The Roadmap to Improve Access and Care for Diverse Communities in Mental Health and Substance Use Recovery

Prepared by:

The Center at Sierra Health Foundation

Twelve HEAR US Phase 1 Partners unite at Sierra Health Foundation for their First In-Person Learning Collaborative Meeting.

Contents

Letter from The Center

HEAR US! Can you hear the voices of California's communities of color, 2S/LGBTQ+ and people living with disabilities? They face unique hardships related to substance misuse and mental health. Not surprisingly, ignoring these voices leads to troubling national statistics and realities, such as:

- In 2020, suicide was the leading cause of death among Asian Americans and Pacific Islanders, ages 10 to 19, and the second leading cause of death among those ages 20-34.[i]
- Black Americans are less likely to finish substance use disorder treatment and are more likely to be asked to leave before treatment is complete compared to their white counterparts.[ii]
- 36% of Hispanic and Latino Americans received mental health services compared to non-Hispanic Whites (52%).[iii]
- From 2019-2020, the American Indian and Alaska Native overdose death rate increased by 39%.[iv]
- 2S/LGBTQ+ individuals are 2.5 times more likely to experience depression, anxiety, and substance misuse compared with heterosexual individuals.[v]
- From 2019-2020, 20.49% of adults in California experienced a mental illness and 16.7% reported having a substance use disorder.[vi]

With funding, support, leadership, and commitment from California's Department of Health Care Services (DHCS), The Center at the Sierra Health Foundation is proud to present this report, "The Roadmap to Improve Access and Care for Diverse Communities in Mental Health and Substance Use Recovery." Like all significant projects, this work could not have been completed alone. A special thanks goes out to the contributors of this project, Health Management Associates (HMA) especially Nayely Chavez, Laura Collins, Michelle Ford, Kelsey Moore, Rachel Johnson-Yates, and Leticia Reyes-Nash; our twelve organization project partners, and most importantly the community members of our partners engaged in this effort.

The hope is that this Roadmap that has been created will be used by local systems, organizations, and individuals throughout California to improve both the access to behavioral health care services and the quality of behavioral health care services provided. Only then can we truly hear and address the needs of our communities most in need.

Executive Summary

Background

In late 2021, The California Department of Health Care Services awarded The Center at the Sierra Health Foundation (The Center) a grant to help improve behavioral health services for underserved communities in our state. In 2022, The Center engaged Health Management Associates (HMA) to develop a community-driven Roadmap that builds on the Substance Abuse and Mental Health Services Administration's (SAMHSA's) guidance for recovery services[vii].

The project focuses on promoting accessible and equitable behavioral health care for people with serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD). An additional focus is on improving this care for underserved populations, including Black, Indigenous, Latine, Asian Pacific Islander, people with disabilities, and 2S/LGBTQ+ communities. The overarching goal of Health Equity in Access to Behavioral Health Recovery Services (HEAR US) is to increase the number and quality of culturally responsive behavioral health recovery services and programs tailored to local needs in California.

"Black Women Rise Together in Sisterhood, Empowering RECOVERY & Health!" - California Black Women's Health Project.

Zima Creason, former President of the Mental Health Association of California and Board President of San Juan Unified School District, spoke at our first HEAR US Partners meeting.

The project included 12 participating organizations and involved four phases that included both a qualitative and quantitative analysis: Creating; Defining; Refining and Finalizing the Roadmap. In each phase, the 12 organizations engaged with stakeholders across California and facilitated focus groups and surveys to assess the specific needs/gaps within their populations, as well as learn about promising community-defined practices and other best practices. In addition, HMA completed a literature review and landscape analysis to provide an overview of best and promising practices in behavioral health. Three additional focus groups were engaged in developing The Roadmap and plan with actionable strategies to improve the accessibility, utilization, and quality of behavioral health recovery services.

The Roadmap to Improve Access and Care for Diverse Communities in Mental Health and Substance Use Recovery

The process informed the development of The Roadmap to Improve Access and Care for Diverse Communities in Mental Health and Substance Use Recovery (The Roadmap) that encompasses a recovery model of care that promotes access to care and health equity across diverse communities. The Roadmap has both foundational principles and core components.

The five foundational principles that should be infused across all programs/services/approaches are the following:

1. Empowerment, autonomy, and self-determination
2. Person-/family-driven
3. Responsiveness to diversity
4. Community connection
5. Hope-centered

An organization's behavioral health services operations, goals, and strategies should reflect those five values.

Guiding Principle: There are overarching beliefs and values that help direct an organization's operations, goals and strategies – the guiding principles formed the foundation of The Roadmap and the strategies outlines.

Core Component: These are five areas of work that will strongly support increasing access and equity for treatment and support for communities in recovery.

Actionable Strategy: Opportunities to take action within your community and organizations are provided to help catalyze more work and increase access and equity. These are not meant to be a finite list, and instead of examples that align with the core components.

Fostering Youth Engagement: United Parents Collaborating with 'One Step A La Vez' for Positive Impact.

Five Core Components

The following five core components of The Roadmap were developed with robust feedback and insight from stakeholders. The components that inform and promote accessible and equitable care for underserved communities include:

Core Component	Definition	Actionable Strategies
Culturally responsive services and systems	Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices, and needs of diverse consumers.	• Foster and support a diverse workforce and leadership that represents the community served. • Develop workforce trainings, demographic data analyses, and policies and procedures to support diversity, equity, inclusion, and belonging (DEIB) within the organization. • Culturally responsive programs (family-based models). • Multi-sectoral/cross system collaborative approaches.
Low-barrier access to services	Broader access to care and services; "the timely use of personal health services to achieve the best health outcomes" (AHRQ.gov).	• Mobile clinics/street medicine. • Telehealth. • App-based interventions. • Integrated/co-located health and services. • Build access to interim engagement options for persons on the waitlist for care.
Integrated peer support across the recovery continuum	Peer support encompasses a range of services, activities, and interactions between people who share similar experiences of being diagnosed with mental health conditions, SUD, or both.	• Career navigation for people with lived experience including employment support. • Development of peer service quality standards for both peers and organizations. • Consumer-operated models (Peer Respite). • Formal supports for employed Community Health Workers & Peers. • Develop integrated peer model for treatment teams.

Core Component	Definition	Actionable Strategies
Harm reduction approach	Promotes health and safety for people who use drugs through low-barrier, non-judgmental, evidence-based services that are designed and conducted in alliance with those they serve	• Safer drug use services, including education and access to sterile injection equipment and other supplies. • Overdose prevention services include prevention and response education, naloxone access, post-overdose interventions, drug checking, and safe drug consumption services. • Harm reduction-oriented case management and healthcare coordination, including linkage to substance use disorder treatment services and other healthcare. • Community outreach services including street/mobile outreach and drop-in centers. • Other low-barrier health and social services that support health and safety for people who use drugs.
Address the needs of the whole person	Person-centered, comprehensive approach to wellness which often is delivered in integrated care settings or through programs that focus on the holistic identity and needs of the individual.	• Certified Community Behavioral Health Clinics (CCBHC). • Recovery Capital Index measure. • Patient/family-centered care models Collaborative care models. • Recreation and Recreational Therapist approach in supporting recovery.

This report further outlines the details of these core components, providing strategies in more detail, and practical examples for each (see Appendix A: Best and Emerging Practices Guide).

HEAR US Project Description

Overview

Health Equity in Access to Behavioral Health Recovery Services (HEAR US) is a special statewide project funded by the California Department of Health Care Services (DHCS) and managed by The Center at Sierra Health Foundation (The Center). The overarching goal of HEAR US is to increase the number and quality of culturally responsive behavioral health recovery services and programs tailored to local needs in California.

HEAR US (Phase 1) involved 12 organizations from across California that help individuals experiencing severe mental illness (SMI), serious emotional disturbances (SED), and substance use disorders (SUD). These partners include:

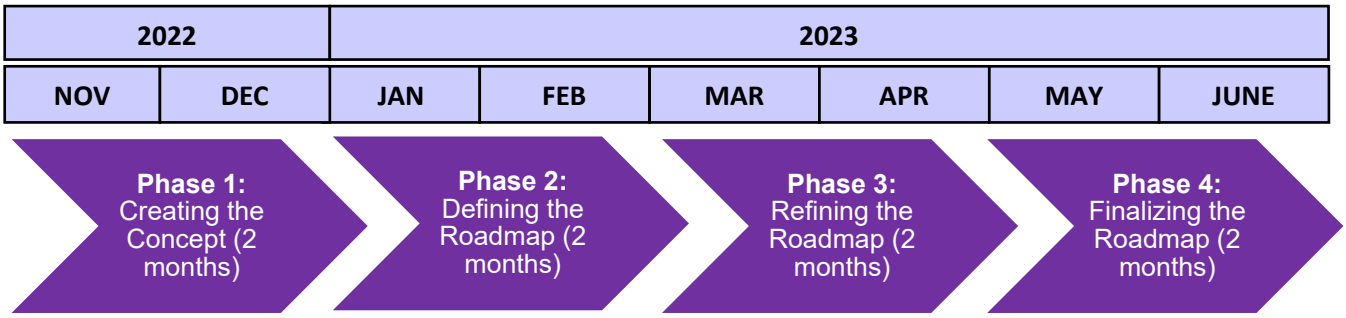
- CA Association of Alcohol and Drug Program Executives, Inc.
- Cal Voices
- California Black Women's Health Project
- California Consortium of Addiction Programs and Professionals
- California Council of Community Mental Health Agencies (DBA: California Council of Community Behavioral Health Agencies)
- Hathaway-Sycamores Child and Family Services (DBA: Sycamores)
- NAMI California
- Peer Voices of Orange County, Inc.
- The California Association of DUI Treatment Programs
- The Happier Life Project
- United Parents
- West Fresno Health Care Coalition (DBA: West Fresno Family Resource Center)

Through this collaborative, iterative process, The Center sought to gain feedback from communities across California to inform future funding opportunities and policies for services, programs, and approaches that will assist in improving access to mental health and substance use disorder services and supports for underserved communities including Black, Indigenous, Latine, Asian Pacific Islander, people with disabilities, and 2S+/LGBTQ+ communities.

12 partner organizations engaged with 1,367 people at a total of 66 events**.** In some cases, they engaged with the same group multiple times, and in other instances, they engaged with a group just once. These engagements included a variety of in-person and virtual modalities, such as surveys, webinars, focus groups, community meetings, structured conversations, and hyper-local engagements with small community groups.

Over the past eight months, we collaborated to co-create The Roadmap to Improve Access and Care for Diverse Communities in Mental Health and Substance Use Recovery across the State of California. This process included four phases of engagement as outlined in Figure 1.

Figure 1: HEAR US Timeline



For each phase, we provided a core set of questions to attain feedback from the community. The partner organizations received a slide deck and questions that they could customize for their specific community. The partner organizations also could adapt the format or setting to best suit the group with which they were engaging for each phase of the process. An example of this was adapting the slide deck into Spanish for largely Spanish speaking communities.

After the data collection phase was completed, partner organizations were asked to submit their information into an online data collection tool. We would then review those data and key findings during our monthly learning collaborative meetings with the partners.

"Placer County's Latine and Native American diverse parents and caregivers shaping mental health services for their children's well-being" - United Parents.

Learning collaborative meetings occurred virtually each month throughout this process except for the first and last meetings, which occurred in person. Those forums allowed partners to share what they learned and best practices for stakeholder engagement. In addition, they provided an opportunity to share research findings, reflect on findings, and provide additional input and insights into the development of The Roadmap.

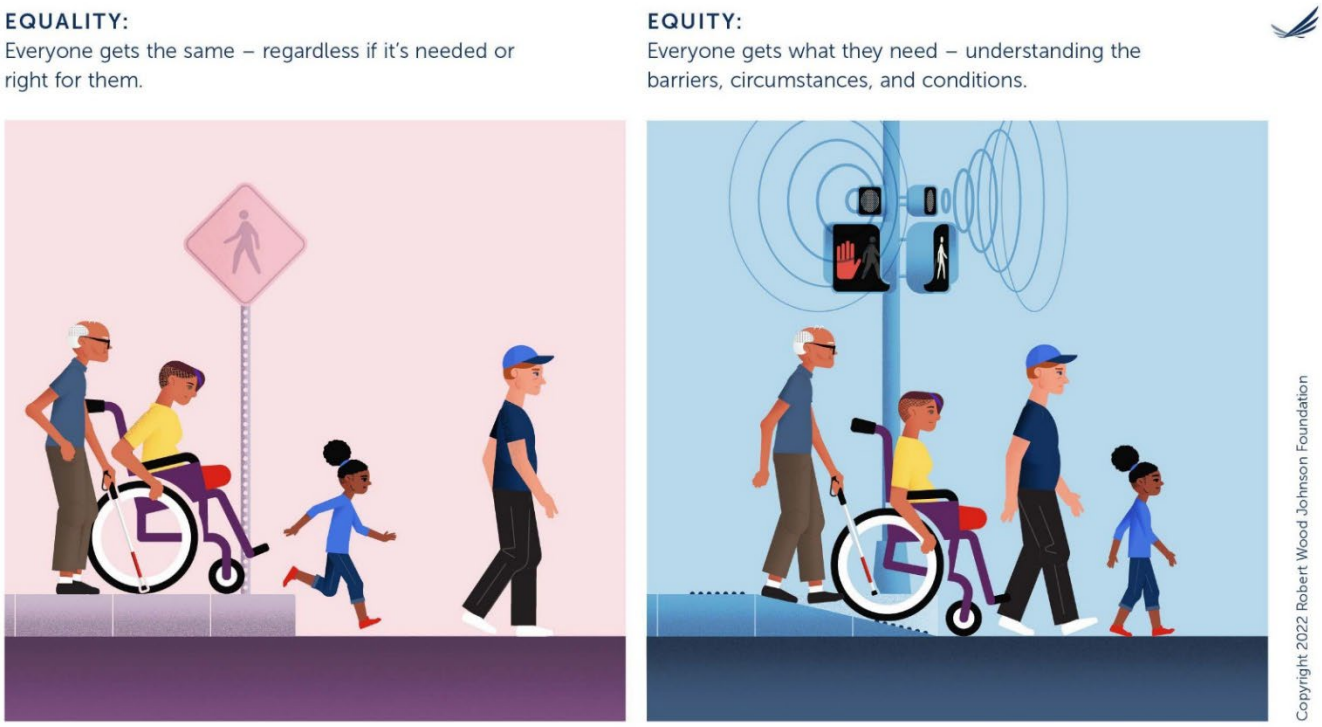
Core Concepts and Language

As we embarked on this process, we hope to accomplish the following:

- Identify and determine ways to break down barriers to access to quality behavior health care services for communities who are underserved.
- Build a behavioral health workforce that is culturally responsive and accountable to the people they serve.
- Foster a person-led approach that prioritizes recovery education and empowerment.
- Lift community voices and ensure parity and representation of behavioral health services.

We also reviewed and discussed how we defined equity, and we often used the concepts highlighted in Figure 2, from the Robert Wood Johnson Foundation, to center our conversations.

Figure 2: Equality versus Equity



The Center describes health equity as a means to achieving the highest possible standard of health for all people, giving special attention to the needs of people at greatest risk of poor health based on social conditions.[viii] Commitment to racial equity means working "to address root causes of inequities, not just their manifestation… [including] the elimination of policies, practices, attitudes and cultural messages that reinforce differential outcomes by race or fail to

eliminate them."[ix] Racial justice encompasses racial equity and adds an explicit focus on "building civic, cultural, and political power by those most impacted."[x]

Overview of the Roadmap to Improve Access and Care for Diverse Communities in Mental Health and Substance Use Recovery

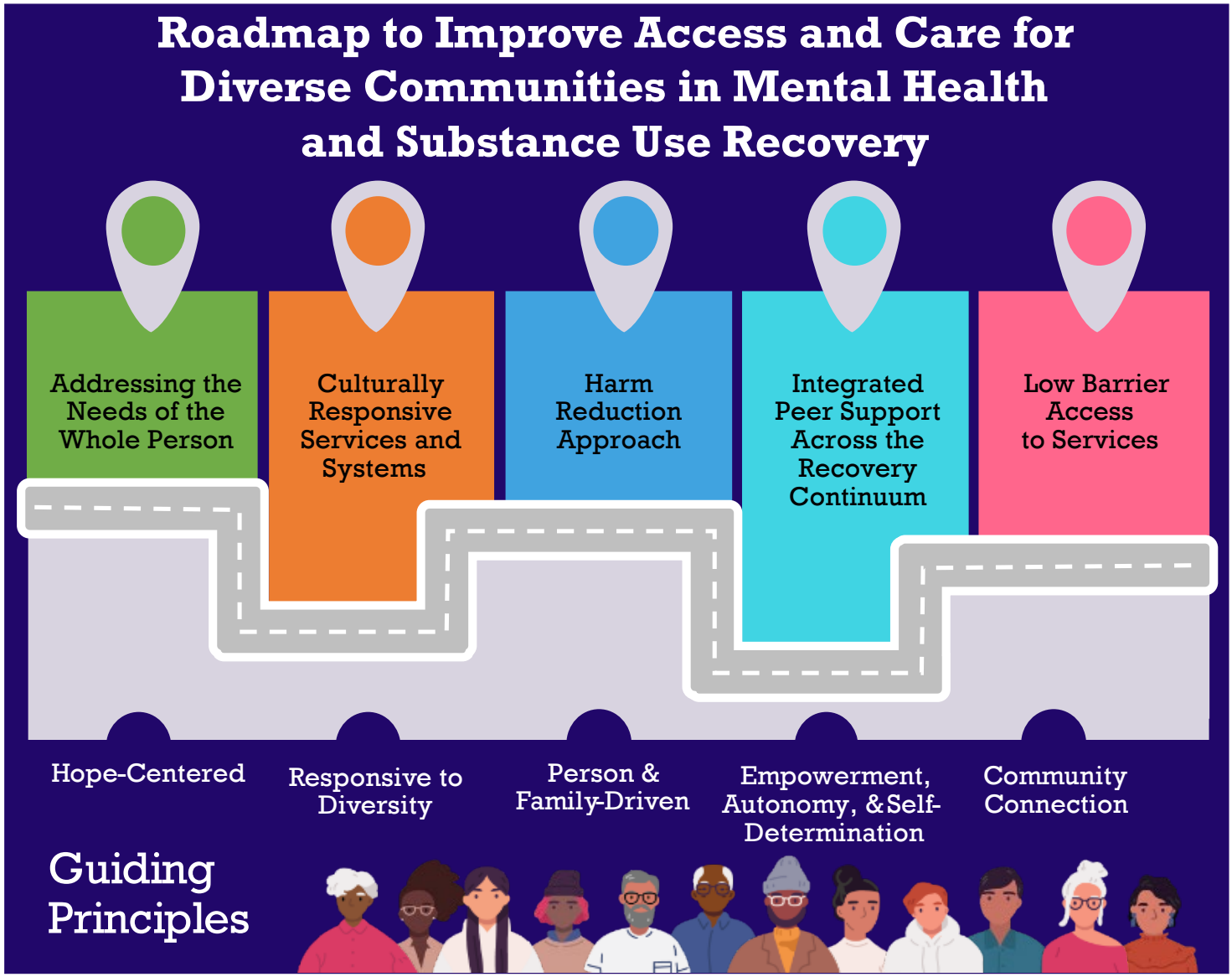
Roadmap Overview

From the literature review, landscape analysis, and robust engagement process with California communities, we now have the Roadmap to Improve Access and Care for Diverse Communities in Mental Health and Substance Use Recovery (The Roadmap).

The Roadmap includes five guiding principles that should inform the design and serve as the foundation of all programs, services, or approaches, as well as five core components that can be implemented to improve access to and equity in behavioral health services explicitly. The Roadmap is meant to serve as an overarching guide to move the systems and providers and organizations that serve people with SMI, SED and SUD in ways that are effective, meaningful, and responsive to the needs of diverse communities, ultimately improving behavioral healthcare.

Guiding the Discussion: Matt Curtis, Managing Director of Health Equity and Access, leads the panel as a facilitator in a dialogue about the Behavioral Health Framework for a brighter future, joined by representatives from the California Department of Health Care Services (DHCS) and Community Ambassador West Fresno.

Figure 3: The Roadmap to Improve Access and Care for Diverse Communities in Mental Health and Substance Use Recovery



Guiding Principles

A set of five guiding principles—defined as the overarching beliefs and values that help direct an organization's operations, goals, and strategies—formed the foundation of The Roadmap and the strategies outlined within. While all the principles stand individually, they are interconnected with the overarching theme of supporting equity and access to programs, approaches, and interventions (see Figure 3). The principles— hope-centered; responsive to diversity; empowerment, autonomy, and self-determination; person-/family-driven; community

connection—were developed based on direct feedback from stakeholders across the engagement process and reflect the voices heard throughout this phase of the project.

These guiding principles should inform all five core components of The Roadmap, and ultimately these principles should be reflected in any program that is aligned with the recovery approach. Examples of programs that are reflective of both the guiding principles and core components are available in Appendix A & B.

Table 1: What We Heard—Guiding Principles

Themes We Heard	Principle
Delivering treatment and recovery supports in a way that demonstrates that there is a strong pathway for recovery and wellness provides hope for people in recovery. Communicating that recovery is a journey with ups and downs is important and peer support is critical to a hope-centered approach.	Hope-Centered
The feedback from communities across the State strongly supported community informed evidence-based practices. Treatment and recovery supports are effective when they are tailored for the community and cultural needs.	Responsive to Diversity
Treatment plans and recovery supports should be determined by the person and centered on the person's needs. In addition, communities shared how important it is to be able to effectively engage families in the recovery journey.	Person/Family-Driven
Communities expressed strong interest in being involved with their own treatment plans. Recovery looks different for different people.	Empowerment, Autonomy, & Self-Determination
Building treatment and recovery supports that foster community connection and relationship are critical for various cultures and communities.	Community Connection

These guiding principles align with SAMHSA's 10 Guiding Principles of Recovery as are indicated in the individual descriptions[xi]. This further complements the expertise the stakeholders have based on their communities and personal experience.

Guiding Principle #1: Hope-Centered

SAMHSA maintains that recovery emerges from hope. This principle carries the understanding that people can and do overcome the challenges (internal and external), barriers, and obstacles that they confront when they are hopeful about the future. The principle also ties into guiding principle #3, which highlights the importance of peers, families, providers, allies, and others who help engender hopefulness.

For The Roadmap, a system that removes barriers and challenges to care, rather than amplifying them, can nourish an individual's sense of hope and, in turn, foster the person's recovery.

"A different approach to therapeutic recovery, utilizing the music of drumming to heal the mind, body, and soul, with active participation from HEAR US participants."- West Fresno Family Resource Center.

Guiding Principle #2: Responsive to Diversity

SAMHSA's principle on diversity indicates that recovery is culturally based and influenced[xii]. Culture and cultural background, in all of its representations—including values, traditions, and beliefs—are paramount in determining a person's journey and unique pathway to recovery. It emphasizes that services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

Additionally, SAMHSA maintains that all organizations should be responsive to the diverse populations they serve. While some services may be provided in a culturally based way in one particular city, they may need to be provided differently in another city. The Roadmap allows each community in California to be responsive to its members diverse cultural needs.

Guiding Principle #3: Person & Family-Driven

SAMHSA's principle on person-driven recovery ties in with Guiding Principle #4, placing patient-choice, preferences, and self-direction at the center, with individuals defining their own life goals and designing their unique paths toward achieving those outcomes[xiii]. SAMHSA highlights the person and family-centered approach with an emphasis on optimizing independence and self-management to the greatest extent possible. This approach includes the promotion of patient/client partnership in their care that ensures patient/client choice related to their preferred services and supports they identify in assisting their recovery and resilience.

The family unit - either biological or chosen - is also intentionally integrated into this guiding principle that supports the recovery process. This concept is of particular interest to the loved ones of children, youth and adults who need or want to have their families more involved in their recovery. This aspect of the Roadmap is rooted in evidence that family members can offer active support as individuals in recovery make decisions about their recovery.

Guiding Principle #4: Empowerment, Autonomy, & Self-Determination

This guiding principle, tying in with Guiding Principle #3, reiterates the importance of choice and independent or supported decision-making for all individuals in recovery. Within this principle are three elements: empowerment, autonomy, and self-determination. Empowerment speaks to the promotion of strength and confidence, autonomy refers to the right or condition of self-government, and self-determination is the process by which a person controls their life.

This three-part guiding principle is reflected in SAMHSA's principles on individual, family, and community strengths and responsibility, as well as within the values of respect and person-driven recovery[xiv]. Specifically, SAMHSA maintains that individuals in recovery should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations[xv]. They also note that taking steps toward recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in oneself are particularly important.

Guiding Principle #5: Community Connection

SAMHSA's principle on community connection states that recovery is supported through relationships and social networks[xvi]. An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who can suggest strategies and resources for change. These support networks include family members, peers, providers, faith groups, community members, and other allies.

For The Framework, community connection, and its various forms at different stages of recovery sets individuals on the path to success.

Community Members and California Council of Community Behavioral Health Agencies at Hear Us Engagement session.

Core Components of The Roadmap

Description of the Core Components

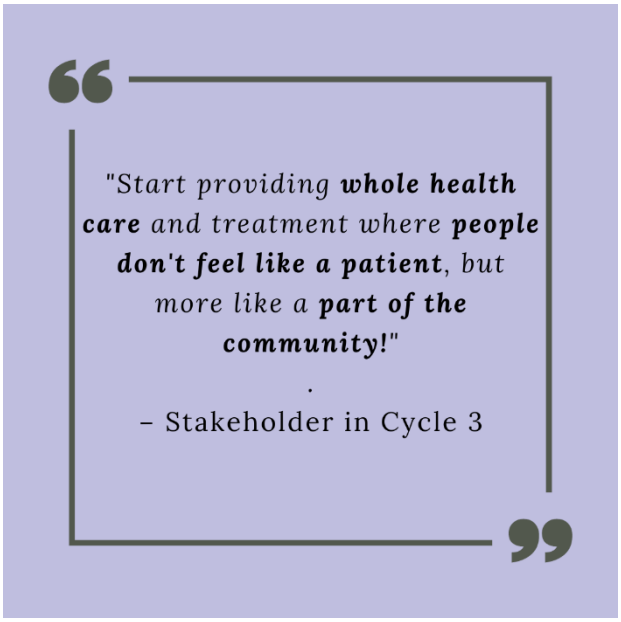
As the five guiding principles inform the design of all programs and services, the five core components of The Roadmap are tactical approaches that if implemented will lead to better access to behavioral healthcare and promote more equitable care delivery in California's diverse communities. These core components, illustrated in Figure 3, were identified through our robust community engagement process as key elements to drive improved equity and access to care for mental health and substance use disorder treatment and recovery supports.

We have outlined these components below, providing overall definitions, models of the component in practice, and actionable strategies, including examples of evidence-based practices, promising practices, and, most importantly, community-defined evidence practices. These actionable approaches are intended to serve as examples, not a finite list of options.

Core Component #1: Addressing the Needs of the Whole Person

Addressing the needs of the whole person requires a person-centered, comprehensive approach to wellness which often is delivered in integrated care settings or through programs that focus on the holistic identity and needs of the individual. **Working to address the whole person acknowledges that a person's needs outside the healthcare realm also drive success and failure for a person's recovery journey.** Driving this approach is the understanding that wellness includes at minimum, a person's physical, mental, cultural, social, and spiritual needs. Integrating multiple aspects of these considerations into the client's prevention, treatment, and interventions promotes comprehensive care that supports the individual's holistic health and wellness.

The foundation to this model is built on an understanding that one service or agency can rarely address an individual's whole-person needs. Service engagement should be oriented to the individual's priorities and preferences, and co-location and streamlined partnership of service providers increases the likelihood of achieving whole-person wellness. Integrating various healthcare services, such as primary care, specialty care, mental health services, social services, social supports, and community resources into the individual's care journey promotes holistic wellness and improves overall outcomes.



It is critical that whole-person, integrated care develop in a manner that is culturally responsive. Additionally, successful implementation of whole-person care requires overcoming various challenges, such as organizational silos, information sharing and interoperability issues, and reimbursement models.

Core Component #2: Culturally Responsive Services and Systems

According to the Office of Minority Health, culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices, and needs of diverse consumers.

> *[The current recovery definition] is **very white washed**. It doesn't take into the consideration **the racism and discrimination** that communities of color experience, and it doesn't take into consideration the **burden that system impacted communities [face]**.*
> – Stakeholder in Cycle 1

Culturally responsive services and systems must be co-designed with communities to meet their unique needs and improve equitable access to recovery services. **Culturally responsive services and systems will help people get the services and support that they need, when they need them, delivered in a way that works best for them.** Behavioral health disparities continue to negatively impact Black, Indigenous, and other communities of color. Culturally responsive services and systems are critical to addressing these inequities by providing high-quality and culturally appropriate care to specific racial and ethnic groups, individuals with diverse gender identities, and individuals with disabilities. The behavioral health workforce, which includes peers, counselors, other clinical staff, administrative staff, and leadership, needs to invest in gaining cultural knowledge of the populations they serve to offer services that likely will engender a greater sense of safety among their clients and thereby improve outcomes.

From 2011–2020, SAMHSA's Office of Behavioral Health Equity was addressing challenges in implementing culturally responsive, evidence-based practices (EBPs) with racial and ethnically diverse populations through its National Network to Eliminate Disparities in Behavioral Health annual training (NNEDLearn). This training teaches teams of practitioners from community-based organizations who serve Black, Indigenous, and other communities of color in implementing culturally relevant evidence-supported behavioral health practices.

EBPs are often viewed as a measure of high-quality, effective care. However, implementing EBPs within racial and ethnically diverse populations may come with certain challenges related to ensuring that these EBPs are relevant and tailored to the community that is accessing these services. These challenges can be addressed through a few different avenues, including:

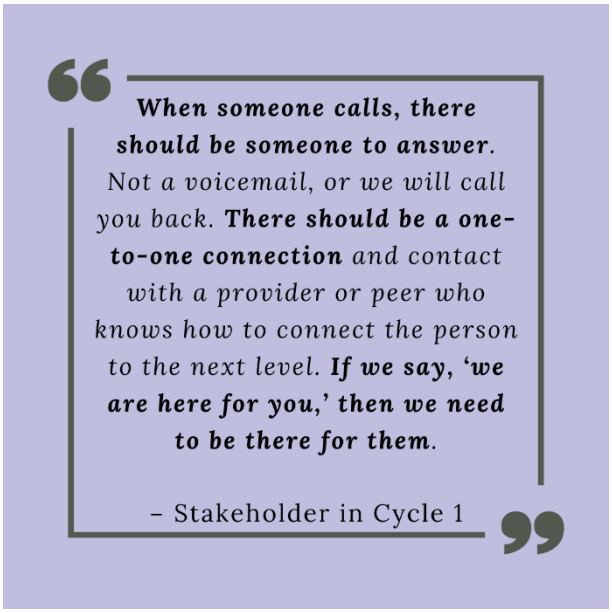
- Having individuals from specific racial and ethnic groups adapt existing EBPs or develop their own interventions based on community-defined evidence.
- Ensuring the inclusion of racially and ethnically diverse individuals in the outcome studies and building the capacity of the behavioral health workforce to implement existing culturally appropriate interventions.

An implementation analysis conducted on NNEDLearn yielded the following findings across all practices:

- An evident need exists for culturally relevant behavioral health practices, based on service recipients' reported level of satisfaction and how well it aligned with the organizations' mission.
- Congruence between the service provider and recipient on key demographic factors greatly facilitates implementation.
- Alumni attribute successful implementation to the flexibility that the practices allowed them to add some degree of customization to meet the needs of specific racial and ethnic groups.
- Alumni face varying challenges, including the need to address barriers to participation.
- Alumni need ongoing support as they make adaptations to ensure fidelity to the model.
- The findings conclude that the culturally relevant evidence-informed behavioral health practices offered through NNEDLearn appear to be having a positive impact on racially and ethnically specific communities.

Culturally responsive practices foster healing that is meaningful to individuals and communities and leads to more positive, long-lasting outcomes. Treatment can be approached in many ways outside of the traditional structure, and it takes a system and a workforce that is dedicated to introspection, unlearning and relearning ways to provide services that are culturally appropriate and equitable to be truly inclusive, and honoring everyone's intersectional identities.

Core Component #3: Harm Reduction Approach



The harm reduction approach promotes individual and community wellness to mitigate the impacts of behaviors that put people at high risk of negative health impacts. This approach honors personal choice, preferences, and autonomy. **Working to meet people where they are in their recovery journey creates a strong opportunity to build trust and relationships with organizations who provide treatment and recovery supports.** Harm reduction models recognize that human behavior is complex and multifaceted, and that risk associated with behaviors occurs along a continuum of severity. The goals of harm reduction are to help individuals stay safe and healthy when they use drugs, to build supportive relationships and connection to community, and to support any positive change in health and social conditions as defined by the person being served.

This philosophy promotes an understanding that people do not have to totally abstain from certain behaviors to reduce their associated risk. By adopting a nonjudgmental and compassionate approach, harm reduction strategies engage directly with community members to reduce transmission of disease, decrease overdoses, improve mental and physical health outcomes, and help individuals lead healthier lives.

Punitive and coercive approaches to behavior modification are ineffective, and in contrast harm reduction empowers people with knowledge and tools to reduce the risk of negative outcomes related to drug use or drug-related policies. This approach is self-directed and responsive to the individual. It is designed to foster trust, empowerment, and collaboration and ensures that the programs reflect the specific needs and aspirations of the communities they serve.

Skillful use of harm reduction can improve outcomes for marginalized communities through its impact on the following:

1. Health equity: Harm reduction programs recognize that individuals have diverse and complex needs that vary according to their cultural environment. Effective harm reduction strategies build upon the strengths of communities, are designed to respect cultural nuances, and result in reduced disparities for marginalized individuals and groups.
2. Social determinants of health: A harm reduction approach is grounded in an understanding that systemic inequalities negatively affect access to preventive and interventional resources, leading to an increase in high-risk behaviors. Harm reduction programming recognizes disparities and provides broad resources to mitigate their effects while being responsive to the cultural needs of the person and community.
3. Community empowerment: Harm reduction strives to bring equitable access to resources that promote increased health and wellness within communities. These resources are offered in a community-centered manner, driven by the stated needs of the community. Implementation of harm reduction strategies should be done in partnership with community members in a way that empowers them to create an environment that self-sustaining in its health and wellness endeavors.
4. Community voice: Harm reduction initiatives center the voices of people with lived experience in the specific programmatic areas and communities of impact. Individual perspectives, choices, and autonomy are respected to promote multiple pathways to self-defined improvement in quality of life. The voice of people with lived experience should be at the center of program development, and these individuals should play a meaningful role in decision-making throughout the process.

Examples of harm reduction techniques have become commonplace and include wearing a seatbelt to reduce the risk of injury in a collision, wearing shin guards when playing soccer, or wearing a helmet when riding a bicycle or motorcycle to reduce the likelihood of death in an accident. In each of these examples, the risk associated with the activity is mitigated in a manner that honors the individual's right to participate in the activity in a safe way.

Core Component #4: Integrated Peer Support Across the Recovery Continuum

Peer support, a core component of The Roadmap, encompasses a range of services, activities, and interactions between people who share similar experiences of being diagnosed with mental health conditions, SUD, or both[xvii]. This model is a key factor of the recovery approach.

People effectively connect with people with similar experiences and build community and relationships, which strengthens a person's recovery journey. More specifically, this component highlights the need for more equitable access and a multidisciplinary approach to services across the continuum, with peer support as a key element. This approach includes care and support outside of the traditional system of behavioral healthcare (i.e., community-driven models). Peer workers practice in a variety of settings, including peer-run organizations, recovery community centers, recovery residences, drug/mental health courts, hospital emergency departments, child welfare agencies, homeless shelters, and behavioral health and primary care settings. This component is intended to fully integrate and uplift the workforce in the recovery system.

Core Component #5: Low-Barrier Access to Services

According to The State of Mental Health in America, the 2023 report that Mental Health America (MHA) issued, 21 percent of US adults are experiencing a mental illness, and 15 percent of US adults experienced an SUD in the past year. Of those experiencing mental illness, 28 percent reported they were unable to receive the treatment they needed, and of those individuals with SUD, 93.5 percent went untreated.

There are a variety of factors that contribute to why behavioral health issues are untreated such as: stigma, lack of resources within the community and health related social needs, such as lack of housing. Creating opportunities for services, treatment and supports that can be accessed easily is critical to increasing positive outcomes for those struggling with mental illness and SUD.

"Engaging Strategy Circle Session at Neighborhood Wellness Foundation with CBHA Facilitators & Community Members."- California Council of Community Behavioral Health Agencies.

Similarly, a study that the National Council for Mental Well-being and the Cohen Veteran's Network conducted assessed Americans' current access to and attitudes toward mental health services, revealed US mental health services are insufficient. Despite high demand, the root of the problem is limited access to care.

> "... ***there should be enough lanes for access to recovery*** *in the continuum of care to give the most people needing recover access* ***while not stigmatizing or limiting funding***.
>
> – Stakeholder in Cycle 3

Low-barrier access can refer to both treatment and shelter/housing. With housing, it refers to minimal requirements to entry; with treatment, it speaks to broader access to care. In other words, low-barrier access allows for "treatment on demand"-type services, such as telehealth, integrated behavioral health in primary care, mobile clinics, and same-day appointments/walk-in clinics.

Low-barrier access ensures and refers to care being provided in a way that removes a multitude of challenges individuals may face in accessing health care services. These barriers may include transportation, language, availability, technology, childcare, complicated processes, and stigma. Low-barrier access to services is crucial to creating pathways for people to receive the care they need quickly, to prevent escalation to a crisis. Access to services that are unique to communities, meeting people where they are - and most importantly - when they need it, contributes to a more equitable and timely recovery approach.

"Fostering Community Mental Health: CBHA and Locals Unite in Strategy Circle at Neighborhood Wellness Foundation." - California Council of Community Behavioral Health Agencies.

Closing Note

Invitation to Implement the Roadmap

As a final call to action, The Center invites providers and community organizations alike that serve people in need of recovery services to actively review and identify what aspects of The Roadmap they can implement and follow up with an action plan. The input from all the stakeholders has been instrumental in shaping the findings that led to The Roadmap.

However, providers of all types can determine and execute the next steps, ensuring both access to services and the provision of welcoming, high-quality services, especially for underserved communities. Some of these next steps can be implemented without additional funding, such as prioritizing diversity when hiring new staff members.

Final Gathering: Twelve HEAR US Phase 1 Partners Reunite at Sierra Health Foundation for Their Last In-Person Learning Collaborative Meeting.

To assist in the implementation of the Roadmap, a Resource Log and a Best Practices Guide has been included in this report's Appendix. Recovery service providers are also invited to review The Center's webpage on Behavioral Health Recovery Services at https://recoveryservicesproject.org/ for additional resources and information.

As we continue to improve the recovery system for all individuals, ongoing input from stakeholders at both the local and state levels will be necessary. More specifically, The Center will collaborate with providers across California as part of a future Request for Proposals (RFP). Further details will be available in late 2023, and a final report will be prepared at the conclusion of the grant period in 2025, highlighting the impact of The Roadmap and the RFP funding connected to its development and implementation.

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Lastly, a special note of gratitude to the individuals who generously contributed to the stakeholder engagement process as well as the ongoing development of The Roadmap. The Center appreciates their commitment to the work of behavioral health and ensuring that those important services are available and meaningful for all. Our gratitude also extends to Health Management Associates who helped coach and cheer on our partners, The Center at the Sierra Health Foundation staff who reviewed and provided input on many versions of this report and assisted this project in different ways, and of course the DHCS team who helped make this report possible.

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Appendix A: Resource Log

Component	Actionable Strategy	Hyperlink
Culturally Responsive Services and Systems	1. Foster and support a diverse workforce and leadership team that represents the community served	Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
	2. Develop workforce trainings, demographic data analyses, and policies and procedures to support diversity, equity, inclusion, and belonging (DEIB) within the organization	SAMHSA's Treatment Improvement Protocol: Improving Cultural Competence
	3. Delivery of Culturally Responsive Programs/Care (Family-Based Models)	Familia Adelante: Multi-Risk Reduction Behavioral Health Prevention for Latino/Hispanic Youth and Families
	4. Delivery of Culturally Responsive Programs/Care (Gender-Based Models)	Prime Time Sister Circles
	5. Multi-sectoral/Cross System Collaborative Approaches	Ma'at Program
Low-Barrier Access to Services	1. Mobile Clinics/Street Medicine	Mobile Treatment for Opioid Use Disorder: Examples from the Field, Part 1, Part 2, and Part 3
	2. Telehealth	(1) Introduction to Telehealth for Behavioral Health Care (2) Virtual Care for Behavioral Health Conditions (2022)
	3. App-Based Interventions	Opportunities to Integrate Mobile App-Based

		Interventions Into Mental Health and Substance Use Disorder Treatment Services in the Wake of COVID-19
	4. Integrated/Co-Located Health and Support Service Clinics	Center of Excellence for Integrated Health Solutions
	5. Build Access to Interim Engagement Options for People on the Waitlist for Care	Peer Worker Overview
Integrated Peer Support Across the Recovery Continuum	1. Career navigation for people with lived experience including employment support	Peer Workers in the Behavioral and Integrated Health Workforce: Opportunities and Future Directions
	2. Development of peer service quality standards for both peers and organizations	Parent, Caregiver, Family Member Peer Training Curriculum Core Competencies
	3. Consumer-Operated Models (Peer Respite)	Peer Respites: A Research and Practice Agenda
	4. Formal supports for employed Community Health Workers & Peers	(1) Supervision a. SAMHSA's Core Fundamentals for Supervisors b. 2022 Landscape Analysis: Supervisor' Fundamental Core Competencies for Supervision of the Peer Worker. (2) Health/Mental Health Supports a. Peer Support among Persons

		with Severe Mental Illnesses: A Review of Evidence and Experience (3) Special Interest Groups a. Support Services for Young Adults With Substance Use Disorders (4) Support for Navigating Social Needs a. Implementing Peer Recovery Coaching and Improving Outcomes for Substance Use Disorders in Underserved Communities
	5. Develop integrated peer model for treatment teams	(1) Peer Recovery Support Services in Correctional Settings (2) Education, Certification, and Roles of Peer Providers: Lessons from Four States (ucsf.edu) (3) Certified Peer Specialist Roles and Activities: Results from a National Survey
Harm Reduction Approach	1. Drug overdose prevention services	Overdose Detection Technologies to Reduce Solitary Overdose Deaths: A Literature Review
	2. Ensure people have safer drug use information and materials	Makin' It Happen- A Coordinated Community Approach to Harm Reduction
	3. Medication Assisted Recovery	Medication-Assisted Treatment for Opioid Use

		Disorder in Jails and Prisons: A Planning and Implementation Toolkit
	4. Community outreach and engagement	Expanding First Response: A Toolkit for Community Responder Programs
	5. Drug overdose prevention services	Overdose Prevention Centers
	6. Promoting practical, nonlinear opportunities for steps toward recovery within services for people who currently use drugs	Abundant Community Recovery Services Mobile Harm Reduction Unit
Addressing the Needs of the Whole Person	1. Linkages & supports to health-related social needs such as: Housing, Food & Employment; 2. Effective case management and warm handoffs	Certified Community Behavioral Health Clinics (CCBHC)
	3. Recovery Capital Tracking	Recovery Capital Index
	4. Family Based Models of Care	Patient-And Family-Centered Care
	5. Effective case management and warm handoffs	IMPACT Model/Collaborative Care
	6. Utilize trauma-informed and person-centered care	The Role of Recreation and Recreational Therapists in Developing a Recovery-Oriented Identity for People with Substance Use Disorders

Appendix B: Culturally Responsive Core Component in Practice

SAMHSA's 2022 report "Adapting Evidence-Based Practices for Under-Resourced Populations," provides examples of how tailoring care, programs, and services to the cultural, social, gender, and other socio-demographic contexts of individuals leads to better outcomes. The following case studies demonstrate different organizations have developed, implemented, and adapted EBPs for under-resourced populations in their communities.

Project Youth AFFIRM

AFFIRM is an eight-module, manualized, group CBT curriculum adapted specifically for LGBTQ+ youth and young adults. After identifying the challenges around a shortage of mental health EBTs for this population, and through conducting an extensive community needs assessment, the developers enhanced the standard CBT structure with additional context, strategies, examples, and modules that speak to the LGBTQ+ experience. A few of these solutions are as follows:

- Embedded a trauma-informed, affirmative practice, and minority stress framework throughout all aspects of the intervention.
- Adapted the CBT components to reflect the unique and varied elements of the LGBTQ+ experience.
- Added modules focused on hope and social supports. A module on hope for the future was added to specifically address hopelessness and suicidality, two common presentations in LGBTQ+ youth.

The following mental health outcomes were identified through longitudinal research on AFFIRM for both in-person and telehealth groups:

- Reduced depression symptoms, as measured by the Beck Depression Inventory (BDI-II).
- Heightened coping skills as measured by the Brief Coping Orientation to Problems Experienced Inventory (COPE).
- Improved stress appraisal, as measured by the Stress Appraisal Measure-Adolescents (SAMA).
- Increased level of hope, as measured by a modified Adult Hope Scale (AHS).

Schools, child welfare and health centers, behavioral health clinics, and community organizations are offering the curriculum both in person and online. Various settings and communities across the United States have implemented the program since it was first developed in 2012. Read more about AFFIRM here.

Choctaw Nation Department of Behavioral Health

The Choctaw Nation Department of Behavioral Health in Oklahoma adapted motivational interviewing (MI) as a culturally resonant and effective form of treatment for members of the Choctaw Nation. Services include outpatient and inpatient counseling, integration of behavioral health with primary care, residential treatment with a particular focus on opioid use disorder, and a residential therapeutic school for children.

Several cultural touchpoints are relevant to how Choctaw Nation members engage with behavioral health services, one being a focus on the collective well-being of the tribe and high motivation to maintain their culture and engage in cultural activities. These cultural tenets are not incorporated into standard MI practice, but were included in the adaptation of evidence-based MI. Some examples include:

- The department integrated behavioral health into primary care, mainly to serve those who are in the "precontemplation" stage of change, indicating a non-readiness or intention to change (Transtheoretical Model of Stages of Change by Prochaska and DiClemente)[xviii].
- Services that incorporate Choctaw values. To adapt MI for members of the Choctaw Nation, practitioners incorporated the Choctaw's focus on identity, collectivism, cultural understanding of time, and traditions like storytelling and stickball.
- Training non-Native staff in the Choctaw culture is important. Many therapists in the Choctaw Nation Department of Behavioral Health are Choctaw themselves, which can increase the therapeutic alliance because of lived experience and shared community. For therapists who are non-Native Americans, the department provides cultural training so they can learn the history of the Choctaw tribe and understand the community's cultural values.

Outcomes

- Qualitative and anecdotal data indicate that the number of behavioral health services offered to tribal members has increased, which has reduced the number of individuals with untreated severe mental illnesses.
- Clients' self-referrals, referrals from their families, and community buy-in to behavioral health services have improved. Clients have shared that they are benefiting from involvement in cultural and traditional activities like social dancing, stickball, and basketry as part of participating in behavioral health services.

Actionable Strategies and Tools

Table 2: Culturally Responsive Services and Systems Actionable Strategies and Tools

Strategy	Tool	Description
1. Foster and support a diverse workforce and leadership team that represents the community served	Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care	This behavioral health guide, developed in collaboration between the Office of Minority Health and SAMHSA, underscores how National CLAS Standards can improve access to behavioral healthcare, promote quality behavioral health programs and practices, and ultimately reduce persistent disparities in mental health and SUD treatment for underserved, minority populations and communities. For each standard, the guide outlines both implementation strategies and examples. Specifically, the section on Governance, Leadership, and Workforce offers strategies and examples of how to recruit, promote, and support a culturally and linguistically diverse governance structure, leadership team, and workforce that is responsive to the population in the service area.
2. Develop workforce trainings, demographic data analyses, and policies and procedures to support diversity, equity, inclusion, and belonging (DEIB) within the organization	SAMHSA's Treatment Improvement Protocol: Improving Cultural Competence	This guide helps professional care providers and administrators understand the role of culture in the delivery of mental health and SUD services.
3. Delivery of Culturally	Familia Adelante: Multi-Risk Reduction Behavioral Health	Familia Adelante (FA) is a psycho-educational, curriculum-based, culturally relevant prevention program focused on

Responsive Programs/Care	Prevention for Latino/Hispanic Youth and Families	helping Latine families manage negative behavioral outcomes associated with stress exposure. The program addresses family and peer communication, positive school bonding, SUD prevention, and sexual health. The program was developed by Richard Cervantes, PhD, and is based on his research to provide a multi-risk prevention program with a family development model for youth with early signs of behavioral or emotional distress.
	Prime Time Sister Circles	Prime Time Sister Circles (PTSC) is a culture-, gender-, and age-specific program focused on helping women make lifestyle changes to improve their health. It is curriculum-based with an interactive support group intervention designed to reduce emotional and physical health disparities and promote healthy habits for mid-life Black women. Based on their own research, Gayle Porter, PsyD, and Marilyn Gaston, MD, developed the program in 2003. Since then, they estimate that approximately 3,000 people have gone through the program across seven states and the District of Columbia.
4. Multi-sectoral/Cross System Collaborative Approaches	Ma'at Program	The Ma'at Program, a supportive, holistic, therapeutic community program of the San Francisco Homeless Children's Network, provides culturally responsive behavioral health care to Black/African-American families and individuals. Ma'at employs a community mental health model, in which neighborhoods, histories, and families are key components in service design and delivery. Community partners, peers, experts, and elders provide oversight to ensure implementation of principles that uphold Black/African-American community members. Ma'at's hub and spoke model empowers collaborations for reciprocal learning. The

		Homeless Children's Network is the hub of all activities, with community partners, such as schools, churches, shelters, family resource centers, SUD treatment programs, and housing sites serving as spokes and referring clients to the hub.

Appendix C: Low-Barrier Access Component in Practice

In SAMHSA's Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness, the authors describe various strategies for effectively engaging hard to reach populations in whole-person care by meeting people where they are and making services accessible. Following is an example of an organization in Denver, CO, that is providing low-barrier services for Native American and Alaska Native individuals who are experiencing homelessness.

Colorado Coalition for the Homeless (CCH)—Services for American Indians and Alaska Natives, Denver

CCH is a nonprofit organization that provides housing, healthcare, and supportive services to individuals experiencing homelessness in Colorado, including Native American and Alaska Native individuals and families. Drawing from a low-barrier housing first approach, in 2020 CCH provided housing, healthcare, employment, and other services to more than 22,700 people, with approximately 708 people identifying as Native American/Alaska Native.

In Denver, the Colorado Village Collaborative helped establish Native-inclusive Safe Outdoor Spaces (SOS), with 30–60 tent accommodations. CCH collaborates with SOS, promoting broader access to care with SOS' intensive case management services via mobile outreach which provides mental health, medical, addiction and nursing services.

CCH also operates the Fort Lyon Supportive Residential Community—a peer-led recovery setting that provides recovery-oriented transitional housing for up to 250 individuals experiencing homelessness. The program includes peer supports and incorporates Indigenous approaches to healing, among other services. Fort Lyon includes the Indigenous recovery model called Wellbriety, through which people can "walk the red road to recovery" using culturally based principles, values, and teachings to promote healing from SUD, co-occurring disorders, and intergenerational trauma.

Finally, another key low-barrier approach of CCH services is the emphasis on integrated health care and their incorporation of a harm reduction model to substance use recovery, including medications for opioid use disorder (MOUD) in some of their programs.

Lessons learned from CCH's program include:

- **Meet clients where they are, both mentally and physically.** CCH adheres to a harm reduction, trauma-informed philosophy and emphasizes flexibility in scheduling. If clients are uncomfortable coming into a clinic, staff provide mental health and SUD treatment services in the community, in encampments, and other locations.
- **Awareness of cultural needs when working with Indigenous populations.** The Native American- and Alaska Native-specific interventions (such as Wellbriety and Talking Circles) are well-received because they integrate native traditions and culture while still addressing the need for support with SUD and mental illness. These culturally informed approaches promote engagement in CCH's low-barrier services.
- **Community-based programming and individualized services and care can co-exist fruitfully**. Indigenous values, traditions, and beliefs place a different emphasis on community obligations, relationships, and reciprocity. Native American Services honors and makes a virtue of weaving communal traditions and knowledge with Western healthcare and housing system approaches. CCH's low-barrier, housing-first approach with these communities is a successful example of this co-existence.

Actionable Strategies and Tools

Table 3: Low Barrier Access to Services Actionable Strategies and Tools

Strategy	Tool	Description
1. Mobile Clinics/Street Medicine	Mobile Treatment for Opioid Use Disorder: Examples from the Field, Part 1, Part 2, and Part 3	Mobile treatment models are a key low-barrier approach, as these programs significantly reduce the multiple barriers to accessing care, including transportation, cost, and stigma. The Bureau of Justice Assistance's (BJA) Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) partnered with a research firm to profile six agencies across the country that are implementing mobile models for treating opioid use disorder (OUD). The 3-part series highlights each of these programs. The goal is to inform jurisdictions considering whether a mobile treatment program would work in their communities and to determine which type of model would fit best.

2. Telehealth	(1) Introduction to Telehealth for Behavioral Health Care (2) Virtual Care for Behavioral Health Conditions (2022)	This US Department of Health and Human Services best practice guide outlines how behavioral and mental health providers can offer and get reimbursement for telehealth services. This article describes the increased use of telehealth to deliver behavioral health services and the growing evidence of the efficacy of virtual care at the provider, patient, and systems levels. Key points that call out the how telehealth increases access as a low-barrier approach include: • Virtual care provides opportunities for prompt and improved access to behavioral health services. • Virtual behavioral health is helping to reduce healthcare disparities, particularly among rural and at-risk populations. • The pandemic highlighted the immense need for more behavioral healthcare services, particularly services embedded in the primary care setting where many patients present first and solely for their mental health needs.
3. App-Based Interventions	Opportunities to Integrate Mobile App-Based Interventions Into Mental Health and Substance Use Disorder Treatment Services in the Wake of COVID-19	As app-based interventions serve as additional low-barrier access-point to services, this article outlines the growing evidence for mobile app efficacy, including how health systems can integrate apps into patient care. If equity in access and effective implementation can be addressed, mobile apps are likely to play an important role in mental health and SUD treatment.
4. Integrated/Co-Located Health and Support Service Clinics	Center of Excellence for Integrated Health Solutions	Integrated behavioral health models of care are an important low-barrier treatment model, improving access to behavioral health services, by

		incorporating these within a primary setting. This model not only improves access, but also addresses the issue of stigma as a barrier to care. The National Council for Mental Wellbeing, through the National Center of Excellence for Integrated Health Solutions grant award from SAMHSA, lists the newest evidence-based resources, tools, and supports for organizations working to integrate primary and behavioral healthcare.
5. Build Access to Interim Engagement Options for People on the Waitlist for Care	Peer Worker Overview	SAMHSA's Bring Recovery Supports to Scale Technical Assistance Center Strategy's (BRSS TACS) Peer Worker Overview initiative provides an overview of peer support and how this type of care can help people gain perspective on recovery based on the lived experience of other people in recovery. This interim engagement and low-barrier approach provides a bridge of support while individuals are waiting to access services.

Appendix D: Peer Support Component in Practice

According to SAMHSA, peer support services are seen as effectively extending the reach of treatment beyond the clinical setting and into the everyday environment of people seeking a successful, sustained recovery process and many providers recognize them as such[xix]. Peer support workers, also known as peer specialists, peer recovery coaches, peer advocates, and community health workers, may engage in the following activities:

- Inspire hope and present as an example of recovery.
- Support anti-stigma efforts regarding mental illness and SUD.
- Support goal setting and recovery road maps using such tools as the Wellness Recovery Action Plan (WRAP).

The peers' success is directly linked to their lived experience, as they bring their own personal knowledge, tools, and trainings to their work with clients. This approach to care has been researched as an EBP and continues to be studied as new models (such as the Peer Bridger) are implemented and found to improve clinical outcomes and reduce crisis center and hospital use.

A variety of providers offer peer support services. Furthermore, the role of peer support is described as a complement to the role of clinical providers, including psychiatrists, social workers, therapists, and case managers. Many organizations, both inpatient and outpatient care centers, integrate treatment team models, with the peer specialist fully integrated.

SAMHSA has developed a series of core competencies for peer workers in behavioral health services, that include:

- Assisting with recovery planning.
- Linking people to resources, services, and supports.
- Providing information about skills related to health, wellness, and recovery.
- Helping peers manage crises.

Actionable Strategies and Tools

Table 4: Integrated Peer Support Across the Recovery Continuum Actionable Strategies and Tools

Strategy	Tool	Description
1. Career navigation for people with lived experience including employment support	Peer Workers in the Behavioral and Integrated Health Workforce: Opportunities and Future Directions	This article highlights factors that promote the growth of the peer workforce, describe multiple programs that hire peer workers, and explore challenges facing the peer workforce in non-healthcare settings. It describes organizational characteristics indicating readiness to hire peer workers, and organizational values, policies and practices that align with recovery-oriented values. It provides an overview the role of peer workers, and supervision and support for individuals in the field.
2. Development of peer service quality standards and competencies specific to Family/Caregivers	Parent, Caregiver, Family Member Peer Training Curriculum Core Competencies	The California Mental Health Services Authority (CalMHSA) provided a country-wide landscape analysis that reviewed and compared the peer training curriculum for family members/caregivers.

		From this analysis CalMHSA identified 11 Core Competencies that should be included in this peer training curriculum: 1. Ethics 2. Confidentiality 3. Effecting Change 4. Behavioral Health 5. Education 6. Communication 7. Parenting for Resiliency 8. Advocacy 9. Empowerment 10. Wellness and Natural Supports 11. Local Resources.
3. Consumer-Operated Models (Peer Respite)	Peer Respites: A Research and Practice Agenda	Peer respites are consumer/peer-operated models of care that provide voluntary, short-term residential programs designed to support individuals experiencing or at-risk of a psychiatric crisis. Peer respites are a "less restrictive" alternative to traditional psychiatric emergency room and inpatient hospital services. These respites are community-based, situated in residential neighborhoods, and are intended to provide a safe and home-like environment.
4. Formal supports for employed Peers, Community Health Workers and other peer-roles	(1) Supervision a. SAMHSA's Core Fundamentals for Supervisors b. 2022 Landscape Analysis: Supervisor' Fundamental Core Competencies for Supervision of the Peer Worker.	1a. In these guidelines, SAMHSA outlines core fundamental attributes for effective supervision of peer counselors, including: • Understand peer roles and practices. • Model recovery-oriented practices. • Development of the unique knowledge and skills needed for peer support practice. • Recognize connections between behavioral health conditions and trauma, health disparities, and social inequity. • Use strengths-based supervision. • Provide a space to address ethical and boundary issues. • Advocate for integrating peer workers into the workplace.

		1b. CalMHSA's report uses SAMHSA and the National Association of Peer Supporters (NAPS) core principles to conduct a landscape analysis of how states establish their supervision standards and make recommendations on how to adopt or revise these implementations. Examples of NAPS core values include: • Peer support is: ○ person-driven ○ voluntary ○ mutual and reciprocal ○ equally shared power ○ strengths-focused • Peer supporters are: ○ open-minded ○ empathetic ○ respectful ○ change facilitators ○ hopeful
	(2) Health/Mental Health Supports a. Peer Support among Persons with Severe Mental Illnesses: A Review of Evidence and Experience	2a. When providing peer support that involves positive self-disclosure, role modeling, and conditional regard, peer staff have been found to increase participants' sense of hope, control, and being able to effect changes in their lives; improve their self-care, sense of community belonging, and satisfaction with various life domains; and decrease their level of depression and psychosis.
	(3) Special Interest Groups a. Support Services for Young Adults With Substance Use Disorders	3a. This article reviews principles of care in recovery support services for young adults, including: • Given their developmental needs, young adults affected by SUD should have access to a variety of recovery support services, regardless of the levels of care they need.

		• The workforce for addiction services provided to young adults benefits from the inclusion of individuals with lived experience. • Recovery support services should be integrated to promote recovery most effectively and provide the strongest possible social support.
	(4) Support for Navigating Social Needs a. Implementing Peer Recovery Coaching and Improving Outcomes for Substance Use Disorders in Underserved Communities	4a. This paper studies the effects of a robust peer-educator training program in a multisite recovery community organization that serves a low socioeconomic area with limited access to care. Findings showed that people enrolled in a tailored evidence-based peer-led program decreased their psychiatric symptoms and increased their housing stability and employment, highlighting some of the social needs facing people with SUD.
5. Develop integrated peer model for treatment teams	(1) Peer Recovery Support Services in Correctional Settings	This technical assistance (TA) package defines peer support in correctional settings, describes core competencies, highlights the use of peer support in different time frames, identifies best practices for integration of peer support into correctional settings, and provides recommendations for program design and implementation.
	(2) Education, Certification, and Roles of Peer Providers: Lessons from Four States (ucsf.edu)	This UCSF report examines factors associated with the successful integration of peer providers into behavioral health care systems, drawing from a summary of the literature and in-depth case studies conducted in four states with strong peer provider workforces. UCSF makes several recommendations for next steps, in order to better optimize the role of peer

		providers in effectively serving individuals with behavioral health needs.
	(3) Certified Peer Specialist Roles and Activities: Results from a National Survey	This study examines where certified peer specialists (CPS) work and what they do. The results may be of interest to funders, agencies, and programs seeking to understand how peers are incorporated into the behavioral health system. The study concludes that peer work needs to be accepted as worthy of pay rather than a volunteer effort. It also highlights challenges in standardizing the role.

Appendix E: Harm Reduction Component in Practice

The Drug Overdose Prevention and Education, Single Residence Occupancy (DOPE SRO) Project in San Francisco

The Drug Overdose Prevention and Education (DOPE) Project is the largest single-city naloxone distribution program in the country. Since its inception in 2003, it has become world-renowned and has been highlighted in Centers for Disease Control and Prevention (CDC) reports and research and has been identified as a best practice program for integrating community-based naloxone distribution. In 2005, it became a Harm Reduction Coalition program.

In San Francisco, many overdose deaths were occurring in private residences because of the decreased likelihood of other people being present to intervene. During COVID-19, shelter-in-place initiatives led formerly unhoused individuals to move into hotels and supportive housing, resulting in twice the risk of overdose. At that time, the risk of overdose was six times higher for Black men than for White men.

The pilot implementation occurred at two single-resident occupancy, supportive housing sites in San Francisco and had occurred in three phases:

1) Assessment: The DOPE team assessed policies, procedures, team knowledge and experience, and barriers to responding to overdoses. They also trained staff and residents on overdose response practices and installed naloxone kits on each floor.
2) Training and recruitment: Residents were recruited to become peer specialists. These roles were compensated and provided site-based harm reduction education, naloxone distribution, and overdose response. Overdose response call buttons also were installed at the sites.

3) Evaluate and learn: Here, recommendations and feedback were evaluated to fine tune the process for ongoing training, peer recruitment, and overdose prevention.

The overall impacts of the project include:

- Increased awareness, access to, and understanding of how to use naloxone.
- Decreased response time to intervene in an overdose because of accessible wall-mounted naloxone and improved team communication.
- Increased self-confidence and self-efficacy among peer specialists, who received compensation for their overdose response work.
- Improved rapport, communication, and trust between residents and supportive housing staff.

Access to Buprenorphine in Primary Care Settings Using the Reducing Infection Related to Drug Use Cost-Effectiveness (REDUCE) Model

The REDUCE model is a closed cohort microsimulation of the natural history of injection opioid use, including complications such as overdose, infective endocarditis (IE), and severe skin and soft tissue infections (referred to as "sequelae"); treatment; and changes in injection behaviors. The model uses a weekly time stamp and tracks all individuals from model initiation until death.

This model is based on the understanding that people with injection SUD use are at risk of sequelae and that this threat increases with the frequency of injection. Upon developing sequelae, individuals are at a high likelihood of facing health complications that result in hospitalization or death.

This study compared the following treatment approaches in primary care:

1. Standard primary care services, where providers refer patients to external addiction care (status quo).
2. Standard primary care services plus onsite buprenorphine prescribing with referral to offsite harm reduction kits (BUP).
3. Standard primary care services plus onsite buprenorphine prescribing and harm reduction kit provision (BUP plus HR).

In the compared models, harm reduction kits contain a package of 10 sterile syringes with injection preparation equipment, safer smoking kit, and skin hygiene and wound care supplies. In the third option, onsite provision of buprenorphine and a harm reduction kit, the kit was supplied at every visit. Therefore, these three services were provided simultaneously and referrals to outside care for these services were unnecessary.

The results from this study demonstrated significant positive impacts when the BUP and BUP plus HR strategies were implemented. BUP and BUP plus HR resulted in 160 fewer deaths per 10,000 people. Compared with the status quo strategy, life expectancy was extended in BUP by 2.65 years and BUP plus HR by 2.71 years. BUP plus HR resulted in 164 fewer skin and soft

tissue infections per 10 000 people. Both the BUP and BUP plus HR strategies decreased mortality from all sequelae by approximately 33 percent compared with the status quo strategy. BUP plus HR provides better outcomes than BUP alone at a lower cost.

Actionable Strategies and Tools

Table 5: Harm Reduction Approach Actionable Strategies and Tools

Strategy	Tool	Description
Drug overdose prevention services	Overdose Detection Technologies to Reduce Solitary Overdose Deaths: A Literature Review	Drug overdoses were a leading cause of injury and death in the United States in 2021. Solitary drug use and solitary overdose deaths have remained persistent challenges warranting additional attention throughout the overdose epidemic. The goal of this narrative review is to describe recent global innovations in overdose detection technologies (ODT) that enable rapid responses to overdose events, especially for people who use drugs alone.
Ensure people have safer drug use information and materials	Makin' It Happen- A Coordinated Community Approach to Harm Reduction	Makin' It Happen is a community-based nonprofit organization that works in partnership with the City of Manchester, NH, to provide regional public health network services, primary prevention around alcohol, tobacco and other drugs, and coordination/facilitation of the region's SUD continuum of care, including prevention, intervention, treatment, and recovery.
Medication Assisted Recovery	Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit	Vital Strategies and the National Council for Behavioral Health have developed a toolkit to help jails and prisons implement and expand access to medications for opioid use disorder, such as methadone and buprenorphine, for incarcerated people struggling with opioid dependence.
Community outreach and engagement	Expanding First Response: A Toolkit for Community	Many communities, particularly ones with large diverse populations, lack properly funded organizations and crisis systems that can provide the care and services needed to reduce jurisdictions' overreliance on police to handle

	Responder Programs	behavioral health crises and social disturbances. Jurisdictions across the country are now reimagining their approach to public safety by investing in community programs that position health professionals and community members trained in crisis response as first responders.
Drug overdose prevention services	Overdose Prevention Centers	Overdose prevention centers are public health facilities that provide people with a non-judgmental, hygienic, supervised space to use their drugs. Centers are staffed by peers and usually healthcare professionals who are trained to intervene immediately in the event of an adverse drug episode, such as an overdose. People who visit the centers to use drugs receive safer use supplies free of charge, such as sterile syringes, tourniquets, cookers, and cotton.
Promoting practical, nonlinear opportunities for steps toward recovery within services for people who currently use drugs	Abundant Community Recovery Services Mobile Harm Reduction Unit	This program specializes in services for Black and Brown communities and uses a mobile unit to travel to the high-risk opioid use areas in the county. Services provided include naloxone training and dispensing, clothing provision, treatment referrals, insurance navigation, and treatment initiation.

Appendix F: Addressing the Needs of the Whole Person Component in Practice

Back on My Feet: A Comprehensive Intervention for People who are Unhoused

https://backonmyfeet.org/about-us/mission-vision/

Back on My Feet is a program designed to "revolutionize the way society approaches homelessness." The model focuses on combining exercise with "practical training and employment resources for achieving independence; an environment that promotes accountability; and a community that offers compassion and hope." The program was founded in Philadelphia in 2007 and is now operational in 16 cities across the United States.

The program serves people who are experiencing homelessness or are at risk of becoming unhoused. The program starts by recruiting individuals from shelters or treatment facilities across the country. From there, members are asked to commit to three early morning runs per

week with progressive distance goals. Once they have participated in 90 percent of their committed runs for 30 days, they are eligible to transition to the Next Steps phase of the program.

In the Next Steps phase of the program, members work with staff to create a "personal road map to independence." Members attend financial literacy classes and job skills training programs. Job skills training includes both soft skills and access to various certifications and licensures. In addition, members are eligible to receive financial support to remove barriers to employment and housing.

The program serves adults ages 18 and older who are from diverse backgrounds and demonstrates impressive outcomes, serving more than 3,000 individuals who, on average, were hired to work in jobs paying nearly double the minimum wage. This program has had significant impacts on emotional outcomes, physical health (specifically blood pressure and obesity), nicotine use, and both housing and employment stability.

Yoga and Substance Use Disorders: A Narrative Review

Yoga is an ancient philosophy and practice with Indian roots that has recently become integrated into many physical health, mental health, and SUD treatment settings.[1] The practice integrates psychological techniques such as mindfulness with physical health techniques that improve strength and flexibility. The above-linked narrative review examines how the incorporation of regular yoga practice into SUD treatment may improve outcomes.

The review suggests that yoga is effective as an adjunct modality for people in treatment for SUD. Yoga was found to benefit people who are trying to recover from using a variety of substances including tobacco, alcohol, benzodiazepines, and opiates. Its efficacy is particularly notable during detoxification and relapse prevention.

During the detoxification period, the body and mind are under a tremendous amount of stress. For example, when a person is discontinuing the use of alcohol, benzodiazepines, or opiates, they often go through a period of significant withdrawal, which may include physical symptoms such as increased heart rate and blood pressure that can be reduced through yogic breathing practices. It was noted that full physical yoga practice is best introduced post-acute withdrawal when the individual is feeling relatively stable psychologically and medically.

Yoga was also found to have a significant impact on reducing precursors to relapse. The studies reviewed found that yoga increased perception of self-control, decreased depression and anxiety symptoms, improved quality of life, improved social health, increased motivation to discontinue use of tobacco, and lower plasma cortisol levels, indicating a reduction in stress.

[1] https://www.nccih.nih.gov/health/yoga-what-you-need-to-know

It was recommended that a yoga intervention be delivered as a complement to SUD treatment and that it begin after the acute detoxification phase and during the period when the person is beginning to incorporate healthier lifestyle practices. Yoga should be taught by a trained practitioner, with a preference for those with lived experience in recovery. It also is suggested that the intervention be offered in a group setting to add social connection to the list of benefits.

Actionable Strategies and Tools

Table 6: Addressing the Needs of the Whole Person Actionable Strategies and Tools

Strategy	Tool	Description
Linkages & supports to health-related social needs such as: Housing, Food & Employment; Effective case management and warm handoffs	Certified Community Behavioral Health Clinics (CCBHC)	Designed to ensure access to coordinated comprehensive behavioral healthcare, CCBHCs provide a comprehensive array of behavioral health services so that people who need care can avoid having to piece together the behavioral health support they need across multiple providers. In addition, CCBHCs provide care coordination to help people navigate behavioral healthcare, physical healthcare, social services, and the other support systems.
Recovery Capital Tracking	Recovery Capital Index	The Recovery Capital Index (RCI) provides a comprehensive picture of a person's well-being using an online, automated survey. The RCI is person-centered and scientifically validated to reliably measure addiction wellness regardless of treatment modality, recovery pathway, or substance used.
Family Based Models of Care	Patient-And Family-Centered Care	Patient- and family-centered care is a whole-person approach to the planning, delivery, and evaluation of healthcare that is grounded in mutually beneficial partnerships between healthcare providers, patients, and families. It redefines the relationships in healthcare by placing an emphasis on collaboration with people of all ages, at all levels of care, and in all healthcare settings. In patient- and family-centered care, patients and families define their family and determine how family members will participate in care and decision-

		making. A key goal is to promote the health and well-being of individuals and families and allow them to maintain their control. This perspective is based on the recognition that patients and families are essential allies for quality and safety, not only in direct care interactions, but also in quality improvement, safety initiatives, education of health professionals, research, facility design, and policy development.
Effective case management and warm handoffs	IMPACT Model/Collaborative Care	The collaborative care model (CoCM) is an integrated care model that provides behavioral health services typically in the primary care setting. This model embraces the whole-person care approach, as it is team-based with the PCP also participating in the care, and includes a consulting psychiatrist. In this model, the patient's medical, mental health, social and cultural needs are addressed collaboratively with the team and with the patient at the center.
Utilize trauma-informed and person-centered care	The Role of Recreation and Recreational Therapists in Developing a Recovery-Oriented Identity for People with Substance Use Disorders	This article highlights pathways of identity transition through SUD recovery and considers the role that recreation can play in the development of a recovery identity. Using the leisure ability model as a template, the article considers how recreation can affirm recovery identities. Further, the article explores the role recreation-based mutual self-help groups can play in enhancing a recovery identity. Finally, the article considers how recreational therapists working with SUD patients can aid the development of recreation supports, by using incentives intended to reduce recidivism and leverage community connections.

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