the challenges—the roles are different, even when people are both a person with lived experience and a family member
- Peers can help family member understand their loved one's experience; about what the person is going through and about what the family member is also experiencing
- Family members and caregivers need to understand that there is a real alternative to 911—family members of both youth and adults require awareness about this resource and also that they will get assistance as well. Stigma, cultural taboos, and confidentiality issues could be overcome for people via 988 crisis line information from a stranger, confidentially (Peers will actually go out to organizations and groups to show what it is like to call a warm line. what does that call look and feel like)
- Family peer support specialists are acting in the role of the peer support specialist in some organizations But these roles are different and need to be treated differently
- Even a person dually certified shifting roles could be problematic bc their advocacy focus can be confusing (eg to other staff, to the individual themselves); could bridge but would take awareness

Definitions & Discussion (15)

2. Staffing and Capacity Building

- What would the optimal level of Peer Support staffing be on a multi-disciplinary team? (e.g., 1 Peer Supporter and 1 Family Supporter?). How is this different in mobile and non-mobile settings?
- What should the minimum level of Peer Support staffing be on a multi-disciplinary team? How is this different in mobile and non-mobile settings?

Definitions & Discussion (16)

2. Staffing and Capacity Building

Are there additional standards or guidelines that would improve Peer support services in the crisis space? (e.g., specialized training, additional role definition, etc.)

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Definitions & Discussion (17)

2. Staffing and Capacity Building

Are there additional resources or supports that would improve the work of Peer Supporters in the crisis space?

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Public Comment Period

Public Comment Guidelines

- **All comments—whether written or spoken—will be shared with the Workgroup in the meeting minutes.**
- If you prefer, you may email your written comment to the project email address: AB988Info@chhs.ca.gov
- Each speaker is allocated 2 minutes to speak unless adjusted by the meeting facilitator.
- A speaker may not share or relinquish any remaining time they have not used to another speaker.
- Speakers may share one time during the public comment period.
- If time in the agenda remains after all individuals who signed up to speak have been called, the facilitator may invite other members of the public to raise their hand to speak. The facilitator will call individuals in the order they raise their hand.
- Speakers shall be civil and courteous in their language and presentation. Insults, profanity, use of vulgar language, or gestures or other inappropriate behavior are not allowed.
- Speakers should not ask questions of Workgroup members or ask Work Group members to respond to their comments directly.

Public Comment Sign-Ups

1. Name

Next Steps

Moving Forward

- All information from today's meeting will be posted on the CalHHS website on the 988-Policy Advisory Groups webpage: Link to Website for CalHHS 998 Crisis Policy

- **Next Meeting of the Workgroup: August 6, 1-3PM Pacific**

Adjourn