September 5, 2019

Peer Voice NC (PVNC), with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), is establishing the North Carolina statewide peer and "consumer" organization dedicated to establishing a unified voice of people with lived mental health and/or co-occurring substance use disorders to impact peer and recovery-oriented policies, practices, and systems.

In support of NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) commitment to growing recovery and peer alternatives throughout the state, Peer Voice NC has engaged its network to gather information and draft a proposed design of a NC Peer Wellness Center Pilot project with affiliated technical assistance and administrative supports for capacity building of Consumer-Operated Services Programs (COSP). Following is a description of the activities PVNC has undertaken and recommendations:

PVNC Outreach

PVNC posted several requests for interest from existing and emerging peer-run programs and organizations to examine and define Peer Wellness Centers. A list was generated of 7 workgroup members inclusive of current Executive Directors of 3 Peer Wellness Centers, NC CPSS that have worked and/or lead similar programs in other states, and others with an interest in assimilating national research and models. The group was comprised of a geographically and ethnically diverse group that met through zoom meetings several times with correspondence between meetings to complete specific tasks.

Framework

In addition to nationally published research, articles and models related to Peer Wellness Centers, the workgroup utilized the NC proposed House Bill 983: Peer Wellness Center Pilot description, and the recent NCDMHDDSAS RFA of Recovery Community Organizations for the substance use disorder peer community to ensure consistency with its structure, requirements, scope of work, and performance standards. Additionally, SAMHSA's definition of Consumer-Operated Services Program (COSP), its related Fidelity Assessment Common Ingredients Tool (FACIT), and 8 Dimensions of Wellness (SAMHSA) were used to provide the framework for the proposed pilot.

Below, please find the proposed Peer Wellness Center pilot description for your consideration. PVNC appreciates the Division's commitment to advancing peer-run alternatives in our state and anticipates an exciting partnership in support of our mutual vision.

Sincerely,

Cherene Allen-Caraco

Project Director

Peer Voice NC

Proposed Peer Wellness Center Pilot Description

1.0 INTRODUCTION

This request for applications (RFA) is in response to the North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services recognition that people with mental health diagnoses and co-occurring substance use disorders do recover, and peer supports are an effective tool for individuals seeking healing, wellness and recovery. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services, known as "The Division" seeks to assist communities in building a peer-operated resource network and hub for individuals seeking recovery from mental health and those with co-occurring substance use disorders.

These funds are designated to build capacity for two (2) independent Peer Wellness Centers that primarily serve people labeled with serious mental illness, severe and persistent mental illness, and co-occurring substance use disorders. A Peer Wellness Center offers a variety of resources, using the 8 Dimensions of Wellness framework (SAMHSA, Swarbrick, et al.), by providing information, access to on-site and community-based resources, and a safe space to explore many different pathways to recovery and healing and an identity beyond "mental patient" and "addict." These environments promote wellness self-management and social connections, offering mutual support from others who have experienced mental ill-being as a primary life disrupting event, yet have obtained well-being through recovery supports, education and self-help practices. This non-clinical, non-coercive and non-forced option of recovery supports involves working with trained Peer Support Specialists who facilitate mutual aid groups, and self-help education of individuals and families about their rights to be an active participant in their care, as well as facilitate access to available external resources that may include safe housing, employment, legal assistance, HIV screening, primary medical care, educational pursuits, financial recovery, spiritual exploration, etc., as defined by each person's interests and needs, promoting whole health and advancing social determinants of health.

The vision for this initiative involves support of one existing Peer Wellness Center that will act in a technical assistance, administrative support and mentoring capacity to a minimum of two (2) additional Peer Wellness Centers throughout North Carolina to build capacity of peer-run organizations. Among the goals include: 1) fostering the start-up of mental health peer-run organizations to establish administrative functions necessary to

independently operate and grow, 2) gathering outcome data regarding the impact of the Peer Wellness Center on recovery as well as the needs, gaps and trends in each community, 3) developing organizational readiness to expand supports to 24 hour Peer Operated Respite Services to ensure recovery-oriented mental health crisis supports in the community, 4) serving as a bridge to individuals in TCLI and others transitioning in and out of systems, settings and services, and 5) enhancing supports for people without services and/or other supports in place.

1.1 PURPOSE

The purpose of this funding is to establish community-based, peer operated mental health and co-occurring recovery array of supports for individuals who may or may not be formally engaged by the local public mental health system of services. In NC, these supports are not currently funded through Medicaid and therefore represent a significant gap in promoting recovery outcomes.

These funds will be directed to one (1) mental health Peer/"Consumer"-Run Organization that currently operates a Peer Wellness Center and has the organizational structures, financial history, and administrative capacity to seed, support and mentor the development of two (2) independent Peer Wellness Centers that primarily serve people labeled with serious mental illness, severe and persistent mental illness, and co-occurring substance use disorders. The grantee must meet the organizational structure, culture and operations defined through the Consumer-Operated Services Program (COSP) and associated Fidelity Assessment Common Ingredients Tools (FACIT) as a mental health consumer-run organization inclusive of individuals with co-occurring substance use disorders. The successful applicant will oversee funds to a minimum of two (2) Peer Wellness Centers external to their own and will offer ongoing technical support for sustainability planning, community engagement, building employees and volunteers, administrative, financial, outcomes and data, human resources and training to develop into COSPs with the FACIT as a continuous quality improvement tool.

1.2 BACKGROUND

North Carolina has a large population of individuals that have mental health and/co-occurring substance use disorders. According to the 2017 LME-MCO Annual Statistics and Admission Report (LME-MCO Report) and 2017 NC Treatment Outcomes and Program Performance Systems Report (NC TOPPS), 70% of the 355,655 North Carolinians served through Medicaid and state funded services were diagnosed with a mental illness and 35.7% had a co-occurring substance use disorder. Further, the NC TOPSS report indicated that of the 12,896 people with at least 1 or more "episodes" of services that received

publicly funded mental health services in 2017, 35.7% were due to mental health only and 78.7% were due to co-occurring mental health and substance use disorders (NC TOPSS, 2018). This data does not reflect individuals without insurance that are receiving county and other funded behavioral health services throughout NC.

The economic and social implications of emotional distress is significant. Nationally, the costs associated with moderate, excessive and harmful drinking were estimated to be at $223 billion in 2006; the estimated costs for North Carolina for the same period was in excess of $6 billion (Sacks et al, 2013). Psychiatric and behavioral health care expenses, as well as those associated with the high costs of chronic medical expenses due to co-morbid health conditions, sustained use of psychotropic medications, and unhealthy lifestyles, constitute a substantial proportion.

For the past several years, the state of North Carolina has experienced a continued increase in the number of individuals with behavioral health needs presenting in acute care emergency departments. In the community of Charlotte alone, Carolinas HealthCare System (i.e. Atrium Health) has experienced a 41% increase in behavioral health volume presenting to Atrium Health's acute care EDs from 2014 to 2016 and a 7.7% increase in inpatient length of stay at their Charlotte and Davidson behavioral health hospitals. Additionally, the primary mechanism for hospitalization has become the use of involuntary commitment (IVC) with Mecklenburg County seeing 15,000 IVCs each year and, according to the 2017 NC Stats Hospital Report, of the 2,303 admissions in that year, 85.5% were done involuntarily (NCDHHS, 2017). This trend is costly to both the individual whom can get caught in an illness identity and traumatization through a cycle of rehospitalization as well as to the healthcare system that pays on average $2,098/day in NC for length of stays between 4-10 days (Henry K. Kaiser Family Foundation, 2017).

With the current climate of Medicaid reform in NC, a prime opportunity for innovation in peer, recovery and resilience-informed resources and services exists. Social determinants of health have been introduced into the language of reform and efforts to transition from fee-for-service to value-based funding and introduction of new policies and service definitions are underway. Unfortunately, many recovery-based alternatives are not funded through Medicaid, leaving a significant gap for all North Carolinians that are in need of access to support and resources, authentic peer support, and growing their personal recovery and resilience through a non-medical treatment paradigm.

The evidence base for consumer-operated services spans a 30-year period, but until 2000's, the identification of evidence-based practices has focused primarily on the

effectiveness of traditional mental health programs. These studies neglected to consider the consumer-operated service elements and outcomes valued by individuals in selecting treatment and services, such as hope, recovery, independence, voice, choice, well-being, self-direction, etc. The few studies of consumer-operated services tended to assess improvements in clinical outcomes such as medication compliance, and reduction in symptomology and hospitalization (Edmundson, Bedell, Archer, & Gordon, 1982; Galanter, 1988; Kurtz, 1988). This "pathologizing" of problems of daily life, was expressed by people with lived mental health experiences as paternalistic with limited hope, expectations and outcomes. Instead, "consumers" continue to identify recovery, personhood, well-being and choice as the most relevant outcomes for mental health programs (Trochim, Dumont, & Campbell, 1993).

According to SAMHSA (2011), "throughout history, peer support has helped people achieve health and wellness. The consumer-operated service model of peer support is now being recognized nationally and internationally. As noted in the New Freedom Commission on Mental Health's final report Achieving the Promise: Transforming Mental Health Care in America (2003): *"Recovery-oriented services and supports are often successfully provided by consumers through consumer-run organizations … Studies show that consumer-run services and consumer providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with a psychiatric diagnosis" (p. 37).*
Funders are increasingly demanding evidence that program models work. In response, consumer-operated programs must continue to demonstrate their role in supporting people's recovery" (COSP, 2011)

Consumer-operated services are fully independent, separate, and autonomous from other mental health agencies, with the authority and responsibility for all oversight and decision-making on governance, financial, personnel, policy, and program issues (Zinman, 1987; Solomon, 2004; Van Tosh & del Vecchio, 2001; Holter, Mowbray, Bellamy, MacFarlane, & Dukarski, 2004). To a large degree, consumer-operated programs are staffed by individuals who have received mental health services (Mowbray & Moxley, 1997; Goldstrom et al., 2004, 2006). In this literature review, the term "consumer" is defined simply as an individual who identifies as having been diagnosed with a psychiatric disorder and/or who uses or has used mental health services (Solomon, 2004).

In its Consumer-Operated Services Programs toolkit (COSP), SAMHSA outlines a variety of evidence, research, models and examples nationally and internationally of the use of COSP's and their outcomes. The data is inclusive of Level IV Evidence of expert reports,

Level III- descriptive studies, Level II quasi-experimental studies, and Level I- randomized control trials. In 1998-2006, the Multisite Research Initiative of Consumer Operated Services Program study was initiated to rigorously gather and evaluate the evidence for COSP. "The study (Campbell et al., 2006) is the largest and most rigorous study of consumer-operated services conducted to date, with 1,827 individuals participating at eight sites nationwide—four drop-in centers, two mutual support programs, and two educational/ advocacy programs—and the respective control programs in traditional mental health service organizations. Study participants were all established users of traditional services." (SAMHSA, 2011)

Among the outcomes that were yielded from this study and others of COSP include:

- ✓ greater overall increase in well-being of individuals participating in COSPs rather than traditional treatments, with those participating more in COSPs having greater gains in wellness;
- ✓ greater use of the consumer-operated services was significantly related to greater gains on most measures of empowerment.
- ✓ greater gains overall in subjective outcomes for those involved in COSP;
- ✓ all COSP scored higher than traditional programs in the Belief System Domain that measures empowerment, choice, recovery, acceptance, respect for diversity and spiritual growth (Johnson, Teague, & McDonel-Herr, 2005);
- ✓ environmental wellness scored higher in COSP and included sense of community, lack of coercive rules, safety, freedom, belonging;
- ✓ self-expression items were significantly associated with well-being and directly connected to peer support, sharing one's story and artistic expression;
- ✓ increased perceptions of self, social functioning and decision making (Roberts et al., 1999; Yanos et al., 2001);
- ✓ Dumont and Jones (2002) showed that access to a peer-operated crisis hostel program produced greater healing/ recovery than traditional hospital-based crisis services.

A whole host of other outcomes related to authentic peer support has also been widely published and includes improved community integration, improved self-esteem (Davidson et al., 2004), increased satisfaction with care (Solomon & Draine, 1995), improved engagement for traditionally alienated people (Rowe et al., 2007), improved social functioning (Davidson et al., 2004), increased access to resources and decreased stigma (Mowbray et al., 1998), greater gain in well-being (Campbell, 2004), increased self-efficacy and enhanced employment (Van Tosh & del Vecchio, 2000). Lastly, various research studies focusing on the impact of peer support relative to hospitalizations, community tenure, and mental health related crises have been conducted and demonstrate that peer support decreases the number of hospital days and readmission rates (Forchuk, 2005).

The link between the service elements of consumer-operated services and positive psychological functioning found in the COSP Multisite Study (Campbell et al., 2006) further validated consumer-provider claims to an important voice in transforming the content and character of community mental health services to a recovery-based system that promotes mental wellness.
In response, the development of the only fidelity model for COSP, the FACIT, was established and outlines ingredients that are critical to the delivery of effective consumer-operated services.

The Division of Mental Health, Developmental Disabilities (DMHDDSAS) is the Single State Agency (SSA) responsible for the delivery of publicly-funded mental health and substance use services. The Mental Health Block Grant maintains that the continuum of mental health recovery and alternative to traditional treatment services should be inclusive of consumer and peer-run organizations. There is consensual agreement among people with mental health challenges and their advocates that authentic peer-run organizations and recovery support services are inadequate and insufficient in the state. North Carolinians with mental health diagnoses often cannot access or afford the support or services that they need. Therefore, many individuals go to the emergency department and other acute settings when experiencing emotional distress.

2.0 ELIGIBILITY

Successful applicants must meet the criteria for a Consumer-Operated Services Program (COSP) and must be a non-profit entity. The definition of a COSP can be found at https://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD. Applicants must have been in business for a minimum of two years and have three months of operating expenses in savings prior to this award. Potential awardees must register with the Secretary of State's office to be eligible to conduct business with the State of North Carolina and must also register as a vendor on the Electronic Procurement System

3.0 AWARD INFORMATION

This initiative is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) via the Mental Health Block Grant. We anticipate one awardee. Indirect cost rates are capped at the de minimus rate of 10% unless applicants have a federally approved rate in excess of this amount. Indirect cost proposals must be submitted and approved by the Division prior to implementation of a contract with the subawardee.

Awardees must comply with uniform administrative requirements, cost principles, and audit requirements for federal awards.

Recipients must create sustainability plans for operational continuity within one year of award. No cost sharing or match is required with this subaward. Recipients must expend funds in accordance with allowable costs for federal awards. Costs must be allowable per the awarding grant and agency, allocable and matching the appropriate activity to the aligned award, and reasonable, as these are public funds.

4.0 SCOPE OF WORK

The Contractor shall perform the following tasks and submit the following output deliverables:

A. 1. The Contractor shall be responsible for the strategies and processes required to more formally establish the two (2) Peer Wellness Centers as COSP's, using the FACIT as a continuous quality improvement tool

a. The Contractor shall work with the Division and two (2) Peer Wellness Centers to determine the type of services to be offered at the Peer Wellness Centers

b. The Contractor shall support the two (2) Peer Wellness Centers to develop a sustainability plan as well as 3-4 year plan for a Peer-Operated Respite Service (PORS)

2. Outputs (Performance Measures):

a. A list of recommended recovery and wellness support services;

b. The number of outreach activities conducted;

c. The types of services and supports offered by the Contractor;

d. The number of people in recovery reached; and

e. The completed sustainability plans.

f. Results of fidelity reviews using the FACIT including continuous quality improvement plans for each Peer Wellness Center

B. Build capacity for a minimum of two (2) Peer Wellness Centers across the state.

1. The Contractor, in collaboration with designated Division staff, shall be responsible for providing technical assistance and
support to the previously identified Peer Wellness Centers across the state and any additions made to those.

a. The Contractor shall conduct outreach and technical assistance to each center on no less than a quarterly basis.

b. The Contractor shall collaborate with Peer Wellness Center staff to conduct outreach including but not limited to listening events/meetings with people in recovery to determine the recovery supports that can be offered at the centers and who will be providing them.

c. The Contractor shall provide other technical assistance as requested or needed by the

centers.
d. The Contractor shall review monthly invoices submitted by the Peer Wellness Centers and reimburse as appropriate.

e. The Contractor shall provide administrative support inclusive of HR, health insurance, financial, data, QA/QI to build the capacity of the Peer Wellness Center
f. The Contractor shall assist each Peer Wellness Center in the development of a sustainability plan.

g. The Contractor shall network the Peer Wellness Centers to ensure consistency, planning and shared wellness tools

5.0 PROGRAMMATIC REQUIREMENTS AND PRIORITIES

Programmatic requirements include focus on mental health stigma reduction, promotion of recovery values and concepts, and advocacy for recovery-oriented systems of care in the community. Feedback from the community served must be included as a data-driven process to steer supports offered at each Peer Wellness Center, including hours of operation. The FACIT must be utilized as a continuous quality assurance tool.

5.1 PERFORMANCE STANDARDS AND EXPECTATIONS

Applicants shall comply with all federal and state requirements for subawards. The North Carolina State Budget Manual outlines parameters for allowable and unallowable costs at the state level, and the code of federal regulations, title 2, part 200 outlines requirements and restrictions for sub awardees receiving federal awards. Sub awardees must comply with all uniform guidance related to the Substance Abuse Prevention and Treatment Block Grant, CFDA 93.539. As a functioning COSP will adhere to those principles and work with newly funded Peer Wellness Centers to ensure their development is consistent with COSP standards. Awardees must adhere to Chapter 143C-6 and 09 North Carolina Administrative Code 03M in addition to 2 Code of Federal Regulations Part 200.

Successful awardees must submit quarterly progress reports in addition to monthly financial status reports. Division staff will conduct a minimum of one site visit per year to review financial and programmatic reports to ensure compliance with state and federal regulations.

5.2 CONTRACTOR QUALIFICATIONS AND CAPACITY

Sub awardees must have internal controls in place and use generally accepted accounting principles (GAAP). Sub awardee must meet the qualifications of a COSP as defined by SAMHSA. Successful applicants will show no more than two audit findings in their most recent audit. At least one staff member of this organization must be trained as a Certified

Peer Support Specialist. Sub awardees must understand and value multiple pathways to recovery and be able to articulate the various options individuals may use to find and sustain recovery from mental health and co-occurring substance use disorders. Key personnel outlined in the Sub awardee’s contract must not be replaced without prior notification of the awarding agency, DMHDDSAS. Subcontracting of this work must be preapproved in writing by the funding entity.