2024

Peer Support Services Across the Crisis Continuum

Connected and Strong

Second in a Series of Ten Technical Assistance Briefs to Foster Unity and Strengthen Continuity Across Crisis Response and Treatment Systems

SAMHSA
Substance Abuse and Mental Health Services Administration

Peer Support Services Across the Crisis Continuum

Acknowledgments

Authors: Amy Brinkley, CRS/CHW, CAPRCII & Justin Volpe, CRPS-A

Peer Support Services Across the Crisis Continuum was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201700024I/75S20321F42001. Tison Thomas served as contracting officer representative.

Disclaimer

Public Domain Notice

Electronic Access

This publication may be downloaded from https://store.samhsa.gov

Recommended Citation

Brinkley A, Volpe J: *Peer Support Services Across the Crisis Continuum*.
Publication No. PEP24-01-019. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024.

Originating Office

Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, SAMHSA. Publication No. PEP24-01-019. Released 2024.

Nondiscrimination Notice

The Substance Abuse and Mental Health Services Administration (SAMHSA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). SAMHSA does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

Publication No. PEP24-01-019

Released 2024

Abstract

With the rollout of 988 as a universal crisis line number in July 2022, there is an urgent need to understand how best to integrate peer support workers into crisis services across the full crisis continuum. Although there is a growing desire to integrate peer support workers within crisis services, and there are some places that are doing this well, it is not happening across the full crisis continuum in all states. There are also very few resources dedicated to the implementation of peer support services. This paper offers promising and best practices to help circumvent current challenges for integrating peer support workers into the full crisis continuum. Specifically, it explores several resources available to states and organizations related to peers working in the crisis continuum, the definition and evolution of peer support services, and available national/federal guidance on the integration of peers and people with lived experience into the crisis continuum. Lastly, this technical assistance paper provides examples of the many states that are employing peers within crisis settings across the crisis continuum, overcoming challenges and barriers. This paper also looks at future directions to continue to ensure that this work evolves and grows in meaningful and positive directions.

Highlights

- Resources and guidance about peers in crisis services should include a focus on the practical integration of peers within the full crisis continuum.
- There is a need for national standardization of peer support training, certifications, and competencies for peer workforce.
- Peer support workers in the crisis continuum should equitably reflect the community they are serving.
- Standardized data collection showing where peers are engaging in the crisis continuum is needed. Existing data have many gaps and do not tell the full story.

Recommendations

1. **Behavioral Health Leaders** should continue to identify and develop easy-to-access toolkits, resources, organizational readiness scales, and best practice guides specifically focused on peer support services delivered within the crisis continuum for local community stakeholders. These should include (but not be limited to) model training curricula, core competencies for peer support workers in crisis settings, and organizational readiness scales to be shared with states, territories, and providers.

2. **Peer Support Leaders** should continue to seek out and create leadership opportunities in local, state, and federal government spaces.
3. **States** that provide peer recovery support should consider adding peer and recovery data collection measures to evaluate outcomes and inform program improvements.
4. **Crisis Service Providers and Funders** should track data about where and how peers are being used across all settings, counties, and states, to help with standardization, best practices, and expansion efforts for peer support workers in these spaces.
5. **Treatment Providers and Crisis Service Delivery System Leaders** should incorporate clear communication with staff (peers and nonpeers) into standard operating procedures regarding the role of peer support staff and ensure transparency on the role of peer support workers in all settings and adequate supervision by trained supervisors for peer support workers.
6. **Peers, Stakeholders, and Treatment Providers** should provide access to adequate training for peers to ensure competency in reaching all communities and to ensure hired peer workers represent the communities they serve in both demographic backgrounds and lived experiences.
7. **Crisis Service Providers and Funders** should encourage peer support inclusion in all crisis settings. This should include funding peer-run respites and other non-clinical peer-led services within crisis settings, recognizing that these would not replace clinical crisis services, but would provide an additional avenue for support when appropriate and facilitate diverse peer outreach to underserved communities.

Introduction

Since the Substance Abuse and Mental Health Services Administration (SAMHSA) released its *National Guidelines for Behavioral Health Crisis Care* in 2020, the United States has experienced a whirlwind of events coalescing in significant forward progress in behavioral health care, and more specifically in the crisis services space.[1] On July 16, 2022, "988"—an easy-to-remember, three-digit code—went live within the United States as the National Suicide & Crisis Lifeline. However, 988 goes further than the original Lifeline, evolving into a broader crisis line. Its go-live date will forever be marked as a historic moment for the behavioral health workforce, including peer support service practitioners.

Unfortunately, the COVID-19 pandemic only further solidified the need for crisis services to be firmly established everywhere.[2] And, with the impetus to grow crisis services, many advocates and stakeholders are now weighing in on the implementation of behavioral health crisis service systems and integration of peer support workers across the continuum of behavioral health care. The role of peers in crisis response is a critical part of this national discourse. As such, although there is a desire to expand the role of peer support workers in crisis services, more research, data collection, and practical guidance are needed to ensure the success of these important efforts.

The Biden Unity Agenda serves as a major driver toward strengthening the workforce and incorporating the importance of the role of peers across the continuum of care. In the first of the 2024 Technical Assistance Coalition papers produced by the National Association of State Mental Health Program Directors (NASMHPD) on behalf of SAMHSA, *Connected and Strong: Strategies for Accessible and Effective Crisis Response and Mental Health Services,*[3] Pinals and Schofield emphasize the importance of

"Peer support worker" defined

In this paper, "peer support worker" is defined in accordance with SAMHSA's definition: "someone who has been successful in the recovery process who helps others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process."[a]

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

[a] Advisory: Peer Support Services in Crisis Care. Substance Abuse and Mental Health Services Administration (SAMHSA), 2022. https://www.samhsa.gov/resource/ebp/advisory-peer-support-services-crisis-care

connecting and strengthening systems, linkages, and supports across multiple sectors to help achieve the goals of the Unity Agenda.[4] This paper, the second in the *Connected and Strong* series, focuses on one way to strengthen system capacity by building in peer support services in crisis and other behavioral health service systems in a meaningful and productive way. This paper therefore attempts to expand and contribute to the literature on peer support workers by providing a snapshot of current issues, highlighting the need for more specific guidance, and offering recommendations for integrating peers generally and in crisis services in particular.

The National Perspective: Peers in Crisis Services

The actual implementation of peer support services varies significantly across states. This section walks through some of the key national/federal guidance to states that includes a focus on peer support across the crisis system and highlights peer roles, best practices, key considerations for integration of peers in crisis systems, and what the full crisis framework includes in terms of space for peer support integration.[5]

Although 988 implementation and crisis service approaches vary from state to state, federal recommendations include the integration of peer support workers within the crisis continuum. This paper will unpack how peer support workers are currently being integrated within crisis services and the broader crisis ecosystem. National guidelines emphasize the importance of a "No Wrong Door" approach to crisis services, and peers are ideal conduits for this approach due to their ability to create trusting relationships quickly, elicit longer engagement from clients, and lead crisis follow-up efforts. As crisis services should be accessible to anyone, anywhere, and at any time, peer support workers should be available throughout the crisis continuum for anyone, anywhere, and at any time.[6]

Crisis services include:

1. Someone to call (crisis lines accepting calls and dispatching support as appropriate)
2. Someone to respond (mobile crisis teams dispatched to the caller when appropriate)
3. A safe place for help (crisis receiving or stabilization facilities, or—for youth—a safe place to be, with the emphasis on stabilizing the crisis at home or wherever is safest for the youth, understanding that sometimes home will not in the moment be the safest place)

What peer support workers should do:

- Serve as a role model.
- Provide support during a crisis.
- Help with goal setting and wellness planning.
- Make connections with other services and supports.

What peer support workers should not do:

- Perform work that does not meaningfully contribute to care.
- Act as a sponsor, therapist, or clinician.
- Assess, diagnose, or treat an individual.
- Assimilate into other roles.

SAMHSA's *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* spells out implementation guidance for crisis services and details the importance of addressing the recovery needs of individuals in crisis.[7] Key elements of SAMHSA'S toolkit are that crisis services should include a commitment to a no-force-first approach, supportive environments, and a significant role for peer support workers (which will be the key in creating a no-force-first approach and supportive environment). SAMHSA further recommends hiring credentialed peer support workers with direct lived experience across all three spaces of crisis services—someone to call, someone to respond, and a safe place for help. The SAMHSA guidelines delineate the need for the implementation of peer support across all three elements of the crisis continuum, but not all states are universally or uniformly implementing peers.

SAMHSA's *Advisory: Peer Support Services in Crisis Care* was released in June 2022.[8] It highlights peer support as an "evidence-based practice that promotes improved outcomes for recipients of services that includes reduced hospitalizations, lower overall costs of services, increased service utilization, increased treatment engagement, improved quality of life, increased functioning, and decreased behavioral health symptoms."[9] Protecting the role integrity of peer support workers is also significantly highlighted as a need due to the potential of "peer drift." Peer drift occurs when peer support workers operate outside of their scope as a peer support provider. In some instances, this happens when nonpeer workers marginalize peer workers and/or peer workers assume assigned tasks that do not align with the authentic peer support role.

Crisis roles for peer workers can be especially difficult due to the complicated nature of crisis situations, which may trigger distress in the peer support worker due to past traumatic experiences.

***Figure 1: Key Considerations from SAMHSA's* Advisory: Peer Support Services in Crisis Care**

- Role integrity
- Stigma
- Recruitment and retention of peer support workers
- Sustainability and funding of peer support services
- Certification and state requirements

Advisory: Peer Support Services in Crisis Care. Substance Abuse and Mental Health Services Administration, 2022. https://store.samhsa.gov/product/advisory-peer-support-services-crisis-care

The SAMHSA guidance on peers in crisis services includes areas that this paper highlights: Key considerations for peers, how peers are utilized across the crisis continuum, and how states are integrating the peer workforce into this continuum of services. The key considerations of SAMHSA's *Advisory: Peer Support Services in Crisis Care* are noted in **Figure 1**.

It is astonishing that, despite the considerable focus by national crisis service leaders on the significant role of peer support workers in crisis services, there is still a lack of literature, research, and toolkits specifically aimed at implementing and establishing best practices for peer support in crisis services and settings. The resources highlighted in **Figure 2** may be of interest to peer support workers who have voiced concerns over the lack of organizational readiness tools, resources, and scales to address the absence of recovery-oriented culture in clinical workspaces. Overall, there is an apparent need to establish the roles of peers across the crisis continuum. As such, Recommendation 1 aims to move the field forward via the development of instruments, aids, and measures to advance the role of peer support and minimize the risk of peer drift in building crisis services that are robust and peer inclusive.

SAMHSA convened a technical expert panel in 2023 that worked on the development of domains and model standards for peer certifications and included the voices of people with lived experience in this endeavor. SAMHSA released a National Model Standards for Peer Support Certification in April 2023 to make progress on the goal of universal adoption, recognition, and integration of the peer mental health workforce as outlined in the 2022 Presidential Unity Agenda.

However, each state still has its own set of competencies, ethics, core qualifications, education requirements, testing, fees, and recertification policies for obtaining a peer support specialist certification, meaning there is no reciprocity across states and territories. In January 2023, the SAMHSA-funded Peer Recovery Center of Excellence released a comparative analysis report on states' existing peer certification standards and programs.[10] The report found that all states and

territories have peer support worker certifications except American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and South Dakota (note that based on author knowledge, the Pacific Jurisdictions do offer peer support worker certifications through the Pacific Behavioral Health Collaborating Council & Certification Board, and Puerto Rico is in the process of developing certification.) Of states with certifications, 34 offer a single, integrated certification for people with lived experience in mental health and/or substance use recovery, 14 offer separate certifications for people with experience of mental health or substance use challenges, and 17 allow people with experience as a family member or caregiver of a person with a mental health or substance use challenge to become certified. The website for the SAMHSA-funded mental health technical assistance center Copeland Center Doors to Wellbeing (https://www.doorstowellbeing.org) lists states' peer certification requirements, qualifications, and policies.[11]

Figure 2: Some Resources Related to Organizational Readiness and Measures to Consider

- Peer Integration and the Stages of Change Toolkit (New York State Office of Alcoholism and Substance Abuse Services)
- Organizational Self-Assessment: Integrating Peer-Delivered Services in Certified Community Behavioral Health Clinics (National Council for Behavioral Health)
- Certified Community Behavioral Health Clinics, Peer-Delivered Services, and Peer-Operated Agencies: Opportunities for Collaboration and Expansion (New York Association of Psychiatric Rehabilitation Services, Inc., and the National Council for Behavioral Health)

Regarding peers in the crisis service continuum, according to the NASMHPD Research Institute's (NRI's) 2022 State Profiles report, *State Mental Health Agency Workforce Shortages*, 22 states had special training curricula to train peer specialists to work in the behavioral health crisis system.[12] There are no standardization or best practices yet developed on the competencies required for the peer support worker in the crisis space, as the variation of implementation for training and competencies is still broad. For example, in Arizona, peers are required as part of the crisis system to be certified as behavioral health paraprofessionals (BHPs) and must have graduated from a peer training program. Arizona allows the provider to determine which training vendor they want to use to train peer supporters, paraprofessionals, and BHPs working within crisis services. Whereas in Georgia, peers receive additional training (along with other staff from those providers) specific to crisis supports (hotlines, warmlines, hospitals, emergency departments, crisis stabilization units, and mobile crisis). In Illinois, coordinated training for mobile crisis teams is offered though through Humannovations and RI International (https://www.humannovations.net/crisispeerally).

Peer Support History and Evolution

To fully understand the current state of peer services and where the push for implementation of peer support workers originates, it is important to understand the history of peer support. Several key historical events have helped shape what we now know as peer support services. Peer support began its evolution as advocacy from ex-patients and groups during times when treatment was the most volatile and traumatic. For example, some groups believe that the psychiatric survivors' movement was born from the civil rights movement in the late 1960s and early 1970s and from personal stories of psychiatric abuse.[13]

On October 31, 1963, President John F. Kennedy signed the Community Mental Health Act, which was meant to free many thousands of people with mental illness from life in institutions. This bill was the last piece of legislation President Kennedy signed before he was assassinated three weeks later. Quality of life for people with mental illness in institutions at the time was grim. People were receiving inadequate treatment and primitive medications and suffered due to isolation from family, friends, and community.[14] President Kennedy called for society to embrace a new vision for people with mental health disorders and disabilities—a vision that called for deinstitutionalization and an end to retaliation against people when they complained of horrid conditions in those institutions.

Unfortunately, this vision was never realized. As noted in the NASMHPD 2017 paper *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*, "had the community mental health centers envisioned by the CMHCA been developed to meet the needs of the full spectrum of psychiatric patients, including those with special needs, the system would likely have evolved differently. Instead, a succession of U.S. presidents and Congresses reduced and eventually eliminated federal funding for community-based mental health centers."[15]

Today there is still a significant push by people with lived experience and certified peers to build quality community support for people with behavioral health challenges. With the advocacy movement being steady and strong, there continues to be an expansion of peer leadership positions within local, state, and federal government for people with lived experiences. SAMHSA's Office of Recovery is staffed by people with direct lived experience; NASMHPD has staff of people with lived experience; and most states have an Office of Recovery (mostly reorganized from an Office of Consumer Affairs) within state mental health authorities who are engaged with and/or oversee peer support service programs statewide. Lived experience leadership is embedded at the local, state, and federal level within behavioral health as of April 2023.

Current Utilization of Peer Support in Crisis Settings

Each state implements crisis services through its own interpretation of the national guidance. There also appears to be variation in how states interpret the guidance on integrating peer support workers within the crisis continuum. National data that highlight where peer support workers are employed within crisis call lines, mobile crisis teams, and crisis stabilization services largely do not exist. In 2022, NRI sought to capture data on the peer support workforce in their 2022 State Profiles survey (further delineated below). The subsequent report found that many states were reporting a shortage of peer support workers within crisis settings. However, while NRI's data show shortages of peers in crisis settings, the data do not specify how many states are using *any* peers in those settings.[16]

To understand the current and future landscape of peer support roles within the crisis continuum, existing data about peer support workers in crisis settings need to be unpacked. This would create a more complete picture of the significant roles that peers are already playing in crisis services and the settings where peer support workers are providing services across the crisis continuum. With that in mind, the next two sections discuss (a) existing peer workforce data and (b) the role of peer support workers within crisis prevention, diversion, intervention, and follow-up care.

According to the NASMHPD Research Institute's (NRI's) 2022 State Profiles report, *State Mental Health Agency Workforce Shortages*, although peer support staff is often discussed, it is unclear how many states are actually hiring peers across the crisis continuum.[17] Yet nearly every state is reporting shortages in its workforce across the crisis continuum. More specifically, of 44 states that responded to the survey, the following number of states reported peer support workers as being short-staffed within the categories shown:[18]

17 states reported a shortage of peer support workers within call centers.

24 states reported a shortage of peer support workers within mobile crisis teams.

23 states reported a shortage of peer support workers within crisis stabilization.

18 states reported a shortage of peer support workers within crisis residential.

In addition to the workforce shortages, this same NRI State Profiles report indicated that:[19]

43 states reported using mental health peer support workers.

40 states reported using substance use peer support workers.

34 states reported using parent/family peer support workers.

23 states reported using youth peer support workers.

Of the 44 states that responded, 75% indicated that they were actively recruiting peer support workers; but, without more information, there is no way of understanding where (or in what settings) peer support workers are actively being recruited to work across the broader behavioral health system or crisis service continuum.[20]

Another limitation to these data is the lack of demographic information on the lived experience of the peer support workforce as it relates to suicidal ideas/survivors, which will help the peer support worker connect with the person in crisis significantly.

A comprehensive understanding of data related to how the peer workforce is being integrated across the crisis continuum is needed to help us understand and develop best practices, standards, and implementation strategies to expand peer support workers across the crisis continuum. The need for demographic data to be captured is also great, as the peer support workforce needs to mirror the community served in terms of age, race, sex, and sexual orientation as well as lived experience with mental health challenges and substance use and family member experiences.

Realizing the Potential for Peer Roles Within the Crisis Continuum

The Value of Peers in Crisis Settings

As states consider the various ways to engage with the integration of peer support services (and people with lived experience) across crisis line operations, mobile crisis teams, and crisis stabilization centers, states should consider that people who have experienced suicidality and suicide attempts have lived expertise to assist individuals in similar situations.[21] Considering that 11–50% of individuals who attempt suicide refuse outpatient treatment or quickly stop outpatient treatment following referral, peer intervention for suicidal individuals in crisis services settings has amazing potential.[22] Peer support workers can relate without judgment, communicate hope in a time of great distress, and model the fact that recovery is possible.

The role of peer support workers—specifically peers who are survivors of a suicide attempt and/or survivors of suicide loss—was highlighted in the report from the Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention, *The Way Forward: Pathways to Hope, Recovery and Wellness with Insights from Lived Experience*, in July 2014.[23] The report described ways in which learning from and capitalizing on lived experience can be accomplished. People who have lived experience with crisis, trauma, and/or suicidal ideas and previous attempts can offer understanding, compassion, and awareness of the possible range of thoughts and emotions the person in crisis is likely feeling and thinking. The person with prior lived experience will also have an understanding and knowledge of what worked for them in their own moment of crisis, which can help quickly build trust and connection with the person in crisis. This shared experience allows for an immediate connection and trust-building moment

that can only come through shared experiences. The peer support worker can also model self-care practices and provide a unique and powerful contribution to another person's recovery.[24]

Individuals may receive peer support services along the full continuum of care through a variety of roles and service models. These models, as well as the roles and responsibilities of peer support workers within them, vary depending on the organization and setting.

Components of the Crisis and Acute Care Continuum

SAMHSA's *Advisory: Peer Support Services in Crisis Care* outlines the crisis care continuum and overlays the structure for peer support services and settings, by intensity of care needs, including services intended to avert a crisis, 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, and services aimed to support the individual after the crisis has subsided.[25]

Peer support workers can, and often do, work in every one of these settings. Some of these services are peer-led, such as peer respites, peer warmlines, peer recovery houses, and peer step-up/step-down programs. For example, the peer-run Crisis Stabilization Center in New York serves as an early prototype that exemplifies the power of the peer community working in the crisis stabilization field.[26]

On May 18, 2023, NASMHPD sent an inquiry for feedback to 44 state and territory recovery leads in state government roles through the NASMHPD Division of Recovery Support Services.[27] A total of 17 states provided responses. The purpose of collecting this feedback was to determine the presence of peer workers in different settings of the crisis ecosystem within each state, as outlined in SAMHSA's *Advisory*.[28] The results of this survey are presented in **Table 1.**

Table 1: Peers in Crisis Settings

SAMHSA's Recommendations for Integration of Peers	In a Sample of 17 States, How Many Had These Integrations
Outreach	14
Warmlines	14
Crisis planning	14
Linkage of resources	16
Individual and group digital support	10
Harm reduction	13
Peer-run organizations	16
Mobile recovery centers	6
Outpatient	13
Rehabilitation programs	10
Homeless outreach	12
Inpatient hospitalization care	14
Partial hospitalizations care	5
Short term intensive treatment	9
Linkage to resources such as 23-hour stabilization units/bed, inpatient hospitals, and partial hospitalizations, hospital diversion houses	14

Continued

Table 1: Peers in Crisis Settings, continued

SAMHSA's Recommendations for Integration of Peers	In a Sample of 17 States, How Many Had These Integrations
Crisis hotlines	11
Emergency department care/advocacy	15
Intensive treatment and services	10
Linkage to resources such as emergency department, mobile crisis teams, crisis intervention and response teams, police and correctional diversion	15
Residential stabilization	9
Step-down services	11
One-on-one services	12
Linkage to resources such as crisis receiving and stabilization facilities, crisis respites, Recovery residences, and Living Rooms	15
Post-crisis supports groups	12
Recovery supports	16
Social inclusion and structure	10
In-home peer companionship	4
Self-care supports and digital support such as peer-run organizations, ACT teams, other outpatient and rehabilitative settings	16

Source: Division of Recovery Support Services. NASMHPD, 2023.
https://nasmhpd.org/content/division-recovery-support-services

Peer workers play a crucial role across the crisis ecosystem and its various settings, which we see includes pre-crisis care, sub-acute care, acute care, stabilization, and post-crisis care. By incorporating peer workers at each stage of the crisis ecosystem, states can harness the power of lived experience to enhance crisis services. Let's explore some examples of how peer workers are making a difference in various settings and systems.

1. **Peer warmlines**—A peer support worker warmline provides noncrisis emotional support and assistance to individuals who may be struggling with their mental health. They are staffed by people who have personal experience with mental health challenges (often certified peer support workers) and are focused on providing empathetic and supportive listening and coping strategies. Warmlines have protocols in place for when a caller's distress needs a higher level of support or intervention. Peer warmlines for high risk (non-suicidal) situations are effective at reducing hospitalizations.[29]

2. **Peer-run respites**—A peer-run respite is a voluntary, short-term community-based alternative program for individuals who are experiencing a mental health crisis or distress who do not meet acuity criteria or qualify for acute inpatient psychiatric hospitalization. Unlike traditional clinical psychiatric hospitalization or emergency room care, peer-run respites are run by and for individuals with lived experience of mental health challenges and may be an appropriate alternative to traditional clinical services for some individuals. Peer-run respites are staffed by certified peer support workers and are designed to provide a safe and welcoming environment for individuals to receive support and assistance. Studies have found that individuals utilizing peer-run respites were 70% less likely to use inpatient or emergency services and showed statistically significant improvements in healing, empowerment, and satisfaction.[30,31] Though they do not replace clinical crisis stabilization units, peer respites offer a valuable community-based alternative pathway and should be available to individuals at an appropriate level of acuity.

3. **Peer support workers in schools**—Peer support within school settings involves trained and certified youth peer support workers who offer emotional and informational assistance to students. Peer support can help identify youth who are struggling with mental health challenges before they reach a crisis. It can decrease stigma associated with mental health challenges and encourage help-seeking behaviors, provide social support and connection to students who may be feeling isolated, and increase access to available resources within the school and community.

4. **Peer support workers throughout the criminal justice system**—Peer support in reentry consists of people with a mental health/substance use or co-occurring disorder who also have lived experience with the transition from jail or prison back into the community. People with behavioral health conditions are three to six times more likely than the general population to be represented in the criminal justice system.[32] Peer

support workers are a key component in treatment courts (jail diversion programs, drug/mental health courts, Veterans Courts), prison or jail treatment services, and reentry programs, and can include community supervision programming. The conceptual framework for peers across the criminal justice system and interactions in the community can be seen outlined within the Sequential Intercept Model (SIM), which is a framework that looks across decision points in criminal-legal case processing and aims to intercept a criminal-legal pathway and help reroute or divert people into a treatment pathway.[33] Peer support workers can be used across the continuum of this overlap. They can help people plan for reentry, identify safe housing, and empower with self-awareness about triggers that lead back to the criminal justice system.[34]

5. **Peer support workers in community-based treatment settings such as Certified Community Behavioral Health Clinics (CCBHCs)**—Expansion of peer support services including peer support for family and youth in community-based settings is a form of crisis prevention, intervention, and post-crisis support. Of the original cohorts of CCBHCs, 82% established formal or informal relationships with peer-run/recovery organizations, and a few have established Designated Collaborating Organization arrangements with peer-run/recovery organizations.[35] According to the March 2023 updated CCBHC criteria, access to crisis management services is a requirement. CCBHCs are responsible for providing peer support services delivered by people with lived experience, according to SAMHSA.[36]

6. **Peers on mobile crisis teams**—The role of peer support on mobile crisis teams is to offer hope, build trust, and provide emotional support. Peer support workers draw on their own experiences to help individuals feel heard and understood, share their own recovery stories, and provide examples of coping strategies to use at that moment. Peer support workers working on mobile crisis teams should have a dedicated role in providing peer support, and the use of family peer support should be considered. In Arizona, peer support workers serve alongside mental health clinicians on teams dispatched by local crisis contact centers and public safety answering points that have been approved by the state or county to dispatch mobile crisis outreach to people experiencing mental health or substance use crisis.[37]

7. **Peers in emergency rooms, crisis receiving facilities, Living Rooms, etc.**— In shorter-term crisis stabilization settings, mental health peer support workers provide emotional support, offer coping skills such as grounding exercises, and provide information about community resources such as support groups. Follow-up, post-discharge peer support may be offered depending on the setting and its policies.

8. **Peers in inpatient settings**—Certified peer support workers in inpatient settings provide one-on-one emotional support and facilitate peer support groups. They play a critical advocacy role by helping individuals navigate the health care system and ensure that their

rights and preferences are respected. They also support an individual in post-crisis planning, including preparing to return home. Youth and family peer support can be a valuable asset when children or youth are hospitalized for treatment. Utilizing peer specialists in inpatient settings has been found to mitigate negative experiences and facilitate successful care transitions.[38]

9. **Peer support workers in crisis lines**—Certified peer support workers may also work for crisis call lines such as a local 988 call center. It's critical that peer support workers are able to provide one-on-one peer support and provide it in a way that does not conflict with peer support values. In Colorado for example, callers can choose whether they want to speak to a peer support worker or a crisis counselor. Rocky Mountain Crisis Partners answers Colorado's crisis hotline and peer support line. Calls to Colorado's peer support line jumped 157% and 124% higher in February and March 2020, respectively, than in the same months in 2019.[39]
10. **Peer-led step-up/step-down programs**—A peer-run step-up/step-down program is a mental health support program that offers both crisis stabilization and short-term residential support services. It is staffed by peer support workers and individuals with lived experience of mental health challenges who are trained to provide support and guidance to others going through similar experiences.

Maintaining Peer Support Values in Crisis Service Settings

Although peer support workers have been working in crisis services for some time, the rollout of 988 and associated expansion of the crisis continuum have heightened the concern that peer support workers and others could feel like they are in the midst of a moral conundrum, as some individuals who are experiencing an acute psychiatric crisis may require involuntary treatment to maintain their safety or the safety of others. The peer supporter's lived experience may uniquely inform their perspective in wanting to support the autonomy of the individual. Engaging in the care of an individual who receives involuntary treatment has inherent ethical considerations for all who are involved in providing that care. In such situations, in keeping with person-centered team-based care, there should be transparent communication, respect for all members of the treatment team, a consideration and support of the ethical and emotional implications of the decisions made, and a debriefing after the decision in order to improve team cohesion and improve the quality of care within the team and organization as a whole.

Forced treatment and/or involuntary commitment can occur in cases involving a crisis response that may raise several challenges for peer support workers. Collaborative person-centered approaches to care planning are beneficial, because people are more likely to adhere to treatment plans and choose less invasive and costly treatments if they receive person-centered care.[40] In

addition, SAMHSA established peer core competencies in 2015 for peer workers providing services to people with mental health and substance challenges.[41] Core competencies are "the capacity to easily perform a role or function," and the peer core competencies were developed to "guide delivery and promote best practices within peer support" (p. 2).[42] The SAMHSA peer core competencies that are guiding peer certification trainings, standards, and best practices nationally specifically point out that peer support services should be recovery-oriented, person-centered, voluntary, relationship-focused, and trauma-informed. How peer support workers in crisis service settings can maintain these competencies in all situations should be considered.

Given the reality that peers working in crisis services may brush up against these difficult issues, effective communication, boundaries, and clear role definitions could help address their concerns. Transparency around the role of peer support workers in crisis services where involuntary practices are utilized could help alleviate some of these concerns. Of course, proper supervision of peers and all staff is also going to be a critical component of best practices. In many ways, the use of peers can help promote more positive self-determined choice for service recipients who can see the peers as a beacon of hope in their recovery.

The Role of Supervision

Supervisors of peer support workers play a critical role in helping to maintain the integrity of the peer support role within a crisis service setting.[43] They ensure that peer support workers are practicing within their role and that they are not being asked to perform tasks that are outside the scope of peer support, including clinical or case management services. Supervisors serve as advocates and educators to other staff about the role of peer support and ensure that the peer support role is respected. Ideally, organizations put in place measures to allow for supervision by an experienced peer supervisor, along with clinical supervision. This is the best way to ensure that the values and practice of peer support are maintained.[44] In June 2024, the Center for Medicaid and CHIP Services released a frequently asked questions document that clarified supervision requirements for peer support workers.[45]

Peer Support Services—Bridging Gaps in Underserved Communities

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

cultural brokers, and prevent further distrust of emergency response systems by forming strong, mutual relationships with people served.

Disparities in health care resources and outcomes among these underserved populations create and maintain racial inequities in mental health care. For example, African American men are more likely to be diagnosed with personality disorders such as antisocial personality disorder despite evidence that the incidence of these disorders is relatively consistent across populations.[46] Black men are 13 times more likely to be routed to the criminal justice system for substance use issues than the general population, contributing to increased criminalization of mental illness and substance use.[47] Black youth are two and a half times more likely to be diagnosed with conduct disorder and five times more likely to be diagnosed with adjustment disorder than their White counterparts.[48] These disparities may influence whether individuals receive behavioral therapies or pharmacotherapy within the healthcare system or are routed to criminal/juvenile legal systems. Disparities in mental health outcomes in other populations such as Native Americans and Alaska Natives are also well documented. Thus, Blacks and other minority or non-dominant populations may receive inappropriate treatments when presenting in crisis, further contributing to disparate health and social outcomes.[49]

There is a significant amount of data showing disparities in violent police interactions with people of color in the United States. Numerous studies have found that BIPOC are more likely to experience police use of force, including lethal force, than White individuals.

For example, a study conducted by the National Academy of Sciences found that Black men are about two and a half times more likely to be killed by police than White men. Similarly, data from *The Washington Post's* police shootings database shows that Black Americans are more than twice as likely as White Americans to be unarmed when killed during encounters with police.[50]

Additionally, research by the Center for Policing Equity has found that Black and Latinx people are more likely to experience nonlethal force during police encounters—such as being handcuffed, pepper-sprayed, or pushed to the ground—than White people.[51] Overall, the data show disparities in violent police interactions with certain populations, which should be addressed. The rate of fatal police shootings in the United States is well documented to vary significantly based on ethnicity, with Black Americans experiencing a rate of 5.9 per million of the population per year compared to White Americans' rate of 2.3 per million.[52]

The International Association of Chiefs of Police states that those who don't fall into the category of potentially dangerous behavior are more appropriately handled by mental health provider response and referral.[53] Also, if mental health services and other social support systems are functioning optimally, a much smaller proportion of people in crisis will likely engage in criminal, threatening, or suicidal behavior that becomes the focus of a law enforcement response.[54]

It also recommends considering that, when engaging people in a crisis, assistance should be provided by individuals with specialized training in dealing with mental illness or crisis

situations (e.g., crisis intervention team officers, community crisis mental health personnel, crisis negotiator, or police psychologist).[55]

In light of these disparities, it is crucial that crisis response settings hire peer support workers from diverse backgrounds and with a range of life experiences. The range of experiences that could prove helpful over time in the peer support community could include individuals with lived mental health challenges or substance use experience who have been affected by fatal police shootings. Culturally appropriate staffing must be unique to the communities served, including language and other needs.

One strategy to address mental health stigma in communities of color and improve access to recovery support services for racially and ethnically oppressed individuals is to incorporate cultural competency training for peer support workers. This training should include an understanding of historical trauma in these populations, as well as strategies to create a welcoming and supportive environment for individuals from marginalized communities. Additionally, crisis service providers should be knowledgeable about their state's immigration policies and available support systems to address the unique needs of undocumented individuals with mental illness and substance use challenges. It is also essential for peer support workers to be aware of gender and sexual identity and its impact on mental health, in order to provide equitable treatment and support. By implementing these recommendations, a more inclusive and accessible crisis service system can be created for all individuals.[56]

Working with Diverse Populations

Because crisis services will be serving diverse populations, peer support workers need training and experience to be able to interact with all people in crisis, including veterans, LGBTQI+ individuals, racially and ethnically diverse populations, immigrant populations, neurodivergent individuals, people with criminal and juvenile justice system involvement, older adults, youth, children and young adults, and linguistically diverse populations.[57] Due to national workforce shortages, crisis service providers serving more than one specialized population will require peer support workers to adapt to serve multiple populations. Specialized training for people without the lived experience of the target population is difficult but can be achieved in environments that are trauma-informed, in which employees are aware of their own implicit biases, and in which there is a positive, open, and welcoming organizational culture.

The Role of Family Peer Support

Although adult-serving mental health peer support workers are the most common in crisis settings, there remains a significant opportunity for the utilization of family peer support and youth peer support workers. With the youth mental health crisis growing, crisis response systems that engage with youth and young adults should include youth peer support specialists. Youth peer support follows the same definition of adult peer support but focuses on a younger age

group and ideally utilizes peer support workers who are younger.[58] Organizations hiring youth peer support worker specialists must consider the needs of hiring and retaining a younger population.

Family peer support initially involved a peer support worker who has lived experience as a family member or caregiver of a child, youth, or young adult who has engaged in one or more child-serving systems.[59] In recent years, this definition has expanded to include family members and caregivers of adult children.[60] Given that family members can play a critical role in providing support to a loved one in a mental health crisis, family peer support should be part of the crisis services offering.

Trauma-Informed Practices for Peer Support Services and Training

Peer support can play a highly important role in interrupting the retraumatization cycle that would allow the service recipient to find treatment in their healing process that is person-centered. "According to SAMHSA, effective peer support for trauma survivors is rooted in: providing a sense of safety; trustworthiness and transparency; collaboration and mutuality; empowerment, voice and choice; and awareness of cultural, historical, and gender issues."[61]

> **"Developing trauma-informed peer services is crucial."**
>
> ***—Shery Mead, Trauma Informed Peer Support***

Trauma-informed peer support is essential in crisis services because individuals who are in crisis may be experiencing or re-experiencing trauma, which can impact their mental, emotional, and physical well-being. Trauma-informed care recognizes that traumatic experiences can affect a person's thoughts, behaviors, and emotions and that they may require specialized care and support to heal. Peer support workers with lived experience of trauma can provide valuable support to individuals in crisis, as they can offer empathy, understanding, and hope. Peer support workers can also provide a sense of community and connection, which is essential for individuals who may feel isolated and alone during a crisis.

In addition, trauma-informed peer support can help individuals feel more comfortable accessing crisis services, as they may feel more comfortable discussing their experiences with someone who can relate to their struggles. This can help reduce stigma and increase engagement with services, leading to better outcomes for individuals in crisis. Overall, trauma-informed peer support is critical in crisis services as it provides a unique form of support that is sensitive to the needs of individuals who have experienced trauma and can help them on their path to healing and recovery.

When a peer support worker understands the effects of trauma on an individual they are serving, they will shift their approach on how they interact with the person. To achieve this level of trauma-informed care, a peer support worker must be in a healing place in their own recovery to understand their own issues. They must also understand the trauma of the person they serve, the trauma from a systemic level, and how systems have failed to serve the community. Trauma-Informed Peer Support Trainings (TIPS-NASMHPD) and Trauma-Informed Care Training can better help gain this perspective for peer support workers and supporting staff they work with.[62]

Crisis Responder Models and Alternative Model Approaches

Resources Related to Trauma-Informed Care

- **SAMHSA Evidence-Based Practices Resource Center —Resource for Implementing Trauma-Informed Approach:** Practical Guide for Implementing a Trauma-Informed Approach
- **Mental Health America—Trauma-Informed Peer Support:** CPS Blog: Trauma-Informed Peer Support | Mental Health America (mhanational.org)
- **Shery Mead—White Paper on Trauma-Informed Peer Services:** Trauma Informed Peer Support (healingattention.org)
- **KIVA Centers—Trauma-Informed Peer Support (TIPS):** Trauma-Informed Peer Support (TIPS)—Kiva Centers
- **NASMHPD Webinar Series—Trauma-Informed Peer Support:** Webinar Series on Trauma-Informed Peer Support | National Association of State Mental Health Program Directors (nasmhpd.org)

Responder Model Approaches

Nationally there is increasing interest in adopting models to improve engagement of people experiencing a behavioral health crisis that minimize the use of law enforcement and when needed bring in joint or co-response.[63] Co-responder models vary in practice but typically involve law enforcement and behavioral health clinicians (sometimes peers) working together in responding to a person in a behavioral health crisis.[64] There is no consensus on which model is most effective, and programs should be adapted to the local context, as pointed out in the August 2020 NASMHPD paper "Cop, Clinicians, or Both?"[65] For example, a state police pre-arrest diversion program in Delaware uses a co-responder model to break the cycle of arrest and incarceration of people with mental or substance use disorders.[66] Funded through a braiding of state opioid response grants and a SAMHSA Transformation Transfer Initiative (TTI), this model relies on peer support to accept warm hand-offs from police. There are also co-responder model variations to consider, as is highlighted

in a January 2020 publication from Policy Research Inc., "Responding to Behavioral Health Crisis via Co-Responder Models."[67] This publication notes that "co-responder teams fall into intercepts 0 and 1 within the commonly used Sequential Intercept Model to inform community-based responses to the involvement of people with mental health and substance use disorders in the criminal justice system."

The Sequential Intercept Model, or SIM, recognizes that law enforcement plays a dual role across these two intercept points and is often the first to respond to individuals in crisis.[68] When law enforcement responds to calls for service involving individuals experiencing a behavioral health crisis, it is often related to unmet treatment needs, not major crimes or violence.[69] The sixth brief in this series, *Crisis Systems Coordination and Collaboration: Leveraging Strengths and Opportunities of 988 and 911*, outlines various best and promising practice models for mobile crisis teams, including alternatives to co-response and models involving peers.[70]

Crisis Responder Model Variations[71]

- Law enforcement calls for after-event support.
- Fire department and/or emergency medical services join law enforcement and clinicians.
- Multi-professional teams join, especially for substance use interventions.
- Law enforcement calls for nonclinical support.
- Peer support workers join law enforcement.
- Clinical staff advise from dispatch centers.
- Behavioral health navigators join law enforcement at point of reentry.

Crisis Response Model Approaches That Incorporate Peers

According to National Alliance on Mental Illness, 44% of people incarcerated in jail and 37% of people incarcerated in prison have a mental health condition—and people with mental illness are booked into the nation's jails roughly 2 million times every year.[72] Millions more end up in emergency departments that are often ill-equipped to address mental health crises, often waiting hours or days to access care. Communities that currently have robust crisis services estimate that more than 80% of crises are resolved on the phone, and mobile crisis teams, staffed by behavioral health professionals, are dispatched when an in-person response is needed—with most dispatches resolved in the community.

In addition to that, Mental Health America (MHA) issued a policy statement calling out the need for alternatives to calling 911 and the dispatching of law enforcement personnel in response to mental health and substance use crises.[73] Further, MHA's policy statement indicates that alternative response models can resolve many of the problems associated with police involvement in behavioral health crisis. The cited reasoning for alternative approaches to

behavioral health crisis was that "non-behavioral medical emergencies, such as heart attacks, strokes, and non-vehicular accidents, are often handled by the 911 system. But rather than dispatching a police officer, an ambulance is sent."[74] A law enforcement response to a mental health crisis is almost always stigmatizing for people with mental illnesses and should be avoided when possible. MHA also asserts that peer crisis services can be considered as an alternative to psychiatric emergency department or inpatient hospitalization in some cases. Peer crisis services are operated by people who have experience living with a mental illness (i.e., peers).[75] Peer crisis programs are designed as calming environments with support for individuals in crisis.

Alternative crisis response model examples and resources are:

- **Crisis Assistance Helping Out On The Streets (CAHOOTS), Eugene, Oregon**[76]—Launched in 1989, CAHOOTS provides mobile crisis intervention 24/7 in Eugene and is dispatched through the Eugene police-fire-ambulance communications center. CAHOOTS dispatches a nurse or EMT alongside an experienced mental health worker for calls concerning situations such as welfare checks, mental health episodes, public intoxication, psychological crisis, assessment, information, referral, or advocacy.[77]
- **Olympia, Washington, Crisis Response Unit**[78]—Olympia's Crisis Response Unit (CRU) launched in April 2019. CRU is contracted by the Olympia Police Department and is on call daily from 7 a.m. to 9 p.m. CRU partners with the Familiar Faces program, which uses peer specialists to help identify and assist individuals with complex health and behavioral health problems who frequently and persistently have contact with the Olympia Police Department's Walking Patrol.[79]
- **STAR, Denver, Colorado**[80]—In June 2020, Denver launched its Support Team Assisted Response (STAR). The program provides person-centered mobile crisis response to community members who are experiencing problems related to mental health, poverty, homelessness, and/or substance use issues.[81]
- **New Mexico Call Centers**[82]—Statewide peer-to-peer warmlines staffed by peer workers who partner with the crisis access line to conduct warm handoffs to peer-to-peer warmlines that are Medicaid reimbursable.[83]
- **Minnesota Mobile Crisis Teams**[84]—Peers provide services during all phases of the crisis response (crisis assessment, crisis intervention, crisis stabilization, and community intervention).[85]
- **Pennsylvania Peer-Run Crisis Residential**[86]—Provides temporary services to support individuals experiencing emotional distress and/or emergent crisis. Employed by peers who use their lived experience to assist others. Services are voluntary, short-term, overnight, and available 24/7 days a week to Columbia, Montour, Snyder, and Union

County residents 18 years of age or older experiencing a psychiatric crisis or emotional distress.[87]

A list of studies demonstrating the efficacy of peer-run crisis services can be found online at the National Empowerment Center website.[88] Also located there is a directory of peer respites.[89]

Funding for Peer Support Services

This final section takes on an important issue in the development of a robust peer support workforce across the crisis continuum: financing these services. States fund peer support workers with a diversity of funding streams, including SAMHSA Block Grants, general revenue, Medicaid, and other federal, state, and local dollars to varying degrees. Though not comprehensive, following are some basic funding mechanisms that can be leveraged to support peer services.

Sample of Federal Funding Opportunities Available for Peer Services (Including but Not Limited to Crisis-Specific Peer Services)

- Substance Use Prevention, Treatment and Recovery Support Block Grant[90]
- Community Mental Health Block Grants[91]
- SAMHSA Discretionary Grants[92]
    - Building Communities of Recovery (BCOR) Grants[93]
    - Recovery Community Services Program (RCSP) Grants[94]
    - Statewide Family Network Grants[95]
    - Statewide Consumer Network Grants[96]
    - Harm Reduction Grants[97]
    - Targeted Capacity Expansion Special Projects Grants[98]
    - Treatment, Recovery and Workforce Support Grants[99]
    - State Opioid Response (SOR) Grants—States Only[100]
- SAMHSA 988 Grants
    - Cooperative Agreements for States and Territories to Improve Local 988 Capacity[101]
    - Support for 988 Tribal Response Cooperative Agreements[102]

- Cooperative Agreement for the National Suicide Prevention Lifeline and Disaster Distress Helpline[103]
- Cooperative Agreements for 988 Suicide & Crisis Lifeline Crisis Center Follow-Up Programs[104]

- Treatment, Recovery, and Workforce Grants[105]
- Bureau of Justice COSSUP Grants[106]
- Health Resources and Services Administration (HRSA) Grants[107]

Medicaid Options for Funding Peer Support Workers

- State Plan Rehabilitation Service Options
- Health Home State Plan Option
- Section 1915 (i)
- Section 1115 Demonstration Waivers
- Certified Community Behavioral Health Clinic Demonstrations[108]

Some additional resources regarding funding for peer support workers in crisis services to review include:

- **Medicaid and CHIP Payment and Access Commission (MACPAC)**—In July 2019, released an issue brief outlining Medicaid's role as a payer of recovery support services and states' coverage of recovery support services.[109]
- **National Academy for State Health Policy (NASHP)**—In August 2022, released a blog detailing various ways states are incorporating peer support workers into crisis services as well as how states are funding peer services within crisis services.[110]

Conclusion

The integration and implementation of peer support services across the crisis continuum continue to expand and have the potential to grow significantly more. The integration of effective and quality peer support into crisis settings should be expected across every state and community. Standardization of data collection is still needed to describe the types of services where peers are being utilized and where their work is still needed. If behavioral health systems are to reach the full potential of quality peer support services, adequate reimbursement rates for peer support (particularly in crisis care) are a must. As states continue to implement peer support services

across the crisis continuum, there is still so much to learn and so much to gain from state-to-state sharing opportunities.

Many Consumer Affairs/Office of Recovery divisions within state government have a limited number of staff who do not have the time, energy, or resources to research the necessary information for proper implementation of peer services across crisis services. Most of these offices have one staff person trying to run all the peer/recovery support services for their state. Often silos within state government also prevent adequate interagency collaboration within state mental health authorities. The peer/recovery community leaders are often criticized for a lack of research, data, and professionalism, but there have been many barriers to the development of this knowledge base due to limited funding for peer wages and peer-run services as well as limited funding for research, proper data collection, and research-based outcomes and evaluations. The peer support workforce must also reflect the community served for equity to be achieved and for authentic peer support service delivery to be achieved. For true, authentic voices to be heard and recognized for the value that peer support workers bring to the crisis space and to other aspects of behavioral health services, it is imperative that proper data collection measures and recovery-oriented outcome measures be put in place.

Moreover, beyond collecting and tracking data on the use of peer support workers in crisis settings, clear delineation of and education about their roles and adequate supervision are necessary for the successful implementation of peer services. Increasing the number of peer respites and other nonclinical settings as an option for those who do not meet acuity criteria, expanding mobile crisis teams, and diverse peer outreach to underserved communities are critical for a comprehensive crisis response system as part of a complete continuum of behavioral health services.

The recommendations in this paper are not all-inclusive, but they reflect areas of high priority for strengthening the workforce in crisis services with peer support workers. The eight key recommendations for enhancing the role of peer support workers across the crisis continuum are vital to ensure that individuals in crisis, especially those from marginalized communities, receive appropriate and effective support. The need for national toolkits and resources, model training curricula, and core competencies for peer support workers is urgent to standardize the delivery of peer support services and enhance organizational readiness scales to be shared with states, territories, and providers.

The implementation of these recommendations to augment peer support is a critical step in building a crisis response system that is accessible, effective, and trauma-informed for all individuals experiencing crisis.

Authors:

Amy Brinkley, CRS/CHW, CAPRCII
Senior Recovery Support Systems Coordinator, National Association of State Mental Health Program Directors

Justin Volpe, CRPS-A
Senior Peer Support Coordinator, National Association of State Mental Health Program Directors

References

[1]National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Substance Abuse and Mental Health Services Administration, 2020

[2]Pinals DA: From Crisis to Care: Building From 988 and Beyond for Better Mental Health Outcomes. National Association of State Mental Health Program Directors (NASMHPD), 2022

[3]Pinals DA, Schofield G: Connected and Strong: Strategies for Accessible and Effective Crisis and Mental Health Services. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

[4]Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, as Part of Unity Agenda in His First State of the Union. The White House, 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

[5]National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Substance Abuse and Mental Health Services Administration, 2020

[6]Ibid.

[7]Ibid.

[8]Advisory: Peer Support Services in Crisis Care. Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/resource/ebp/advisory-peer-support-services-crisis-care

[9]Ibid., p. 1

[10]Nichols M, Saubers T, Kues D, et al: 2023 Update to the Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States. Peer Recovery Center of Excellence, 2023. https://peerrecoverynow.org/product/2023-update-to-the-comparative-analysis-of-state-requirements-for-peer-support-specialist-training-and-certification-in-the-u-s/

[11]Peer Specialists. Copeland Center for Wellness and Recovery. https://copelandcenter.com/doors-wellbeing/peer-specialist-database

[12]State Mental Health Agency Peer Specialist Workforce, 2022. NASMHPD Research Institute, Inc. (NRI), 2022

[13]Oaks D: The evolution of the consumer movement. Psychiatr Serv 2006; 57:1212–1212

[14]DiGravio V: The last bill JFK signed—and the mental health work still undone. WBUR News, October 23, 2013. https://www.wbur.org/news/2013/10/23/community-mental-health-kennedy

[15]Pinals DA, Fuller DA: The vital role of a full continuum of psychiatric care beyond beds. Psychiatr Serv 2020; 71:713–721, p. 8. https://psychiatryonline.org/doi/10.1176/appi.ps.201900516

[16]State Mental Health Agency Workforce Shortages Across the Crisis Continuum. NRI, 2022

[17]State Mental Health Agency Peer Specialist Workforce, 2022. NRI, 2022

[18]Ibid.

[19]Ibid.

[20]Ibid.

[21]National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Substance Abuse and Mental Health Services Administration, 2020

[22]Kessler RC, Berglund P, Demler O, et al: Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005; 62:593

[23]National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Substance Abuse and Mental Health Services Administration, 2020

[24]The Way Forward: Pathways to Hope, Recovery, and Wellness With Insights From Lived Experience. Washington, DC, National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, 2014

[25]Advisory: Peer Support Services in Crisis Care. Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/resource/ebp/advisory-peer-support-services-crisis-care

[26]Pandya H: The Future of Crisis Care Isn't in a Hospital—Introducing People USA's Crisis Stabilization Center. Cision PRWeb, 2023. https://www.prweb.com/releases/the-future-of-crisis-care-isn-t-in-a-hospital-introducing-people-usa-s-crisis-stabilization-center-861240458.html

[27]Division of Recovery Support Services. NASMHPD, 2023. https://nasmhpd.org/content/division-recovery-support-services

[28]Advisory: Peer Support Services in Crisis Care. Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/resource/ebp/advisory-peer-support-services-crisis-care

[29]988 Convening Playbook: States, Territories, and Tribes. NASMHPD, 2022

[30]Croft B, Isvan N: Impact of the 2nd story peer respite program on use of inpatient and emergency services. Psychiatr Serv 2015; 66:632–637. https://pubmed.ncbi.nlm.nih.gov/25726982/

[31]Greenfield TK: A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. Am J Community Psychol 2008; 42:135–144. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2782949/

[32]Pfefferle S, Steverman S, Gault E, et al: Approaches to Early Jail Diversion: Collaborations and Innovations. Office of the Assistant Secretary for Planning and Evaluation, 2019. https://aspe.hhs.gov/reports/approaches-early-jail-diversion-collaborations-innovations

[33]The Sequential Intercept Model (SIM). Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

[34]Intercept 4: ReEntry. Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/criminal-juvenile-justice/sim-overview/intercept-4

[35]Rosenthal H, Schwartz E, Hill T, et al: Certified Community Behavioral Health Clinics, Peer-Delivered Services and Peer-Operated Agencies: Opportunities for Collaboration and Expansion. New York, New York Association of Psychiatric Rehabilitation Services, Inc.; Washington, DC, National Council for Behavioral Health, 2019

[36]Person- and Family-Centered Care and Peer Support. SAMHSA, 2023. https://www.samhsa.gov/certified-community-behavioral-health-clinics/section-223/care-coordination/person-family-centered

[37]988 Convening Playbook: States, Territories, and Tribes. NASMHPD, 2022

[38]Smith TE, Abraham M, Bivona M, et al: "Just be a light": Experiences of peers working on acute inpatient psychiatric units. Psychiatr Rehabil J 2017; 40:387–394. https://psycnet.apa.org/record/2016-49035-001

[39]Hepburn S: The Chronic Misunderstanding of the Peer Role in Behavioral Health. #CrisisTalk, 2021. https://talk.crisisnow.com/the-chronic-misunderstanding-of-the-peer-role-in-behavioral-health/

[40]Miller E, Stanhope V, Restrepo-Toro M, et al: Person-centered planning in mental health: A transatlantic collaboration to tackle implementation barriers. Am J Psychiatr Rehabil 2017; 20:251–267

[41]Core Competencies for Peer Workers. Substance Abuse and Mental Health Services Administration, 2015. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers

[42]Ibid.

[43]National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Substance Abuse and Mental Health Services Administration, 2020

[44]Ibid.

[45]Center for Medicaid and CHIP Services: Frequently Asked Questions. 2024. https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf

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

[47]Hansen HB, Jackson JF: Addiction, drug policy, and Black clinical innovations; in Black Mental Health: Patients, Providers, and Systems. Washington, DC, American Psychiatric Publishing, 2019

[48]Fadus MC, Ginsburg KR, Sobowale K, et al: Unconscious bias and the diagnosis of disruptive behavior disorders and ADHD in African American and Hispanic youth. Acad Psychiatry 2020; 44:95–102

[49]Pinals DA, Edwards ML: Crisis Services: Addressing Unique Needs of Diverse Populations. Alexandria, VA, NASMHPD, 2020

[50]Jenkins J, Mathur M, Muyskens J, et al: Police Shootings Database 2015–2023: Search by Race, Age, Department. Washington Post, 2023. https://www.washingtonpost.com/graphics/investigations/police-shootings-database/; Edwards F, Lee H, Esposito M: Risk of being killed by police use of force in the United States by age, race–ethnicity, and sex. Proc Natl Acad Sci 2019; 116:16793–16798

[51]Center for Policing Equity. 2023. https://policingequity.org/

[52]Number of People Shot to Death by the Police in the United States From 2017 to 2023, by Race. Statista, 2023. https://www.statista.com/statistics/585152/people-shot-to-death-by-us-police-by-race/

[53]Responding to Persons Experiencing a Mental Health Crisis. International Association of Chiefs of Police, 2018. https://www.theiacp.org/resources/policy-center-resource/mental-illness/

[54]Ibid.

[55]Ibid.

[56]Pinals DA, Edwards ML: Crisis Services: Addressing Unique Needs of Diverse Populations. Alexandria, VA, NASMHPD, 2020

[57]Ibid.

[58]Welch M-B, Baird C, Seibel C: What Is Peer Support and What Is NOT Peer Support? Portland, OR, Portland State University, 2017

[59]Parents and Families. Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/brss-tacs/recovery-support-tools/parents-families

[60]Family Peer-to-Peer Support Programs in Children's Mental Health: A Critical Issues Guide. Rockville, MD, National Federation of Families for Children's Mental Health, 2008

[61]Hendry P: Trauma-Informed Peer Support. Mental Health America, Center for Peer Support, 2023. https://www.mhanational.org/cps-blog-trauma-informed-peer-support

[62] Trauma-Informed Peer Support Curriculum Trainer's Manual. NASMHPD, 2013

[63] Krider A, Huerter R, Gaherty K, et al: Responding to Individuals in Behavioral Health Crisis via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers. Policy Research, Inc., 2020; Pandya H: The Future of Crisis Care Isn't in a Hospital—Introducing People USA's Crisis Stabilization Center. Cision PRWeb, 2023. https://www.prweb.com/releases/the_future_of_crisis_care_isnt_in_a_hospital_introducing_people_usa_s_crisis_stabilization_center/prweb19304201.htm

[64]Balfour ME, Stephenson AH, Delany-Brumsey A, et al: Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies. Psychiatr Serv 2022; 73:658–669

[65]Ibid.

[66]NASMHPD Research Institute, Inc. Jail Diversion Delaware. Falls Church, VA: NASMHPD Research Institute, Inc.; May 2023. Available at: https://www.nasmhpd.org/sites/default/files/2023-05/Jail-Diversion-Delaware-508.pdf

[67]Krider A, Huerter R, Gaherty K, et al: Responding to Individuals in Behavioral Health Crisis via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers. Policy Research, Inc., 2020

[68]Shah SA: Dangerousness and civil commitment of the mentally ill: Some public policy considerations. Am J Psychiatry 1975; 132:501–505

[69]Wood JD, Watson AC, Fulambarker AJ: The "gray zone" of police work during mental health encounters: Findings from an observational study in Chicago. Police Q 2017; 20:81–105

[70]Stephenson A, Naturale A, Miller A, et al.: Crisis Systems Coordination and Collaboration: Leveraging Strengths and Opportunities for 988 and 911. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

[71]Krider A, Huerter R, Gaherty K, et al: Responding to Individuals in Behavioral Health Crisis via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers. Policy Research, Inc., 2020

[72]Bronson J, Berzofsky M: Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–12. Washington, DC, U.S. Department of Justice, 2017

[73]Position Statement 59: Responding to Behavioral Health Crises. Mental Health America, 2017. https://www.mhanational.org/issues/position-statement-59-responding-behavioral-health-crises

[74]Ibid.

[75]Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. SAMHSA, 2014

[76]CAHOOTS—White Bird Clinic. https://whitebirdclinic.org/cahoots/. Accessed July 30, 2023

[77]Ibid.

[78]Crisis Response & Peer Specialists. Olympia, WA. https://www.olympiawa.gov/services/police_department/crisis_response.php. Accessed July 30, 2023

[79]Ibid.

[80]Support Team Assisted Response (STAR). WellPower, 2023. https://www.wellpower.org/star-program/

[81]Ibid.

[82]Falkner R, Manz J, Antezzo M: States' Use of Peers in the Mental Health Crisis Continuum. National Academy for State Health Policy, 2022. https://nashp.org/states-use-of-peers-in-the-mental-health-crisis-continuum/

[83]Ibid.

[84]Ibid.

[85]Ibid.

[86]The PATH Home. Pennsylvania Department of Human Services, 2023. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/PATH.aspx

[87]Ibid.

[88]Evidence for Peer-Run Crisis Alternatives. National Empowerment Center, 2023. https://power2u.org/evidence-for-peer-run-crisis-alternatives/

[89]Directory of Peer Respites. National Empowerment Center, 2023. https://power2u.org/directory-of-peer-respites/

[90]Substance Abuse and Mental Health Block Grants. Substance Abuse and Mental Health Services Administration, 2023. https://www.samhsa.gov/grants/block-grants

[91]Community Mental Health Services Block Grant. Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/grants/block-grants/mhbg

[92]Grants. Substance Abuse and Mental Health Services Administration, 2023. https://www.samhsa.gov/grants

[93]Building Communities of Recovery. Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/grants/grant-announcements/ti-19-003

[94]Recovery Community Services Program—Statewide Network. SAMHSA, 2022. https://www.samhsa.gov/grants/grant-announcements/ti-17-006

[95]Statewide Family Network Program. SAMHSA, 2022. https://www.samhsa.gov/grants/grant-announcements/sm-15-001

[96]Statewide Consumer Network Program. SAMHSA, 2020. https://www.samhsa.gov/grants/grant-announcements/sm-15-002

[97]Harm Reduction Grant Program. SAMHSA, 2022. https://www.samhsa.gov/grants/grant-announcements/sp-22-001

[98]Targeted Capacity Expansion Special Projects Grants. SAMHSA, 2022. https://www.samhsa.gov/grants/grant-announcements/ti-22-002

[99]Treatment, Recovery and Workforce Support Grants. SAMHSA, 2023. https://www.samhsa.gov/grants/grant-announcements/ti-23-021

[100]State Opioid Response Grants. SAMHSA, 2023. https://www.samhsa.gov/grants/grant-announcements/ti-22-005

[101] Cooperative Agreements for States and Territories to Improve Local 988 Capacity. SAMHSA, 2023. https://www.samhsa.gov/grants/grant-announcements/fg-23-006 -:~:text=States and territories are expected,988 infrastructure and effective coordination

[102]Support for 988 Tribal Response Cooperative Agreements. SAMHSA, 2023. https://www.samhsa.gov/grants/grant-announcements/fg-23-005

[103]Cooperative Agreement for the National Suicide Prevention Lifeline and Disaster Distress Helpline. SAMHSA, 2021. https://www.samhsa.gov/grants/grant-announcements/sm-21-005

[104]Cooperative Agreements for 988 Suicide and Crisis Lifeline Crisis Center Follow-Up Programs. SAMHSA, 2023. https://www.samhsa.gov/grants/grant-announcements/fg-23-003#:~:text=The%20purpose%20of%20the%20program,Lifeline%3B%20(2)%20providing%20enhanced

[105]Treatment, Recovery, and Workforce Support Grant. SAMHSA, 2022. https://www.samhsa.gov/grants/grant-announcements/ti-20-013

[106]Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP). Washington, DC, U.S. Department of Justice, 2023. https://www.bja.ojp.gov/program/cossup/about

[107]Behavioral Health Workforce Education and Training (BHWET) Program for Paraprofessionals. Health Resources and Services Administration. (n.d.). https://www.hrsa.gov/grants/find-funding/HRSA-21-090

[108]Section 223 Demonstration Program to Improve Community Mental Health Services. Medicaid. (n.d.). https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html

[109]McMullen EK: Recovery Support Services for Medicaid Beneficiaries With a Substance Use Disorder. Medicaid and CHIP Payment Access Commission, 2019.

[110]Falkner S, Manz J, Antezzo M: States' Use of Peers in the Mental Health Crisis Continuum. Portland, ME: National Academy for State Health Policy. https://nashp.org/states-use-of-peers-in-the-mental-health-crisis-continuum/. Accessed October 31, 2023.