Peer Models and Usage in California Behavioral Health and Primary Care Settings

INTEGRATED CARE ISSUE BRIEF

November 2013

FUNDED BY:
Counties through the Mental Health Services Act and
Administered by the California Mental Health Authority

PRODUCED BY:
CalMHSA Integrated Behavioral Health Project
Karen W. Linkins, PhD, Jennifer J. Brya, MA, MPP, Gary Bess, PhD, Jim Myers, MSW, Sheryl Goldberg, PhD, MSW
AGD Consulting
Alaina Dall, MA

Contents

Figures

KEY CONSIDERATIONS FROM THIS ISSUE BRIEF

The purpose of this issue brief is to review how peers are used in agencies that provide behavioral health and/or primary care services, and to describe the important role peers play in recovery of others with mental health or substance abuse issues. **Research has shown that peers provide valuable services by working with consumers, assuring consumers gain access to the services they need, and reducing consumer experiences of stigma and discrimination. The use of peers in integrated care settings is a key strategy to reducing both personal and institutional stigma.**

The history of the consumer/survivor movement began in the **1960s** when President Kennedy signed the Community Mental Health Center Act, and moved people with mental illness out of institutions and into community settings. In the **1970s**, people who were released began meeting in groups to share feelings of anger about the abusive treatment they experienced while they were there, and their need for independent living. These groups coalesced and a liberation movement began. The **1980s** saw the emergence of self-help/peer support programs and drop-in centers. Rights protection organizations were developed and more consumers/survivors began to sit on decision-making bodies. In the **1990s**, consumers/survivors were employed in the mental health system and in self-help programs, including in management level jobs. Self-help/peer support programs received federal and other system funding. Principles of self-determination, choice, rights protection, and the reduction of stigma and discrimination continued to be advanced. In the **2000s**, the Mental Health Services Act involves consumers/survivors at all levels of the mental health system.

Peers function as advocates, navigators, or guides, thereby ensuring that consumers receive timely and comprehensive care, and are fully engaged in their treatment processes. **When used in the workplace, peers improve the understanding of mental illness among providers and other employees of service agencies by sharing the recovery perspective and raising awareness of the consumer culture.** Developing positive relationships between peers and their co-workers is considered among the most effective ways to reduce stigma.

The MHSA has funded numerous programs that utilize or train peers to help others on their path to recovery. At the same time, lack of reimbursement, lack of understanding about the value of peer contributions in the workforce, and lack of formal training, create barriers to more agencies making use of peer services. Standardized training and certificate programs would lend credibility to the peer role, but students would need to be assured that jobs were available upon completing the programs.

INTRODUCTION

The purpose of this issue brief is to review how peers are used in agencies that provide behavioral health and/or primary care services, and to describe the important role peers play in recovery of others with mental health or substance abuse issues. The Integrated Behavioral Health Project (IBHP) team conducted a **statewide needs assessment** of the status of integrated behavioral health trainings and activities in California. The IBHP project was administered by the California Mental Health Services Authority (CalMHSA) with funding from the Mental Health Services Act's Prevention and Early Intervention component. Over 150 individuals were interviewed across the state in 2012 as part of the needs assessment process (see **Attachment 1**). The interviewees' information and insights, as well as additional research conducted by the IBHP team, resulted in a series of issue briefs that summarize key findings pertaining to counties, primary care, peer model services, substance abuse services, and workforce.

This issue brief includes key findings from **interviews with peers, peer supervisors and county leadership and staff**, as well as a **targeted literature review** that focused on the history of the peer and consumer movement. The IBHP team also obtained information from organizations promoting the peer model, such as Working Well Together, Migrant Health Promotion, and the Pennsylvania Peer Support Coalition.

Research has shown that peers provide valuable services by working with consumers, assuring consumers gain access to the services they need, and reducing consumer experiences of stigma and discrimination. Thanks in part to the Mental Health Services Act, there are many programs in California that include the use of peers to help others on their path to recovery. At the same time, lack of reimbursement, lack of understanding about the value of peer contributions in the workforce, and lack of formal training, create barriers to more agencies making use of peer services. Standardized training and certificate programs would lend credibility to the peer role, but students would need to be assured that jobs were available upon completing the programs.

Integrating mental health care with primary care services is a strategy for improving access and reducing stigma. Offering behavioral health services in nontraditional settings encourages participation by people wanting to avoid the stigma surrounding mental health treatment.

The mental health and substance abuse fields have approaches to recovery that have evolved over time, and that today rely on the use of peers, consumers, survivors, and persons with lived experienced. These terms reflect the philosophies of the consumer movement that value the inclusion of people in recovery in the development and delivery of services (see **sidebar**).

Several terms are used to describe peer services, but sometimes the definitions blend as individuals identify with multiple roles. Generally, a **peer** is an individual who shares the experience of addiction, mental health issues, or medical concerns, and has recovered.[1] A peer demonstrates empathy and caring, and provides information and assistance to someone as part of their recovery. A **consumer** is someone who has received services from the public mental health system as a result of a diagnosis of mental illness.[2] A **person with lived experience** is someone who was diagnosed with mental illness or substance abuse, or whose family member was diagnosed. The term "**survivor**" has more of a political connotation that first emerged after state-run psychiatric hospitals were closed. A person may define himself or herself as a survivor if he or she experienced mental health problems and used psychiatry or mental health services. These terms set the tone for the roles these individuals play in delivering services, but they also remind the broader community of the importance of how language is used in the mental health and substance abuse fields – a topic that will be expanded upon later in this brief.

Terms

Consumer: Someone who has received services from the public mental health system as a result of a diagnosis of mental illness.

Peer: A person in recovery who has shared another individual's experience of addiction, mental health issues, or medical concerns.

Person with lived experience: Persons diagnosed with mental illness or substance abuse, or their family members.

Survivor: An individual who is self-defined as a person who has experienced mental health problems and has survived psychiatry or mental health services.

INTEGRATED CARE AND THE ROLE OF PEERS

There is an emerging body of information suggesting that integrated care programs contribute to a reduction of stigma and discrimination experienced by persons with mental health and substance use problems. Integrated care is defined as services in which providers consider all of an individual's health conditions in the course of treatment, including physical illness, mental disorders, or substance use, in which these providers coordinate care for the patient or client.[3]

A core value within all MHSA initiatives is the reduction of stigma and discrimination in the workforce and for those seeking the diagnosis and treatment of mental illness.[4] **Stigma** refers to *"negative beliefs (e.g., people with mental health problems are dangerous), prejudicial attitudes (e.g., desire to avoid interaction), and discrimination (e.g., failure to hire or rent property to such people.)"*[5] **The use of peers in integrated care settings is a key strategy to reducing both personal and institutional stigma.** Peers, consumers, people with lived experience, and survivors can function as advocates to ensure that consumers receive timely and comprehensive care, and are fully engaged in their treatment processes.[6] In primary care settings they can serve as an integral part of the health care team.

HISTORY

The history of the consumer/survivor movement began in the **1960s** when President Kennedy signed the Community Mental Health Center Act, and moved people with mental illness out of institutions and into community settings. Over subsequent decades, the movement continued to strengthen, and by the **2000s**, especially most recently with programs funded by the Mental Health Services Act, consumers/survivors have been involved at virtually all levels of the mental health system. See **Figure 1**, The History of the Consumer/Survivor Movement over the Past Five Decades, on the next page.

1960S – COMMUNITY MENTAL HEALTH CENTERS

President John F. Kennedy recognized that government had a responsibility to consumers to assure goods were safe and that consumers had the information they needed to make good choices. In 1962 he issued a *"Special Message to Congress on Protecting the Consumer Interest"* outlining **four consumer rights**:[7]

(1) ***The right to safety*** *-- to be protected against the marketing of goods which are hazardous to health or life.*
(2) ***The right to be informed*** *-- to be protected against fraudulent, deceitful, or grossly misleading information, advertising, labeling, or other practices, and to be given the facts he needs to make an informed choice.*
(3) ***The right to choose*** *-- to be assured, wherever possible, access to a variety of products and services at competitive prices; and in those industries in which competition is not workable and government regulation is substituted, an assurance of satisfactory quality and service at fair prices.*
(4) ***The right to be heard*** *-- to be assured that consumer interests will receive full and sympathetic consideration in the formulation of government policy, and fair and expeditious treatment in its administrative tribunals.*

Kennedy tied these rights not only to goods but also to medical care, and arguably to mental health services as well. The following year, in 1963, President John F. Kennedy signed the **Community Mental Health Center Act**. The intention of the act was to deinstitutionalize people with mental illness and place them into community settings where they could receive local services. The deinstitutionalization movement was fueled by concerns over civil rights and the poor conditions in institutions. Between 1955 and 1980, the population in state mental institutions decreased from 559,000 to 154,000.[8] The consumer/survivor movement continues to advocate for many of these same consumer rights – an individual's rights to safe medication and other treatment; being given the facts needed to make informed choices about one's own care; the right to choose the care one receives; and the right to be heard in the development of government policy and programs.

Figure 1: The History of the Consumer/Survivor Movement over the Past Five Decades

1970s – Consumer/Survivor Movement

The consumer/survivor movement started in the 1970s in response to decades of inhumane treatment of people in state hospitals.* During this time, state hospitals across the country were being shut down, and people who were released began meeting in groups to share feelings of anger about the abusive treatment they experienced while they were there, and their need for independent living. Eventually these groups coalesced with the common desire for personal freedom and radical system change, and a liberation movement began.[9] The groups that were part of this movement developed key principles. Members were:

- Against forced treatment
- Against inhumane treatment such as certain medications, lobotomy, seclusion, restraints, and electroconvulsive therapy (ECT)
- Against the medical model, usually described as anti-psychiatry
- For the emerging concept of consumer/survivor-run alternatives to the mental health system
- For involvement in every aspect of the mental health system

About the Consumer/Survivor Movement of the 1970s:

"This decade was a time of finding each other and realizing that we were not alone, a time of militant groups and actions, a time of self and group education, and a time of defining our core values. It was a time of finding and growing our voice out of the anger and hurt bred by the oppression of the mental health system. It was a time of separatism as a means of empowering ourselves."

Sally Zinman
The History of Mental Health Consumer/Survivor Movement, 2009

The groups' members, who described themselves as "psychiatric inmates," were primarily located on the east and west coasts. The groups had militant names like *Network Against Psychiatric Assault*, *Insane Liberation Front*, and *Mental Patient Liberation Front*. Group members developed a communication vehicle called *"Madness Network News,"* and held the annual *"Conference on Human Rights and Against Psychiatric Oppression"* at campgrounds and college campuses.

1980s - Self-Help/Peer Support

In the 1980s the groups became more streamlined and its members began the process of re-entering the world that they felt had previously betrayed them. The mental health system began

* The information in this section is based on the excellent presentation developed by Sally Zinman entitled, *"History of the Consumer Survivor Movement."* It was one of three presentations given as part of "The History of the Mental Health Consumer/Survivor Movement" webinar on December 17, 2009, sponsored by SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health. Sally Zinman is viewed by many as the founder of the consumer movement. She has been active in the mental health consumer/survivor empowerment movement for over 30 years and has founded and led various advocacy organizations during that time.

funding self-help/peer-support programs and drop-in centers such as *On Our Own* in Baltimore (1983), *Berkeley Drop-In Center* (1985), *Ruby Rogers Drop-In Center* in Cambridge, Mass. (1985), and *Oakland Independence Support Center* (1986). The federal National Institute of Mental Health Community Support Program funded consumer/survivor-run programs. Statewide consumer-run organizations such as the California Network of Mental Health Clients began in 1983. Rights protection organizations were developed and there were gains in protective legislation. More consumers/survivors began to sit on decision-making bodies.

1990S – CLIENT-RUN SYSTEMS CHANGE

The 1990s saw the fruition of changes sought in the mental health system in the previous decade, such as consumers being employed in the mental health system and in self-help programs, including in management level jobs. Growth emerged in self-help/peer-support programs with system funding, and federal funding of two consumer/survivor-run technical assistance centers to support self-help programs throughout the country. During this time the consumer/survivor involvement was noticeable at most levels of the mental health system, and client-run research began. The same principles as the earlier days were expressed in positive terms, such as:

- Self-determination and choice
- Rights protections
- Stigma and discrimination reduction
- Holistic services
- Self-help/peer-support programs
- Involvement in every aspect of the mental health system – “Nothing about us without us”
- The concept of recovery (encompassing all of the above)

2000S – RECOVERY, WELLNESS AND THE MENTAL HEALTH SERVICES ACT

In the 2000s system culture change has occurred at all levels of the mental health system as a result of consumer/survivor involvement. The **Mental Health Services Act** (MHSA) has consumer/survivor values embedded throughout, such as voluntary promotion of self-help/peer-support programs; involvement of consumers/survivors at all levels of the mental health system; inclusion of consumers/survivors to train the mental health work force; and promotion of recovery as a goal. The Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) **National Consensus Statement on Mental Health Recovery** reflects basic consumer/survivor principles. Generally speaking, consumer/survivor-run programs and peer-support are essential components of most mental health programs.[10]

DEFINITIONS AND THE IMPORTANCE OF LANGUAGE

In 2010, SAMHSA Administrator Pamela S. Hyde, JD, invited a discussion about terminology in the mental health and substance abuse fields.[11] She did this because early during her tenure she realized that many people, including her, felt that nearly every term used in the mental health and substance abuse fields were problematic in some way. Definitions for *"mental health," "behavioral health," "substance use," "recovery,"* and the name of the people receiving services, all had their own inherent connotations and controversies. In the last category for example, the term "*consumer*" was viewed by some providing feedback as demeaning; *"client"* suggested a power/subordinate relationship; *"patient"* was too medical; and *"survivor"* was too political, as if the system and treatment are dangerous in their own right.

The SAMHSA administrator's view was that while language is important, the field should not become distracted by the topic, and instead should agree on what terms are acceptable and what terms should not be used at all. As she said, what really matters is not getting distracted by the words that are used, but rather respecting one another and engaging in the work that needs to be done. **Figure 2** shows some of the comments and concerns around terminology, and illustrates how difficult it can be to agree on the words that are used.

The concept of ***"recovery"*** is one that has received significant attention in terms of creating an agreeable definition. At one time, SAMHSA had separate definitions for *"recovery"* based on whether it referred to someone with mental health or with substance use issues. In 2010, behavioral health field leaders as well as people in recovery and other stakeholders set out to create a common definition of *"recovery"* for all. The working definition of recovery is *"a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."* See the definition and four dimensions supporting a life in recovery in the **sidebar**.[12]

Definition of *Recovery* from Mental Disorders and/or Substance Use Disorders:

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Dimensions Supporting a Life in Recovery:

Health: Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
Home: A stable and safe place to live;
Purpose: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
Community: Relationships and social networks that provide support, friendship, love, and hope.

SAMHSA News Release, 12/22/2011

Figure 2: Public Comments about Behavioral Health Terminology

On Mental Health

- The term "mental health" leaves out mental illness, and we really need to focus on the latter.
- "Mental illness" leaves out emotional well-being and the growing science of prevention.
- "Mental health" leaves out substance abuse and/or addictions while "behavioral health" misconstrues the disease nature of mental illness and addictions.

On Behavioral Health

- "Behavioral health" implies a chosen behavior, easily stopped if a person just had enough willpower.
- "Behavioral health" focuses too much on symptomological behaviors that people cannot control.
- "Behavioral health" is a term that encompasses both substance abuse/addiction and mental illness/health.

On Substance Use

- "Substance use disorders" is too strong and does not recognize that a person can be abusing substances long before he/she can be characterized as having a disorder.
- "Substance abuse" is too soft and does not recognize the nature of substance use disorders or the importance of prevention.
- The medical model of "disease" is not consistent with the experience of people who believe they are simply unique individuals labeled for not conforming to this world's expectations.

On Recovery

- "Recovery" is a term for substance abuse or addictions but is not well defined for mental illnesses.
- "Recovery" means abstinence (including prescription medications).
- "Recovery" is a journey. Some can be on a path to recovery or in recovery while using substances, taking medications, or experiencing symptoms of mental illness such as hallucinations, flat affect, or flight of ideas.

On Individuals

- The term "consumer" is demeaning or does not work for the addictions world.
- "Client" suggests a power/subordinate relationship.
- "Patient" is too medical.
- "Survivor" is real and yet too political, as if the system and treatment are dangerous in their own right.

Source: Hyde PS. (2010, March/April). What's in a term? Considering language in our field. SAMHSA News. www.samhsa.gov/samhsaNewsletter.

THE VALUE AND ROLES OF PEERS

Peer models not only work, but peers provide essential services to people with mental health issues that better aid in recovery. The **New Freedom Commission on Mental Health** stated:[13]

> *"Studies show that consumer-run services and consumer-providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with a psychiatric diagnosis" (p. 37).*

For people with co-occurring substance abuse and mental health issues, studies have found that peer support offered in concert with traditional mental health treatment improves outcomes for people with a dual diagnosis. This is because people with both diagnoses respond better to peers who have experienced something similar and have recovered, and who can help them engage in substance-free activities.[14]

> *"A growing body of evidence suggests that peer-provided, recovery-oriented mental health services produce outcomes as good as and, in some cases superior to, services from non-peer professionals."*
>
> Judith A. Cook, 2011
> Professor of Psychiatry
> Director, Center on Mental Health Services Research and Policy
> University of Illinois at Chicago
>
> Source: Peer-Delivered Wellness Recovery Services: From Evidence to Widespread Implementation, Psychiatric Rehabilitation Journal, v. 35, No. 2, p. 87

Peer programs build on the experience and sensitivities of consumers, and focus on practical issues of accessing and utilizing health and behavioral health services, and working toward recovery.[15] Peers function as advocates, navigators, or guides, thereby ensuring that consumers receive timely and comprehensive care, and are fully engaged in their treatment processes.[16] Peers accompany consumers to treatment, and help to frame and normalize mental illness by sharing their own experiences and feelings. Peers model language and behaviors consumers can use when interacting with service providers, and they empower consumers as they learn how to advocate for their needs. They inform consumers about their rights, and educate health care staff about mental illness and how to respond to consumers. **By working with peers, consumers and families receive more person-centered care.** They perceive that someone is "in their corner," and they experience increased satisfaction with overall services. Perhaps most importantly, peers offer living proof that someone with a difficulty similar to their own can lead a productive and fulfilling life.

PEER ROLES IN BEHAVIORAL HEALTH CARE

Peer-based service models are becoming increasingly popular in the mental health arena, in particular for individuals with co-occurring mental health and substance use issues.[17] Serving as a peer is something that people in recovery often do to satisfy their desire to give back to their community by serving others. Examples of peer roles are as follows:[18]

- A **peer leader** in stable recovery provides social support to a peer who is trying to establish or maintain recovery. Both individuals are helped by this type of interaction.
- A **peer mentor or coach** helps a peer set recovery goals, develop recovery action plans, and solve problems related to recovery, such as finding sober housing, making new friends, finding new ways to use spare time, and improving job skills.
- A **peer support specialist** is a person living with a mental illness or in recovery from substance use disorder who provides mentoring, guidance, and support services to others with mental health or substance abuse issues.[19]
- A **12-step sponsor** works with the peer within the 12-step framework and focuses on providing guidance regarding the 12-step program.

"Self-disclosure and using one's own story as means of enhancing the value of the service is an important dimension of the recovery mentoring or coaching role. In addition, a peer mentor or coach implicitly holds himself or herself out as a recovery role model.

As described by William White (2006), this core competency entails 'modeling of core recovery values (e.g., tolerance, acceptance, gratitude); the capacity for self-observation, self-expression, sober problem-solving; recovery-based reconstruction of personal identity and interpersonal relationships; freedom from coercive institutions; economic self-sufficiency; positive citizenship and public service.'"

SAMHSA. (2009). What are Peer Recovery support Services?

PEER ROLES IN PHYSICAL HEALTH CARE

In primary care medical settings, the peer role is filled by *promotores,* community health workers, or patient navigators. Peers are typically from the community served by the clinic, or they are patients with first-hand experience with a particular condition. Among other duties, people in these roles facilitate communication, improve care access, and provide outreach, education, and culturally competent care.[20] People in these roles may volunteer, be paid stipends, or be paid wages as employees. These roles are described in more detail below:

***Promotores de Salud*/Community health workers**: Community health workers are trusted community members who share the ethnicity, language, socioeconomic status, and life experiences of the community they serve. *Promotores* are Spanish-speaking community health workers who work with Latino populations. *Promotores* and community health workers can work with a patient on enhancing provider-patient communication, adherence to treatment recommendations, disease self-management, and navigation of the health care system. They are also often tapped by health care

systems to help providers increase their cultural sensitivity to the communities they serve.[21,22]

Patient navigators: The patient navigator helps patients understand their recent diagnosis or disease, as well as their treatment and care options. They may help the patient find doctors, link patients to specialists, and accompany him or her to medical appointments. When multiple providers are involved, the navigator will help coordinate care. Navigators also provide interpretation services for patients who may not speak sufficient English – or English-speakers confused with complex medical jargon. The navigator helps the patient figure out insurance eligibility and coverage options, and ensures medical records are correct and bills are paid.[23,24] The model is widely used in cancer prevention and treatment programs,[25] in diabetes self-management, and in the HIV/AIDS field.[26] The focus is identifying barriers to health care and helping the patient to overcome them.

When used in the workplace, peers improve the understanding of mental illness among providers and other employees of service agencies by sharing the recovery perspective and raising awareness of the consumer culture. The development of positive relationships between peers and their co-workers is considered among the most effective ways to reduce stigma.[27] Health care providers interested in improving their sensitivity to clients with mental illness can engage consumers to advise them on how to reduce or eliminate stigma and discrimination in their treatment environment or operational processes. Consumers can also educate staff about mental illness and how to respond their clients.

PEER MODELS IN CALIFORNIA

In evaluating the extent to which peers or persons with lived experience are being used in the provision of mental health and substance use services in California, the **Technical Assistance Collaborative/Human Services Research Institute** (TAC/HSRI) concluded that they are an **"untapped workforce."**[28] These researchers report that the integration of physical health, mental health, and substance use, in addition to the use of peers in the provision of behavioral health services, helps to promote more efficient and effective use of the limited mental health workforce.[29]

Examples of peer-led behavioral health programs offered in many California counties are shown in **Figure 3**. A detailed description of the Wellness Recovery Action Plan (WRAP), a peer-led group program, is provided in the **sidebar**.

Wellness Recovery Action Plan

The Wellness Recovery Action Plan (WRAP) is an evidence-based, peer led intervention for adults with mental illness that takes place in a group setting. Trained peers lead the program. They guide participants through a process of identifying their personal wellness resources and then helps them develop a plan to use these resources on a daily basis to manage their mental illness. The model is used by mental health departments throughout California and the nation.

Source: SAMHSA's National Registry of Evidence-based Programs and Practices.

PEER MODELS FUNDED BY THE MENTAL HEALTH SERVICES ACT

The **Mental Health Services Act** funded programs and services, including peer programs and services, to support improved behavioral health in California through the following MHSA components:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET)
- Innovation (INN)

For example, MHSA established a **statewide technical assistance center** to promote the employment of peers in the public mental health workforce. **Working Well Together**, a collaborative project involving California Institute for Mental Health, the California Network of Mental Health Clients, the California National Alliance on Mental Illness, and United Advocates for Children and Families, assist county mental health agencies in "recruiting, hiring, training, supporting, and retaining peers," and with related issues of stigma and discrimination.[30]

Figure 3: Examples of Peer-Based Programs in California

- In **Alameda County, Lifelong Medical Care** has subcontracted with the Independent Living Center to recruit, train and supervise **peer health coaches** who are embedded in the clinic's staff.
- In **Amador County**, **Spanish-speaking Latino staff** provide health education and support within their own communities. Staff address consumer barriers to accessing services, such as culture, stigma, language and mistrust. **Promotores** are being trained in specific mental health engagement and resources.[31]
- **Contra Costa County's consumer-operated wellness center** has implemented **Peer Support Whole Health** (PSWH), in which peer specialists help mental health clients with co-occurring chronic medical conditions to choose and record a health goal, then helps the clients develop strategies on how to reach that goal.[32]
- The **Glenn County** department of mental health has **coach, parent-partner, peer youth-age-transition-workers, and peer-mentor** positions as part of their Consumer Pathways Program.
- **El Dorado County's Consumer Leadership Academy** offers peer-training, peer supportive skills training and training related to consumer leadership in the community.[33]
- In **Humboldt County, Open Door Community Health Center** uses a **peer-led promotora program** to reach and engage the county's Latino population. Trained teens also serve as **peer educators** in their teen clinic.
- The **Los Angeles Department of Mental Health** is using MHSA dollars to implement the **Peer-Run Integrated Services Model** (PRISM), in which peers work with other peers to aid them in their recovery by linking them with needed primary care, behavioral health, and housing services.[34]
- The **Madera County** mental health department employs a team of trained **peers stationed at the Madera Community Hospital Emergency Department** to engage clients and their families experiencing a crisis. The team also provides these services when clients are discharged.
- The **Mendocino County** mental health department sponsors peers' participation in a **health navigator certification program** offered by Sonoma State University.
- In **Monterey County**, the **Alternative Healing and Promotores de Salud** focus on addressing cultural barriers to seeking mental health care and stigma around mental health, a major barrier in the Latino culture.
- The **Orange County** mental health department is employing trained **consumer mental health workers**, supervised by licensed mental health staff to provide behavioral care at primary care sites and to coordinate and monitor physical health care at behavioral sites.
- The **Riverside County** mental health department employs 60 full-time peer specialists as **care navigators** to help acquaint clients with offered treatments, facilitate processing, assist with health care visits and to offer support, encouragement and advocacy.
- In **San Diego County,** the **Senior Peer Promotora Program** provides outreach, education, and engagement activities to assist older adults and their families in accessing mental health and primary care services, with concurrent emphasis on keeping them in treatment.[35]

Source: Unless otherwise noted, sample programs were identified through an IBHP analysis of MHSA Workforce Education and Training, and Innovation plans.

MHSA funding has increased the number of peers employed in the public mental health care system.[36] Approximately one-third of **Innovation** work plans included the use of peers, consumers or family members (paid or volunteer); 59% had peers as part of intervention teams; and 44% included training for peers or family members.[37] Out of 448 proposed **Workforce Education and Training (WET)** projects (also called "actions"), 195 (43%) involved consumers or peers in some capacity. Upon further analysis, these projects are grouped into the following themes: [38]

1. **Trainings for consumers to provide services**

   Almost one-third of projects (32%) included trainings designed to prepare consumers to fill specific positions to provide services to other consumers; train-the-trainer programs designed for consumers to train others; and programs in which consumers provided trainings as experts to an audience.

2. **Consumer career pathways**

   Over one-quarter (29%) included projects with a specific process designed to recruit and train consumers for entry into the mental health field. Pathways could be systemic and formal, such as collaborating with the local community college to establish a certificate program, or an agency policy that created paid placements for volunteers once training was complete.

3. **Recruiting and retaining consumers**

   Over one-quarter (26.2%) involved projects that had an objective to recruit paid or volunteer consumers, increase their success in the workplace, and/or increase retention.

4. **Training for the consumer's personal development**

   Almost one-quarter (22%) had projects that included objectives related to personal development training for consumers, such as workforce entry, wellness and recovery, and technical training.

5. **Financial incentives for consumer recruitment**

   These projects (19%) included objectives to offer financial incentives, such as scholarships, stipends or reimbursement, in order to recruit or encourage consumers to enter or progress in the mental health career field. Some programs were designed for any community member, but priority was given to consumers with lived experience.

6. Consumer professional development

These projects (16%) developed peers for leadership and advisory roles by training them on how to approach participation in forums, decision making, evaluation, responding to surveys, and providing input on training or curriculum content.

7. Training non-consumer staff on consumer culture

These projects (15%) referenced training for non-consumer staff that shared the experience of receiving services from the perspective of the consumer. Projects also included the integration of the consumer voice into trainings and programs.

8. Efforts to integrate consumers into the workforce

These projects (13%) promoted, educated, or raised awareness of the benefits consumers offer to clients by working in the mental health field. Focal areas included changes in hiring policies to reduce barriers or recognizing life experience as comparable with work experience or formal education.

BARRIERS TO UTILIZING PEERS IN PRIMARY CARE AND BEHAVIORAL HEALTH SETTINGS

LACK OF MEDICAID REIMBURSEMENT

In states such as Massachusetts, Pennsylvania, Oklahoma, Texas, Georgia, Wyoming, Connecticut and Minnesota, peer and family support services are a distinct Medicaid-reimbursable service, which helps promote the engagement of peer-direct services in behavioral health.[39] In most cases, peer support is included under the Rehabilitation Option within their state plans. States that bill Medicaid for peer support services follow guidelines developed by the Centers for Medicare and Medicaid, which include the development of a certification program for peer support specialists.[40]

Peer-related services are not eligible for third-party payment through California's Medi-Cal system. Yet under the State Plan for Specialty Mental Health Services, peer providers can bill for specialty mental health services within their scope of practice under the category of "other qualified providers," and use the same Medi-Cal codes as licensed providers.[41] Despite serving a significant proportion of Medi-Cal beneficiaries, federally qualified health centers and community clinics are not able to bill Medi-Cal for services provided by peers.

LACK OF UNDERSTANDING ABOUT THE VALUE OF PEER CONTRIBUTIONS IN THE WORKFORCE

The role of peers in various service settings is emergency and continues to grow, however the use of peers as providers has yet to reach its full potential and impact. **Peers are more commonly involved as volunteers and employees in behavioral health programs and less involved in primary care services.** They are more commonly found in public agencies and less involved in private agencies.

Key Finding

The workforce needs to be educated about the role and value-added services that peers bring (i.e., the unique experience and skill set of peer providers).

Employers and systems of care need to be educated about the unique experience and skill set of peer providers. Agencies and professionals across primary care, mental health and substance use sectors need greater awareness and knowledge regarding the role and value of peer specialists in service delivery. Agency professionals and non-professionals alike are sometimes resistant to the inclusion of peers as co-workers. Peer roles are often not conveyed well to staff beyond the managers' level, so employees are not prepared to recognize their roles and

contributions. Staff sometimes view peers as a form of tokenism, or as taking jobs. In integrated care settings, peers are often viewed as having a role in support groups, but not as part of the care team.[42] More work is needed to explain and demonstrate the value added by using peers in primary care and integrated care settings.

LACK OF FORMALIZED TRAINING

There is a need to research and adopt standardized training materials and content for peers on stigma and integrated care. While "lived experience" is a catchall concept that validates the involvement of peers, each experience is unique to the person. Presently, universal standards have not been established to define how much training is required for a peer specialist to be considered competent in her/his position. This fact points to the need to develop core competencies for peer providers. Targeted training is needed for peers that is appropriate to their setting – wherever they are working. Training formats need to be developed that maximize access to content for peers in remote locations. Supervisors of peers also need to be trained in order to make the most of the peers' expertise and to provide the necessary support.

In many states, although not in California, peer providers can become certified.[43] More than 20 states are currently providing certifications for peer specialists.[44] The required training protocol ranges from 40 to 100 hours.[45] In California, since peers are not certified, training and competencies are not standardized. There is little consistency across the state in terms of hiring practices, qualifications, duties, and supervision.[46] A state-sanctioned certification would lend credibility and legitimacy to peer providers in California.[47]

CERTIFICATION PROCESS FOR PEERS IN CALIFORNIA

A peer certification program will most likely be required in order for services to be reimbursed by Medi-Cal. The *Working Well Together* organization is engaged in an inclusive and comprehensive process to develop standards and a statewide certification program for peer providers, as well as strategies to bill Medi-Cal for peer-delivered services.[48] *Working Well Together* held five regional forums on state certification in Spring 2012 to review the research on and use of peer models. They concluded that the certification of peer specialists would help to reduce stigma and discrimination, and would increase the value placed upon using peers in the workplace.[49] However, the lack of employment opportunities for peers once they become certified is probably the most significant barrier to developing a certification program. Certification alone would not ensure that positions would be available in county mental health systems or in health care systems. If positions became available, the workforce would need to be educated about how to make the best use of peers, and how to assure mutual professional respect.

PEER TRAINING RESOURCES

Given that research has shown the effectiveness of peer workers, peer training programs and internships have emerged, though at present most are based within mental health provider agencies.[50]

- The **California Association of Mental Health Peer Run Organizations** (CAMHPRO) incorporated in spring 2012 to serve as a statewide consumer-run peer stakeholder organization offering resources for training.
- Peer specialist training manuals are also available from such sources as the **National Association of Peer Specialists**. **Pacific Clinics** in Los Angeles County has specialized training programs to prepare peers for work with consumers,[51] and several

Peer Training Resources

- **California Association of Mental Health Peer Run Organizations**
  http://camhpro.org
- **National Association of Peer Specialists**
  www.naops.org
- **Recovery Innovations**
  www.recoveryinnovations.org
- **SAMHSA-HRSA Center for Integrated Health Solutions**
  www.integration.samhsa.gov
- **Working Well Together**
  http://workingwelltogether.org/

California counties, such as Los Angeles, San Bernardino, Santa Barbara, and Tuolumne counties, have developed peer programs, sometimes in partnership with local educational institutions.[52]

- **SAMHSA's Center for Integrated Health Solutions** is finalizing curricula for its Peer Support Whole Health, Wellness and Resiliency initiative, a national training program for peers.

- **Online resources** such as *recoveryinnovations.org*, offer advanced training peer practice training course (80 hours of class time plus internships) through Recovery Innovations of California.

RECOMMENDATIONS

From research and practice articles, key informant interviews, focus groups, and reviews of reports and websites, there is consensus that **peers play an important role in integrated care across a continuum of services**. They are the bridge between behavioral health and primary care services, and vice versa, and they also link at-risk and marginalized populations (i.e., people with SMI and other underserved populations) to other resources in the community that may affect their access to and utilization of services. Since peer services are not generally reimbursed by third-party sources, costs associated with training, hiring, deployment, and supervision typically come from special grant programs such as MHSA.

Developing and disseminating resources that articulate the value and role of peers across various settings. Although research has shown that peer models are effective, the use of peers has been limited primarily to mental health and substance use service providers. Primary care providers could make more use of peers in team-based care, or for outreach, health coaching, self-management or *promotora* services. Resources are needed to share with organizations that do not currently make use of peers, especially in integrated health settings where the use of peers would enhance integrated services and reduce stigma. Health plans need to be educated about the potential role consumers can play in service delivery (e.g., outreach, engagement, and health coaching).

Data collection on peer services that will provide the evidence to establish the "business case" for funding peers in settings that currently do not receive reimbursement. Organizations interested in using peers will need to continue to advocate for reimbursement, but in order to do so will need data that demonstrate their effectiveness in achieving the Triple Aim of quality outcomes, increased patient/client satisfaction, and reduced costs. Studies will need to be constructed with input from peers on the definition of quality, on factors that contribute to satisfaction with services, and on the many areas of cost savings that could be realized. Data

are also needed on how peers create positive outcomes in multiple settings, including integrated care settings.

Training, certification, job development and ongoing support. While there appears to be support for the inclusion of peers, there can also be resistance by provider and other staff. In order for peers to be effective, they need to be supported while on the job and have clear role definition and expectations. In addition, there is a need for training standards and certification programs in order to standardize the job duties and competency levels. However, students will need to be assured job openings are available once they complete their training. While research has demonstrated the value of peers, more work needs to be done to further define their role and gain broader acceptance in primary care and behavioral health agencies.

ATTACHMENT 1: KEY INFORMANTS

Key Informant	Position	Organizational Affiliation
County/State Departments		
Rus Billimoria, MD, MPH	Senior Director Medical Management	Los Angeles Care Health Plan
Libby Boyce, LCSW	Homeless Coordinator, CEO	Los Angeles County Systems Integration Branch
Clayton Chau, MD, PhD	Associate Medical Director & on the BOD at CiMH	Orange County Department of Mental Health
Rene Gonzales, MA	Assistant Superintendent	Los Angeles Unified School District
Debbie Innes-Gomberg, PhD	District Chief	Los Angeles County Department of Mental Health, MHSA Implementation and Outcomes Division
Robyn Kay, PhD	Chief Deputy Director	Los Angeles County Department of Mental Health
Penny Knapp, MD	Professor Emerita, Department of Psychiatry and Behavioral Sciences	University of California, Davis, Health System
Gladys Lee, LCSW	Mental Health District Chief of the Planning, Outreach and Engagement Division	Los Angeles County Department of Mental Health
Cuco Rodriquez	Mental Health Services Act Division Chief	Santa Barbara County, Department of Alcohol, Drug and Mental Health Services
Susan Sells	MHSA Program Manager	Tuolumne County Behavioral Department of Mental Health
Inna Tysoe	Staff Mental Health Specialist	California Department of Mental Health
Kim Uyeda, MD, MPH	Director of Student Medical Services	Los Angeles Unified School District Division of Student Health and Human Services
John Viernes, MA	Director of Substance Abuse and Control Programs	Los Angeles County Department of Mental Health
Tina Wooton	Consumer Empowerment Manager	Santa Barbara County, Alcohol, Drug and Mental Health Services
Educational Institutions and Programs		
Pat Arean, PhD	Professor, Department of Psychiatry	University of California, San Francisco
Jan Black, LCSW	Behavioral Analysis	California Social Work Education Center
Rick Brown, PhD	Director	University of California, Los Angeles, Center for Health Policy Research
David Cherin, PhD	Director	Department of Social Work – California State University, Fullerton School of Social Work
Liz Close, PhD, RN	Professor and Chair – Department of Nursing	Sonoma State University

Key Informant	Position	Organizational Affiliation
Bette Felton, PhD	Professor of Nursing (Retired)	California State University, East Bay, School of Nursing
Gwen Foster, MSW	Director, Mental Health Programs	University of California, Berkeley, School of Social Welfare
Tom Freese, PhD	Director of Training ISAP	University of California, Los Angeles
Celeste Jones, PhD	Director	California State University, Chico, School of Social Work
Gene "Rusty" Kallenberg, PhD	Professor	Department Family & Preventive Medicine University of California, San Diego
James Kelly, PhD	President and CEO	Menlo College
Beth Phoenix, RN, PhD, CNS	Health Sciences Clinical Professor and Program Director, Graduate Program in Psychiatric-Mental Health Nursing; President-Elect, American Psychiatric Nurses Association (APNA)	University of California, San Francisco, School of Nursing
Adrienne Shilton	Program Director at CIMH	California Institute for Mental Health
Michael Terry, DNP, APRN-PMH/FNP	Associate Clinical Professor, Psychiatric Mental Health Nurse Practitioner Program; President-Elect American Psychiatric Nurse Association-CA Chapter	University of San Diego
Jurgen Unutzer, MD, MPH, MA	Director, AIMS Center for Advancing Integrated Mental Health Solutions	University of Washington
Belinda Vea, PhD	Student Affairs Policy and Program Analyst, Office of the President	University of California
Diane Watson	AIMS Center for Advancing Integrated Mental Health Solutions	University of Washington
Janlee Wong, LCSW	Executive Director	National Association of Social Workers, California Chapter
National/State Associations		
Neal Adams, MD, MPH	Deputy Director, Special Projects	California Institute for Mental Health
Gale Bataille, MSW	Independent Consultant	California Institute for Mental Health
Susan Blacksher, MSW	Executive Director	California Association of Addiction Recovery Resources
Carmela Castellano, JD	CEO	California Primary Care Association
Jennifer Clancy, MSW	Project Director	California Institute for Mental Health
Serena Clayton, PhD	Executive Director	California School Health Center Association
Alaina Dall, MA	Behavioral Health Network Consultant	California Primary Care Association
Steve Eickelberg, MD	President	Medical Education and Research Foundation
Tom Freese, PhD	Director of Training	Pacific Southwest Addiction Technology Transfer Center, University of California, Los Angeles

Key Informant	Position	Organizational Affiliation
Lori Futterman, R.N. PhD	Clinical Assistant Professor of Psychiatry	University of California, San Diego
Sallie Hildebrandt, PhD	Previous President	California Psychological Association
Victor Kogler	Director	Alcohol and other Drug Policy Institute
Jo Linder-Crow, PhD	CEO	California Psychological Association
Judith Martin, MD	Medical Director	California Society of Addiction Medicine
Donna Matthews, ASW	Project Manager	California Institute for Mental Health, Working Well Together
Glenn McClintock, MSW	Project Manager	Mental Health Association of San Francisco
Helyne Meshar	Member, Board of Directors	California Association of Alcohol and Drug Program Executives
Rhonda Messamore	Executive Director	California Association of Alcoholism and Drug Abuse Counselors
Sandra Naylor-Goodwin, PhD	President, CEO	California Institute for Mental Health
Kerry Parker, CAE	Executive Director	California Society of Addiction Medicine
Tom Renfree	Executive Director	County Alcohol and Drug Program Administrators Association of California
Kathleen Reynolds, MSW	Vice President, Health Integration and Wellness Promotion	National Council for Community Behavioral Health
Alice Ricks, MPH	Senior Policy Analyst	California School Health Center Association
Michael Ritz, PhD	Member and on the 2013 Finance Committee	California Psychological Association
Patricia Ryan, MPA	Executive Director	California Mental Health Directors Association
Ken Saffier, MD	Grant Director	Medical Education and Research Foundation
Rusty Selix, JD	Executive Director	Mental Health Association of California and the California Council of Community Mental Health Agencies
Albert Senella	President, Board of Directors	California Association of Alcohol and Drug Program Executives; and Chief Operating Officer, Tarzana Treatment Center
Eduado Vega, MA	Executive Director	Mental Health Association of San Francisco
Health Plans		
Dale Bishop, MD	Medical Director	Health Plan of San Joaquin
Richard Chambers	President	Long Beach-based Molina Healthcare California
Dianna Daly	Program Development Manager	CalOptima
Susan Fleischman, MD	National VP for Medicaid	Kaiser Foundation Health Plan

Key Informant	Position	Organizational Affiliation
Elia Gallardo, Esq	Executive Director, Duals Program	Alameda Alliance for Health
Mary Giammona, MD, MPH	Medical Director and Director of Quality	Health Plan of San Mateo
Liz Gibboney, MA	Deputy Executive Director/COO	Partnership Health Plan of California
Nadine Harris, RN	Quality Improvement Coordinator	Partnership Health Plan of California
Kelly Hoffman	Manager, Medical Operations	Inland Empire Health Plan
Lee Kemper, MPA	Executive Director	County Medical Service Program
Howard Khan, MA	CEO	Los Angeles Care Health Plan
Dana Knoll, MPH	Director Of Operations	Watts Healthcare Corporation
Ellie Littman, MSN, MRP	Executive Director	Health Improvement Partnership of Santa Cruz
John Ramey	Executive Director	Local Health Plans of California
Patricia Tanqueray, DPH	CEO	Contra Costa Health Plan
John Wallace	COO	Los Angeles Care Health Plan
Community Health Centers, Clinics, Clinic Consortia		
Marty Adelman, MA	Mental Health Coordinator	Council of Community Clinics, San Diego
Lynn Dorroh, MFT	CEO	Hill Country Community Clinic, Shasta County
Elena Fernandez, LCSW	Behavioral Health Director	St. John's Well Child and Family Center, Los Angeles County
Brenda Goldstein, MSW	Behavioral Health Director	Lifelong Medical Center, Alameda County
John Gressman, MSW	CEO	San Francisco Community Clinic Consortium
Nicole Howard, MPH	Director	Council of Community Clinics, San Diego
Michael Mabanglo, PhD	Behavioral Health Director	Mendocino Community Health Center, Mendocino County
Susan Mandel, PhD	Director	Pacific Health Clinics
Leslie Manson, PsyD	Behavioral Health Director	Open Door Community Health Center, Humboldt & Del Norte County
Sandeep Mital, MD	Director, Clinical Services	Community Clinic Association of Los Angeles
Elizabeth Morrison, LCSW	Director of Talent and Culture	Golden Valley Community Health Center, Merced County
Jennifer Sale, LCSW	Director of Behavioral Health	Sierra Family Medical Center, Nevada County
Peter Van Houten, MD	CEO, CMO	Sierra Family Medical Center, Nevada County
Joan Watson-Patko, MSW	Community Development Manager	Community Clinic Association of Los Angeles

Key Informant	Position	Organizational Affiliation
Foundations, Advocacy Organizations, Consultants		
Becky Boober, PhD	Senior Program Officer	Maine Health Access Foundation
Richard Figueroa, MBA	Director	The California Endowment
Lynda Frost, JD, PhD	Director, Planning and Programs	Hogg Foundation for Mental Health
Neelam Gupta	Director	Los Angeles Health Action
Peter Harbage, MA	President	Harbage Consulting
Peter Long, PhD	President and CEO	Blue Shield Foundation
Benjamin Miller, PsyD	Assistant Professor, Director, Office of Integrated Healthcare Research and Policy	University of Colorado, Denver, Department of Family Medicine
Mary Rainwater, MSW	Director Emeritus	Integrated Behavioral Health Project
Lucien Wulsin	Executive Director	Insure the Uninsured Project
Bobbie Wunsch, MBA	Management Consultant	Pacific Health Consulting Group

Endnotes

[1] Center for Substance Abuse Treatment, (2009). What are peer recovery support services? HHS Publication No. (SMA) 09-4454. Rockville, MD: SAMHSA, U.S. Department of Health and Human Services.

[2] SAMHSA (2013). Statewide Consumer Network Grant, Request for Applications. Appendix J: Definitions.

[3] SAMHSA. Understanding Health Reform: Integrated care and why you should care.

[4] California Department of Mental Health (CA DMH). (2008). Mental Health Services Act Five-Year Workforce Education and Training Development Plan for the Period April 2008 to April 2013.

[5] Clark W, Welch SN, Berry SH, Collentine AM, Collins R, Lebron D & Shearer A. (2013, May). California's historic effort to reduce the stigma of mental illness: The Mental Health Services Act. American Journal of Public Health, v. 103 (5).

[6] This observation represents a synthesis of several comments made by key informants concerning services venues and employment arrangements.

[7] Kennedy JF. (1962, March 15). Special message to the Congress on protecting the consumer interest. Retrieved from http://www.presidency.ucsb.edu/ws/?pid=9108.

[8] Kohanagi C. (2007, August). Learning from history: Deinstitutionalization of people with mental illness as a precursor to long-term care reform. Kaiser Commission on Medicaid and the Uninsured. The Henry J. Kaiser Family Foundation.

[9] Zinman, S. (2009, December 17). The history of the mental health consumer/survivor movement. Presentation sponsored by SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health.

[10] Zinman, S. (2009, December 17). The history of the mental health consumer/survivor movement. Presentation sponsored by SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health.

[11] Hyde PS. (2010, March/April). What's in a term? Considering language in our field. SAMHSA News. www.samhsa.gov/samhsaNewsletter.

[12] SAMHSA. (2011, December 22). SAMHSA announces a working definition of "recovery" from mental disorders and substance abuse disorders. SAMHSA News Release.

[13] New Freedom Commission on Mental Health. (2003). Achieving the Promise: Transforming Mental Health Care in America.

[14] SAMHSA. (2011). Consumer-operated services: The evidence. HHS Pub. No. SMA-11-4633, Rockville, MD.

[15] Interviews with peer navigators and supervisory staff.

[16] This observation represents a synthesis of several comments made by key informants concerning services venues and employment arrangements.

[17] White, W.L. (2006) Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity. Philadelphia Department of Mental Health and Mental Retardation Services, Philadelphia, PA.

[18] SAMHSA. (2009). Center for Substance Abuse Treatment, What are peer recovery support services? HHS Publication No. (SMA) 09-4454. Rockville, MD.

[19] Pennsylvania Peer Support Coalition. Retrieved from http://www.papeersupportcoalition.org/peer/pps.html

[20] Anderson A, Turner A. The cross cultural health care program: Patient navigation: existing programs, current practices, and guidelines for success. Seattle, WA 2007. Available at: www.xculture.org/files/Navigators.Final.Report10.07.pdf.

[21] Migrant Health Promotion. Who are CHWs? www.migranthealth.org.

[22] Office of Minority Health. Definition of *promotoras de salud*. http://minorityhealth.hhs.gov

[23] Sario MS & Solis C. (2012, January 19). Patient navigators help smooth way for patients, providers. California Health Report. Retrieved from http://www.healthycal.org/archives/7163.

[24] Thoms E & Moore D. (2012, December). Issue Brief: the emerging field of patient navigation: A golden opportunity to improve health care. The Center for Health Affairs. Retrieved from http://www.chanet.org/TheCenterForHealthAffairs/MediaCenter/NewsReleases/~/media/A92355F0A6E140F1A13493BC3C349CAB.ashx.

[25] Dohan D, Schrag D. Using navigators to improve care of underserved patients: current practices and approaches. Cancer. 2005;104(4): 848-855.

[26] Bradford, J. B., Coleman, S., & Cunningham, W. (2007). HIV system navigation: An emerging model to improve HIV care access. AIDS patient care and STDs*,* 21(1), S49-S58.

[27] Interview with Donna Matthews, Project Manager, CiMH (May 2012)

[28] Technical Assistance Collaborative/Human Services Research Institute. (2012, February 29). California Mental Health and Substance Use Service System Needs Assessment – Final Report. February 29, 2013.

[29] Technical Assistance Collaborative/Human Services Research Institute. (2012, February 29). California Mental Health and Substance Use Service System Needs Assessment – Final Report.

[30] Technical Assistance Collaborative/Human Services Research Institute. (2012, February 29). California Mental Health and Substance Use Service System Needs Assessment –Final Report. 234.

[31] National Alliance on Mental Illness. (2012, May). MHSA County Programs 2012: Services promoting recovery and reducing homelessness, hospitalization, and incarceration, p.9. Retrieved from http://www.mhsoac.ca.gov/docs/InTheNews/MHSA_Full_Report.pdf

[32] CalMEND (2011). The Integration of Mental Health and Primary Care CPCI Learning Collaborative-Final Report. Sacramento, CA.

[33] County of El Dorado. (2013, April). MHSA FY 2012-13 Update.

[34] County of Los Angeles Department of Mental Health. Mental Health Services Act Innovation Programs brochure. Retrieved from http://file.lacounty.gov/dmh/cms1_185505.pdf

[35] Dall, A. (2011). Environmental Scan: Integrated Physical and Behavioral Health Programs in San Diego County. San Diego. CA.

[36]Technical Assistance Collaborative/Human Services Research Institute. (2012, February 29). California Mental Health and Substance Use Service System Needs Assessment –Final Report. February 29.

[37] Integrated Behavioral Health Project. 2011. Mental Health Services Act (Prop 63): Review of California's Innovation Work Plans. http://www.ibhp.org.

[38] Integrated Behavioral Health Project. 2011. Summary of Workforce Education and Training Work Plans in California, Draft. June.

[39] Technical Assistance Collaborative/Human Services Research Institute. (2012, February 29). California Mental Health and Substance Use Service System Needs Assessment –Final Report. 198. 233.

[40] Working Well Together. (2012). Certification of consumer, youth, family and parent peer providers: A summary of regional stakeholder meeting findings.

[41] Working Well Together. What's Working Well Vol 1. Issue 3, Winter, 2012. www.workingwelltogether.org

[42] Working Well Together. Special Certification Workgroup Call. Minutes. August 13, 2012

[43] Salzer, M.S., Schwenk, E., & Brusilovskiy, E. (2010). Certified peer specialist roles and activities: Results from a national survey. Psychiatric Services*,* 61, 520-523.

[44] Working Well Together (2012). Certification of consumer, youth, family and parent providers: a review of the research. Report produced by Brasher, D. & Dei Rossi, L. www.inspiredatwork.net.

[45] Working Well Together and Department of Mental Health (2012). Certification of consumer, youth, family and parent peer providers: a summary of regional stakeholder meeting findings. Report produced by Brasher, D. & Dei Rossi, L. www.inspiredatwork.net.

[46] Working Well Together. Certification of Consumer, Youth, Family and Parent Providers: A Review of the Research. Report produced by Brasher, D. & Dei Rossi, L. www.inspiredatwork.net.

[47] Technical Assistance Collaborative/Human Services Research Institute. 2012, February 29. California Mental Health and Substance Use Service System Needs Assessment –Final Report.

[48] Information obtained from web research and interviews with key informants.

[49] Working Well Together. What's Working Well Vol 1. Issue 3, Winter, 2012. www.workingwelltogether.org

[50] This observation represents a synthesis of several comments made by key informants concerning training venues and focus.

[51] Interview with Susan Mandel, CEO, Pacific Clinics

[52] Interviews with Tina Wooton Consumer Empowerment Manager, Santa Barbara County; Clayton Chau, MD, Project Lead, Orange County; Innes-Gomberg, PhD, District Chief – MHSA Implementation Unit, LACDMH; and Susan Sells, MHSA Coordinator, Tuolumne County .