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Research Report

Education, Certification, and Roles of Peer Providers: Lessons from Four States

Susan Chapman, PhD, RN

Lisel Blash, MPA

Krista Chan

Kimberly Mayer, MSSW

Victor Kogler

Joanne Spetz, PhD

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UCSF Health Workforce Research Center on Long-Term Care, 3333 California Street, Suite 265, San Francisco, CA, 94118

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Contact: Susan Chapman, Susan.Chapman@ucsf.edu, (415) 502-4419

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Education, Certification, and Roles of Peer Providers: Lessons from Four States

Executive Summary

Peer providers are individuals hired to provide direct support to those undertaking mental health (MH) or substance use disorder (SUD) recovery, often referred to in the literature as "consumers." The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a peer provider as "*a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency*." This 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.

Methods

Arizona, Georgia, Texas, and Pennsylvania were identified as leading states in the employment of peer providers in MH and SUD through a literature review and the input of a national panel of experts convened in February 2015. We conducted site visits to these states, each lasting 3 to 5 days, during which we interviewed policy makers, individuals in training and certification bodies, and staff and leaders in provider organizations.

Findings

- **Policy environment**
  - State-level individuals and consumer advocacy organizations have been instrumental to the development of robust peer support workforces.
  - In 2007, the Centers for Medicare and Medicaid Services (CMS) authorized states to bill Medicaid for MH and SUD peer support.
  - In Georgia and Arizona, settlements from class-action lawsuits require expanded access to behavioral health services in general, and to peer providers specifically.

- **Training and Certification**
  - States must have an accepted statewide training and certification in place to bill Medicaid for peer support services.

- Some states have a single approved training program for MH and/or SUD peer providers, while in other states there are multiple vendors that offer programs that meet curricular guidelines. There is no evidence that one approach is better than the other. In some states, access to peer provider training is limited to individuals who are already employed as peers or who are prescreened as being a good fit for the position.
- SUD training programs are usually separate from MH training programs, although some states have a credential that covers both MH and SUD peer support.
- Seventeen state certification boards have adopted the peer credential offered by the International Certification and Reciprocity Consortium (IC&RC), which allows for limited reciprocity among member states. This credential is largely used by the SUD community but could be used by MH peer providers as well.
- Documentation for billing provides a training challenge for some peer providers, due to their lack of experience in clinical documentation and sometimes limited educational background.

- **Funding for Peer Support Programs**
  - Medicaid is a more important source of funding for peer support in some states than others. Part of that difference is related to whether the state is a Medicaid expansion state under the Affordable Care Act (ACA). Other funding sources, such as state general revenue, federal grants, and private grants, have been important to the development and employment of the peer provider workforce.
  - In some states, only MH peer providers are Medicaid-billable. Peer provider SUD services are less frequently Medicaid-billable but some states have implemented work-around billing mechanisms.
  - Some consumer-run organizations do not bill Medicaid for ideological reasons related to the history and philosophy of the recovery model of care. Some consumer-run organizations also have difficulty meeting supervision requirements and other billing requirements.

- **Employment**
  - There is little data about the employment of peer providers. It is not clear whether there is an adequate supply or surplus of trained peer providers in the states visited.
  - Behavioral health workforce shortages and the availability of funding seem to drive demand for peer providers.

  - Peer providers work in both non-clinical recovery-focused organizations, some of which are consumer-operated, as well as in traditional treatment-oriented agencies.
  - Statewide surveys suggest that many peer providers work part-time, although many interviewed for this study worked full-time.
  - Peer providers generally receive low wages, with little opportunity for wage growth.
  - Some peer providers need workplace accommodations, such as generous leave time, to maintain their own health and recovery.
  - There are few opportunities for career advancement for peer providers; in some organizations, peer providers can take a supervisory role. Many employers support educational advancement of peer providers.

- **Roles of Peer Providers**
  - Incorporating peer providers helps shift MH and SUD services organizations into a "recovery-oriented" model of care.
  - Peer providers work in both peer-based groups and teams with licensed providers.
  - Many peer providers work one-on-one with consumers in the community, at offsite settings such as housing units and drop-in centers.
  - A growing number of peer providers works as forensic peers, assisting incarcerated individuals with serious mental illnesses and addictions to achieve wellness and transition into the community upon release.
  - Although most peer providers interviewed felt accepted and valued in their organizations, many reported that they had faced difficulties with clinical providers understanding their roles or fearing that peer providers threatened their own employment. Peer providers who work in traditional clinical settings reported more challenges with acceptance of their roles.

Conclusions

A growing body of research demonstrates that peer providers can contribute positively to the treatment and recovery of individuals with behavioral health care needs. There is more literature on the efficacy of MH than SUD peer providers. Many states are actively promoting the training, certification, and employment of peer providers. To optimize the role of peer providers in meeting behavioral health needs, a number of issues should be addressed:

- Data on the active employment and roles of peer providers should be collected, either by state agencies or partnering research organizations.

- More research is needed on the impact of SUD peer providers. The majority of rigorous outcomes research on peer providers concerns MH peer providers.
- Employers should develop approaches to ensure that peer provider jobs offer opportunities for advancement and sustainable earnings and benefits.
- Standardized training and certification may enhance job mobility for peer providers.
- Employers should maintain attention to the unique stresses associated with the peer provider role and ensure that peer providers have the workplace accommodations they need to maintain their own health.
- Greater coordination of MH and SUD peer provider training should be considered, especially in light of the prevalence of co-occurring disorders. However, it is important to continue to address the distinct needs of each population.
- Policies should ensure that Medicaid reimbursement requirements do not undermine the unique features of peer providers that make them effective in supporting recovery.

Education, Certification, and Roles of Peer Providers: Lessons from Four States

Introduction

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services, defines a peer provider—also known as a certified peer specialist, peer support specialist, or peer recovery coach —as "*a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency*."[1] The key distinction between peer providers and traditional providers is the ability to draw from lived experience and experiential knowledge.[2]

Peer providers are part of a movement to transform behavioral health care into a "recovery-oriented" care system.[3] Advocates have noted that traditional mental health care and substance abuse treatment has focused on treatment of disease and controlling the symptoms of mental illness and/or addiction. The traditional "medical" model has historically been staffed by licensed and certified behavioral health professionals. The recovery model focuses on empowering the consumers of mental health and substance abuse services, identifying consumers' strengths, involving them in shaping their own care, and maintaining long-term recovery past acute crises.[3] Persons with lived experience recovering from mental illness and substance use disorders are an integral part of the workforce in recovery-focused models of care.

This 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. The policy environments, education and certification structures, and roles of peer providers in these states are summarized, highlighting facilitators to success and ongoing challenges. More background information on this topic can be found in the related document, *The Peer Provider Workforce in Behavioral Health: A Landscape Analysis*, and in the series of 4 case studies on which this report is based. These materials are listed in Related Resources at the end of this Report.

Methods

This project began with a preliminary search of the literature and landscape analysis: *The Peer Provider Workforce in Behavioral Health: A Landscape Analysis*. Arizona, Georgia, Texas, and Pennsylvania were identified as leading states in the employment of peer providers in MH and SUD through this literature review and the input of a national panel of experts convened in February 2015. We contacted state officials, certification boards, training organizations, and provider organizations in each state to better understand the state's service model, and to identify organizations to visit during site visits that lasted 3 to 5 days. During site visits, we interviewed policy makers, individuals in training and certification bodies, and staff and leaders of provider organizations. Where feasible, we collected administrative data from peer provider sites. This report synthesizes key findings from the case studies and landscape analysis.

Key Findings

Policy Environment and the Growth of Peer Support Programs

Growing utilization of peer providers in behavioral health care systems has been facilitated by a number of factors. State-level consumer advocacy and recovery organizations have played a major role in instituting peer support systems, as have federal and private grants and Medicaid policies.

In 1999, Georgia was the first state in the nation to write MH peer providers into its state plan as a Medicaid-billable provider type.[4] The state's first class of Certified Peer Specialists (CPS) graduated in 2001. In 2007, in part because of Georgia's success, the Centers for Medicare & Medicaid Services (CMS) issued a letter to State Medicaid Directors authorizing them to bill Medicaid for MH and SUD peer support services under particular conditions of supervision, care coordination, training, and credentialing.[5] The CMS rationale for this authorization was a number of studies that established peer support as "an evidence-based mental health model of care".[5]

Other states began to follow Georgia's lead. Many states already had peer providers and training programs. However, the ability to bill Medicaid required some standardization of training, established the need for certification, and ensured a degree of financial stability for this type of position. Medicaid billing thus allowed the MH peer provider workforce to grow at a faster pace than might have been the case without this funding option. However, relatively few states permit Medicaid

billing for SUD peer providers; interviewees noted that this has inhibited the growth of the SUD peer provider workforce.

Another factor that influenced rapid adoption of peer providers was class action lawsuits concerning the rights of mental health consumers de-institutionalized from state mental hospitals. Settlements from class action lawsuits in Arizona[6] and Georgia[7, 8] require that states provide specific community-based services to accommodate persons with serious mental illnesses (SMIs), including specific targets for peer and family support, which are monitored and enforced by state agencies.

Training and Certification

In order to include peer providers in a state Medicaid plan, they must complete a state-approved training and certification program.[5] States vary in their approaches to training and certification. Some states, such as Georgia and Texas, have a single vendor for statewide training and certification for MH peer providers. Georgia also has a single vendor providing training and certification for SUD peer providers. Interviewees in single-agency states noted that this unitary approach provides consistency across the state. One challenge that comes with the single vendor model is that access to training and certification may be limited. For example, although MH training courses in Georgia are held around the state, the proctored exam is always offered in just 1 site. Likewise, in Texas, training is primarily held in the state capital, which may entail significant travel costs for participants or sponsoring agencies.

Other states have multiple designated training vendors; Pennsylvania has 2 for MH and Arizona has more than 15 for both SUD and MH. Pennsylvania and Texas have multiple authorized SUD training vendors. Training vendors must adhere to guidelines developed by the state. Interviewees in Arizona felt that the multiple training vendors fostered healthy competition and innovation. While some interviewees in Pennsylvania felt its system offered freedom of choice and competition, others felt the lack of consistency in screening and training standards was problematic.

Interviewees noted that access to peer provider training was not merely an issue of the availability of training programs. Some state training programs prioritize slots for candidates with at least some paid or volunteer experience in the field, current employment as a peer provider, or prescreening for suitability for the role.

Some states have adapted nationally-recognized curricula in their state requirements, most notably the Georgia Appalachian Consulting Model for MH, and

the Connecticut Community for Addiction Recovery[9] curriculum for SUD. Some states have a single approved certification examination for each field. In other states, each training vendor has developed its own certification exam based on state guidelines. Some states' SUD (and occasionally MH) peer provider certification curricula and examinations are aligned with standards developed by the International Certification and Reciprocity Consortium (IC&RC), which provides limited reciprocity across states. However, most IC&RC peer credentials are offered through state boards focused on SUD professionals, and are not necessarily the approved statewide certification in their respective states.

CMS guidelines dictate that states require continuing education units (CEUs) to retain certification. Each state has unique requirements for the amount of continuing education required and how it is monitored. In some states, a statewide certification organization tracks this information, but in others CEUs are primarily tracked by employers, by the state, or by 1 or more training vendors.

Training/Knowledge Gaps Identified

Peer providers interviewed for this study were generally satisfied with the training they had received, reporting it as a transformative experience. However, many noted that training alone could not substitute for on-the-job experience. Interviewees took the continuing education requirements seriously and were enthused about the course offerings and about the opportunity to connect with other peer providers and share experiences.

A consistent theme across states was the need for ongoing training in documentation required for Medicaid billing. Some peer providers have education and computer experience limitations, making computerized and written documentation challenging.

Models of Care

Peer providers are employed in a variety of settings, from traditional treatment-based organizations to recovery-oriented non-clinical organizations. Specific settings in which peer providers work include peer-run respite centers; medical respite centers; state hospitals; drop-in and wellness centers; recovery community centers; transitional and permanent housing sites and recovery houses; jails and prisons and diversion programs (forensics); crisis stabilization units; assertive community treatment teams (ACT); intensive case management teams; detox facilities and medication assisted recovery; and drug, family, and mental health courts.[10] A growing number of peer providers works in primary care settings. Peer

providers are employed in many types of organizations including not-for-profit, government, and for-profit.

The growth of peer employment has been driven by a number of factors, including aforementioned policies regarding Medicaid billing. Behavioral health workforce shortages were noted as an important motivation for adoption of peer providers in all 4 states we visited. States that have adopted the Affordable Care Act's Medicaid expansion have experienced increases in the demand for mental health services, while states that have not expanded Medicaid have less funding available for behavioral health services and fewer consumers who qualify for Medicaid. Both factors motivate employment of peer providers, who are viewed as a cost-effective way to expand access to services.

Some states have policies requiring employment of peer providers. The class action lawsuit settlement in Georgia includes specifications that certain services include at least 1 peer provider on the treatment team.[8] Georgia and Pennsylvania both have policies in place that require publicly funded mental health systems to provide peer support.[11, 12] In Texas, agencies receiving funding as part of a statewide Recovery Initiative are required to hire SUD peer providers.

The increased recognition of the value of peer support as an evidence-based practice, substantiated by research and experience, has also increased interest in developing peer support programs. Policy leaders interviewed in Texas and Pennsylvania highlighted provider/academic partnerships that helped them to establish research evidence of the efficacy of peer support in order to garner political and financial support. However, much of the peer-reviewed research on the efficacy of peer providers is in the field of mental health, with relatively little available on the impact of peer providers in substance use disorders, and even less in co-occurring disorders.

The number of peer providers employed is difficult to establish because training vendors and state agencies rarely track this information. CEUs are required to retain certification, but not always centrally documented. While we spoke with many peer providers who worked full-time, particularly in SUD, statewide and national surveys suggest that employment among MH peer providers is often part-time.[13-18] Interviewees noted several reasons for this: 1) peer providers may not choose to work full-time due to their own recovery issues; 2) peer providers may not be able to work full-time in order to not exceed the SSI income and Medicaid benefit threshold; 3) employers may not offer full-time employment in order to avoid paying high cost health insurance and other benefits; and 4) employers may not have enough demand for full-time positions in some categories of service.

The wages of peer providers are generally low, comparable to other entry-level health care positions such as personal care aides and home health aides.[19] Some human resource representatives at organizations we visited noted that peer providers were very loyal and that turnover rates were low, while other organization representatives noted that due to low pay, poor benefits, and difficult hours, peer providers had very high turnover rates. As demand for peer providers increases, some organizations are reviewing pay and benefits to retain staff.

Some peer providers require workplace accommodation to maintain employment. Human resources staff indicated that peer support staff required no more accommodation than any other staff. However, this may be because several organizations had changed their human resource and leave policies to provide fairly generous accommodations for medical leave and emotional support.

Funding for Peer Support Programs

The importance of Medicaid in funding peer support programs appears related to the overall level of public behavioral health service spending and whether states are Medicaid expansion states under the ACA. Among the states we visited, Arizona and Pennsylvania are among the top 10 states in the U.S. in per capita public mental health spending,[20] and Medicaid covers much of the funding for MH and SUD peer provider positions in Arizona and for MH peer providers in Pennsylvania. In contrast, Georgia and Texas are among the bottom 10 states in public mental health spending,[20] and funding for peer providers in these states is more reliant on state general revenues and state and federal grants, although Medicaid is still an important source of funding.

Some peer-run organizations choose to not bill Medicaid for peer support because of the concern that documentation and supervision requirements might compromise organizational values and their philosophy of peer support.[19] Some peer-run organizations also reported difficulty meeting Medicaid billing requirements because they did not have sufficient revenues to retain the mental health professionals necessary for supervision of peer support staff under Medicaid requirements and State Practice Acts.[5, 21]

In some states, such as Texas and Pennsylvania, organizations cannot bill traditional Medicaid for SUD peer providers. However, Medicaid managed care plans in these states may contract with organizations that employ peer providers and thus provide a payment mechanism for SUD services. For example, the Association

of Persons Affected by Addictions (APAA), a recovery community organization[i] in Dallas was the first community service provider in the nation to negotiate a contract for peer support services through a Medicaid MCO.[23]

Professional Development and Career Aspirations

Career advancement opportunities for peer providers vary by organization, but in general their opportunities are limited. One organization in Arizona had a multi-step career ladder for peer providers with significant pay raises between steps, but this approach is rare. The small size of many peer-run organizations limits career growth. Other peer providers are limited by lack of a baccalaureate education. However, many peer providers have completed college education including counseling degrees and certification.

A number of managers reported that they preferred to fill leadership roles with their own staff and that people with lived experience were employed at every level of the organization. In addition, many organizations hired former clients and, for many of those clients, this was a first job after incarceration or hospitalization, providing a path back into employment. Organizations also supported career advancement by providing support for obtaining CEUs and for pursuing additional training, education, and credentials.

Some states have career advancement opportunities within the peer provider classification for MH peer providers that recognize various combinations of education and experience; Pennsylvania offers training in Certified Peer Specialist supervision, and Texas's State Hospital System has a 3-tiered career ladder for peer providers. The Arizona Department of Health Services/Division of Behavioral Health funded Arizona State University to develop a Peer Career Advancement Academy to provide additional training to certified peer providers to advance their careers.

Impact on Colleagues and Roles in Organization

In some settings such as peer-run organizations, peer providers may work primarily with other peer providers. However, peer providers are increasingly integrated into

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[i] A recovery community organization (RCO) is an independent, not-for-profit organization led and governed by representatives of local communities of recovery. These organizations organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services (P-BRSS). [22]

clinical settings where they work with behavioral health professionals such as case managers, psychiatrists, outpatient directors, licensed clinical social workers (LCSWs), and registered nurses (RNs). They also work closely with staff at collaborating organizations, such as law enforcement officers at state hospitals, and sometimes primary care providers.

Common job titles for peer providers include peer mentor, case manager, housing navigator, community outreach specialist, engagement specialist, peer recovery coach, peer educator, warm line operator, job coach, peer employment specialist, Whole Health and Wellness Coach, and peer supervisor. Peer support specialists are increasingly employed in programs assisting incarcerated individuals prepare for release, and then supporting them in transitioning into their communities post-release. Another emerging role for peer support specialists is that of Whole Health and Wellness coach, working with an RN or physician to help consumers maintain physical as well as mental wellness.

Peer providers often work one-on-one with consumers, although they may also lead groups and teach classes. In many instances, peer providers work in the community, meeting alone with consumers in their homes or other community settings, or in prisons and jails.

Interviewees often contrasted the "medical model" of care that focuses on crisis and treating the symptoms of mental illness or SUD with a recovery-oriented model that is person-centered and focuses on providing long-term support to maintain recovery. Interviews with staff at provider organizations highlighted the impact of peer support in making the culture of their organizations more recovery-oriented and sensitive to consumer needs, re-focusing on the consumer as a full human being with hopes, dreams, skills, and social connections.

Another major benefit of including peer providers on the care teams was their rapport with consumers and ability to identify issues that many clinical staff might miss. In addition, interviewees observed that peer providers can model recovery, effectively engage people seeking services, and calm those in crisis. Several interviewees observed that peer support programs created an environment in which all staff was able to be more open and compassionate about their own mental health and substance use challenges.

Acceptance by Colleagues

Peer providers often reported feeling more accepted in peer-run and recovery-oriented settings, but some interviewees noted that the integration of peer

providers into traditional treatment-based settings contributed to the broader goal of infusing recovery values into these settings, which are the initial point of contact for many in crisis.

Nearly all peer providers and supervisors reported some challenges with non-peer-provider staff and collaborators, at least initially when peer providers were introduced to an organization. Some interviewees noted they heard stories from colleagues at other organizations who felt they'd been hired as tokens, which was more common within states that require agencies to hire peer providers. They expressed concern that this requirement resulted in positions that were implemented simply to fulfill hiring mandates rather than provide real recovery services.

Within their teams, many peer support staff felt valued and accepted, noting that clinicians worked closely with them and solicited their perspective. However, other peer providers reported ongoing tension with staff in some departments in their organizations, or with those in collaborating institutions. A number of interviewees, SUD peer providers in particular, perceived that counseling staff feared they would be replaced by lower-paid, non-licensed peer providers.

Some interviewees at state government and training organizations noted the importance of preparing organizations to work with peer providers and to adopt a recovery-oriented framework. Texas, Arizona, and Pennsylvania have offered training sessions to provider organizations to help them adopt a recovery-oriented culture and effectively employ peer support staff. The state of Pennsylvania also provides and requires training for those supervising MH peer providers.

Implications for Policy

A growing number of states have embraced training, certification, and payment policies that support the employment of peer providers in a variety of behavioral health settings.[10] The incorporation of peer providers appears to enhance the acceptance of recovery-oriented principles and create greater empathy for consumers, while improving the long-term recovery prospects of consumers. To optimize the potential for peer providers to play an active role in behavioral health care, a number of issues should be addressed:

- **Training and Certification.** Establishing statewide standards for training and certification, whether administered by a single or multiple organizations within a state, is necessary to ensure high quality preparation of peer providers and to guarantee the safety and well-being of the people to whom

they provide support services. Many states base their training requirements on well-established curricula. Despite this cross-state commonality, peer provider certification is often not portable. To date, several states do offer reciprocity for SUD and MH peer providers through IC&RC.[24] The International Association of Peer Supporters (iNAPS) and others have advocated for a national peer-run certification for MH peer providers.[25]

- **Tracking Peer Provider Employment.** States should engage in data collection to better understand the employment and roles of peer providers. This can be done through licensing boards, by state agencies, or in partnership with external research organizations such as universities. For example, 3 of the states visited for this study had partnerships with university researchers and survey research projects to provide a snapshot of peer employment conditions. Some states are able to track the number of peer providers that complete CEUs, which might also be a good proxy for employment.
- **Pay and Career Advancement.** Despite growing professionalization and increasingly defined roles and responsibilities, peer providers are still relatively low-paid and many lack adequate benefits.[19, 15] Career advancement opportunities are often limited, although some states and organizations offer development opportunities and career ladders.
- **Job Stress and Accommodations.** While most peer providers interviewed report satisfaction with their employment, the role requires a balance of empathy and self-disclosure while maintaining adequate boundaries with consumers. Ongoing training needs to address these challenges of the peer provider role.
- **Integration between MH and SUD Services**. Although co-occurring disorders are prevalent, mental health and substance use disorders are often treated in distinct organizations with very different cultures. This creates a challenge for peer providers who lack training or certification to work with both populations. Greater collaboration and coordination between these services without jeopardizing the ability to speak to the distinct and different needs of the population could help address this issue.
- **Medicaid Reimbursement.** Medicaid payment seems to enhance employment opportunities for peer providers. However, documentation, billing, and supervision requirements can negatively impact the essence of what makes peer provision powerful—the rapport, empathy, and lack of hierarchy. Peer providers themselves observed that documentation was difficult and took a sizable proportion of their time away from direct service. However, some strategies can be used to address part of this problem. For example, peer providers in Georgia and Arizona reported using collaborative

documentation to set goals and track progress with consumers. These 2 states are among 7 in the U.S. that permit Medicaid reimbursement for peer provider collaborative documentation.[26]

Conclusion

A growing body of research demonstrates that peer providers can contribute positively to the treatment and recovery of individuals with behavioral health care needs.[10] Our site visits to 4 states that are actively promoting the training, certification, and employment of peer providers revealed wide variation in approaches. Peer providers are being employed in an expanding number of roles and are generally highly regarded by the organizations and team members with whom they work. Peer provider roles were similar across states with some innovations particular to a single state. Medicaid billing is an important factor in the growth of peer-provided services although there are challenges with the documentation requirements and differing views on how billing impacts the basic philosophy of peer support. Career growth opportunities for peer providers are limited but some organizations have focused on creating, promoting, and supporting continued education and career growth. Other states may benefit from further development of the peer provider role to address the growing needs for behavioral health services across the nation.

Related Resources

The Peer Provider Workforce in Behavioral Health: A Landscape Analysis

Case Study of Peer Providers in the Behavioral Health Workforce: Arizona

Case Study of Peer Providers in the Behavioral Health Workforce: Georgia

Case Study of Peer Providers in the Behavioral Health Workforce: Pennsylvania

Case Study of Peer Providers in the Behavioral Health Workforce: Texas

Acronyms Used in this Report

ACT – Assertive Community Treatment
APAA - Association of Persons Affected by Addictions
CEU – Continuing Education Unit
CMS - Centers for Medicare and Medicaid Services
CPS – Certified Peer Specialist
EMT – emergency medical technician
IC&RC - International Credentialing and Reciprocity Consortium
iNAPS - The International Association of Peer Supporters
LCSW - licensed clinical social worker
MH – mental health
RN – Registered Nurse
SAMHSA - The Substance Abuse and Mental Health Services Administration
SMI – serious mental illness
SUD – substance use disorder

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