ASH Redesign Phase III
Peer and Family Workgroup Recommendations

In a continued effort to prioritize "*People First"* as a principle and to strive for diverse peer and family representation within the ASH Redesign effort, all ASH Redesign workgroups and the Brain Health Steering Committee included either peer and/or family representation, as well as continued collaborative work within the Peer and Family Workgroup (membership listed in Appendix A). Following the ASH Redesign 2021 report and Phase II peer and family workgroup effort, the following aims were prioritized for the Phase III workgroup:

- Research peer and family collaborative programs to integrate into the campus
- Develop and propose specific expansion of peer services
- Recommend alternative practices to the current hospital approach

The workgroup addressed these aims in two separate phases of the workgroup process and used several engagement strategies to collect diverse peer and family input into understanding and arriving at recommendations.

Process: Diverse Peer & Family Representation

Diverse representation was identified as a critical overarching goal for peer and family engagement. Furthermore, the workgroup determined it would strive to seek diverse input from peers and family members across the service area. We suggest that this diverse representation could be prioritized throughout the service continuum and within ASH peer services. Peer and family voices are critical for identifying gaps and solutions in the behavioral health continuum of care. The group reached out through HHSC peer support specialist and family partner statewide stakeholder calls, as well as to NAMI Texas stakeholder contact lists, to collect input using a survey that explored needs for peer and family services expansion. Based on feedback gathered in areas ranging from evidence-based successful programs to expansion of peer services, the group arrived at the following recommendations.

Recommendations

1. **Peer and Family Leadership at the State Level for State Hospital Systems**

One need consistently identified by stakeholder input and our workgroup member process was an increased representation of peer and family leadership and direction at the state level. Specifically, peer leadership representation could be incorporated into state hospital programming and oversight. Given the success of the HHSC *Peer and Recovery Services Programs, Planning and Policy Office* in expanding peer and family community-based supports and services, incorporating peer and family partner leaders to have a more directive role in shaping state hospital continuum services and supports could advance approaches to care delivery. Recognizing the value of peer support specialist and family partner leaders at the state level further secures the HHSC commitment to expanding peer and family

driven state hospital continuum services. Engagement at a leadership level would set the precedence of including peer and family workforce as a core aspect of a person's care team.

2. Expanding the Peer & Family Support Services Continuum

Consistently identified throughout our group's work was a need to expand diverse, person-directed peer and family services broadly across the ASH service area. In this effort, workgroup members emphasized the state could comprehensively identify community peer services throughout the service area, collect public information on programming that is evidenced based or promising in practice, and continue to engage, collaborate, promote, and expand peer and family directed services, advocacy, and organizations. Scanning the entire ASH service area would help identify and address critical resources, assets, and gaps to provide a more in-depth understanding of how to best expand peer and family support services. Family partner and other supports are equally critical across the continuum and could also be prioritized in efforts to identify and address resources and gaps. The work group recommends that a scan of available services would benefit those in need of peer and family services. Often it was mentioned by work group members that at discharge services were recommended that were no longer available. A provider list for peer and family services that is updated regularly would enhance connection of people to the services in an efficient manner and decrease gaps in services as well as hospital readmissions.

3. Peer Bridges

Workgroup members consistently identified a need for strong peer-supported bridging for people discharged from ASH into the community. The workgroup recommends establishing designated teams of peer specialists in the community to work with ASH peer specialists to develop a strong discharge bridge program. A peer bridge pilot could be commissioned to establish a scalable model for ASH and other state hospital systems.

One model reviewed by the workgroup is the peer bridge model in Massachusetts, through the Kiva Centers, where certified peer support specialists work both within the state hospital and in the community to support both care settings. Kiva Centers representatives help link people to post-hospital life after discharge from state hospital systems in supporting warm, peer-driven connectivity and transitions.

In addition, Kiva Centers is the statewide certification body for Peer Specialists in Massachusetts, in which the Centers, along with peer bridging and respite, provide extensive experience in supervising peer specialists, training, and providing technical assistance and consulting. The Centers prioritize trauma-informed approaches and environments, policy formulation, and disability advocacy. The model established by Kiva Centers is one that might be tested as a demonstration project on the ASH campus and, if successful, expanded throughout the region. Kiva Centers are financially supported through a braided system of state funding, grants, and philanthropy. As expansion of peer services is implemented, a bridging program would assist in a warm hand off or discharge from a state hospital setting guiderails for the person back into their community. Currently, peer specialists are unable to continue their services after a person is discharged from ASH, leading to a potential gap or stall in care as the person transitions from settings. The bridge program we recommend would close that gap.

4. Peer Workforce

Workgroup members also determined that continued peer support specialist and family partner workforce development is critical to expand and enhance peer and family supports for state hospital systems. Peer workforce development and advocacy would maintain the integrity of the peer support specialist and family partner roles, and support respect of peer specialists and family partners. We recommend that HHSC ensure at a minimum that peer support specialists and family partners are receiving the training, supervision, and support they need to help others while balancing their own self and community care. Peer support specialists and family partners could have access to free and affordable training to deliver evidence-based, peer-driven programs. Further, as indicated above, peer and family leaders in directing positions, particularly in state hospital upper administration could assist with advocating for the peer and family workforce. As Peer Support Specialists and Family Partners are expanded in the service continuum of care, their wages need to be representative of competitive living wages and opportunities to have upward mobility and a career trajectory.

The potential for peer burnout and turnover is high and has become more precarious given the impact of the COVID-19 pandemic. Peer supervision that is peer-driven in which specific understanding of needed supports for professional development, in leadership, and in self-care is fundamental. Lived experience counting augmenting other training and education could be prioritized in HHSC hiring; human service curricula must include courses focused on peer support and how to best use the skills that peers bring to an organization. The work group recommends HHSC invest substantially in recruiting and retaining peer specialists throughout the mental health continuum.

5. Peer Respite

Another priority area is peer-run crisis respite, which would serve to prevent hospitalization and support needs for people discharging from ASH and transitioning back into the community. Peer respite also plays a crucial role in circumventing crisis cycles. The workgroup recommends that HHSC further investigate existing peer-run crisis respite efforts nationally, review organizational plans and costs from these, in order to design respite opportunities as a step-down from ASH. Collecting data from various models from other states would help inform a resource and cost-effective approach to expand this important post-hospital support.

The workgroup endeavored to research a particular model of peer respite, offered by the Kiva Centers in Massachusetts; the Karaya Peer Respite is funded through the Office of Health and Human Services and is contractually overseen by the Massachusetts Department of Mental Health. In the model, peer respite services are offered on site and remotely. The peer respite house has six bedrooms, where guests can stay five to seven days, or in rare cases for a maximum stay of one month. The per-day cost is approximately $350, less than half the cost of staying in ASH.

A Peer Crisis Respite center would be an appropriate service added to the ASH service area and campus in order to expand the brain health platform. Such a resource would provide alternative care options for individuals in crisis, avoiding arrest or an unneeded hospital stay. As a result, the center would also assist in individuals to receiving the right care, at the right time, in the right place.

6. Continued Need for Peer and Family Voice in Implementing the New Austin State Hospital

The peer and family voice has been an important and valuable component of the ASH Redesign process. The workgroup emphasizes, along with these recommendations, that prioritizing peer and family input is valuable not only for planning a care continuum, but in ongoing dialogue in the administration of the new hospital. Doing so will ensure the hospital responds in a way that establishes services and supports that link one in supportive peer and family networks both within the hospital and then out into to the community.

Conclusion:

The Peer and Family Work Group of ASH Redesign recommends expansion of peer and family services throughout ASH, HHSC, and the continuum of care. Incorporating these valuable services provided by people with lived experiences and family members of people with lived experiences supports the *People First* principle that the ASH Redesign maintains and intends to perpetuate throughout the continuum of care. All recommendations are scalable from demonstration projects to service expansion and then potentially statewide initiatives. As a next step, HHSC can continue to enhance and expand their peer and family support services throughout their service array. From expansion it is imperative to increase the workforce by providing sustainable and competitive living wages and the opportunity for career growth. HHSC has the opportunity to develop a brain health platform campus at ASH with a person-centered focus and through the recommended bridge programs and peer run crisis respite centers, HHSC can truly enhance a person's care experience and recovery.

Appendix A: Peer and Family Work Group Members

Name	Organization/Role	Role
Parker LaCombe	Director of Peer Services, ASH	Co-Chair
Greg Hansch	Executive Director, NAMI Texas	Co-Chair
Noah Abdenour	Director Peer and Recovery Services Programs, Planning, & Policy, HHSC	Member
Darrin Acker	Executive Director, Communities for Recovery	Member
Lauv Bruner	State Hospital Construction Project Coordinator, Health & Specialty Care, HHSC	Member
Sonja Burns	Mental Health Advocate	Member
Felicia Mason Edwards	Certified Family Partner Coordinator, Peer & Recovery Services, Planning and Policy, HHSC	Member
Dulce Gruwell	Peer Program Coordinator, NAMI	Member
Colleen Horton	Director of Policy Hogg Foundation	Member
Jason Johnson	Director of Peer Services, Hill Country MHDD	Member
Matthew Lovitt	Peer Policy Fellow, NAMI Texas	Member
Cory Morris	Coordinator of Local & State Mental Health Initiatives, Department of Psychiatry & Behavioral Sciences, Dell Medical School	Member
Peggy Perry	Director of Quality Management, Health & Specialty Care System, HHSC	Member
Jody Schulz	Retired NAMI Brazos Valley Executive Director, current MHFA Coordinator Contractor with MHRA Brazos Valley	Member
Sherley Spears	Cultural Consultant	Member