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San Francisco

*UCSF Health Workforce Research Center  
on Long-Term Care*

## Research Report

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# The Peer Provider Workforce in Behavioral Health: A Landscape Analysis

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# **The Peer Provider Workforce in Behavioral Health: A Landscape Analysis**

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## **The Peer Provider Workforce in Behavioral Health: A Landscape Analysis**

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### **Executive Summary**

#### ***Introduction***

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 resilience.*”<sup>1</sup> The key distinction between peer providers and traditional providers is the ability to draw from lived experience and experiential knowledge.<sup>2</sup>

Peer support for addictions recovery has a long history in mutual-aid and peer-based recovery support groups that developed either as supplements to or substitutes for professional medical care. Peer support for mental health recovery arose out of the civil rights movements of the 1960s and 1970s as a reaction to the enforced treatment and incarceration of persons with mental illnesses. While peer providers have traditionally worked as volunteers, changes in mental health and SUD treatment and recognition of the importance of long-term recovery support have led to a professionalization of this role with formalized training and certification, and the potential for paid employment.

#### ***Methods***

This report summarizes the findings of a landscape analysis on the topic of peer providers in mental health (MH) and substance use disorder (SUD) treatment services. To describe the landscape, we used a series of terms to capture the many titles and roles peer providers play, and conducted a literature search of peer-reviewed and published studies and reports, as well as a search of the “grey” literature on several topics, including:

1. Peer Support Roles, Organizational Settings, and Models of Care

2. Integration of Peer Providers into Traditional Care
3. Evidence of Efficacy of Peer Support
4. Policy and Financial Infrastructure for the Peer Support, including Billing, Reimbursement, and Sources of Funding for Peer Support Programs
5. Training and Certification for Peer Support
- 6.

We conducted a Web-based search to find reports from government and private agencies, and targeted searches in PubMed and other databases for peer-reviewed articles. We also reviewed the bibliographies of promising articles and reports, and were referred to published and unpublished reports by subject matter experts.

### ***Key Findings***

Because of increasing interest in the use of peer providers as an evidence-based, billable practice, there is a growing body of peer-reviewed literature on this topic. However, the grey literature (that which is not peer reviewed) is more extensive and is our predominant source of information on peer provider programs, funding streams, training, and certification. The findings from our literature search of key topics are summarized as follows:

#### ***Peer Support Roles, Organizational Settings, and Models of Care***

- Peer providers, also known as peer support specialists in mental health, and peer recovery specialists or peer recovery coaches in addiction treatment, work in a number of roles in a variety of settings, including peer-run and operated recovery organizations, which are largely non-clinical in nature, to traditional care settings such as mental health clinics, substance use disorder treatment centers, psychiatric hospitals, and inpatient substance use disorder recovery services.
- Peer providers also work in housing facilities; in jails and prisons, where they work to transition incarcerated individuals back into the community; and increasingly in primary care, where they serve as whole health and wellness coaches.

### Integration of Peer Providers into Traditional Care

- Both mental illness and addiction are stigmatized identities, marked by social exclusion and shame. Qualitative studies suggest that stigma creates challenges in employing peer providers alongside non-peer colleagues, especially in traditional treatment settings.
- Friction between traditional and recovery-oriented systems of care is an additional barrier to integrating peer providers.
- The literature suggests a number of benefits to organizations and individuals of integrating peer providers, including increasing organizational perceptiveness of consumer conditions and needs and a potential to facilitate greater trust and engagement from consumers.

### Evidence of Efficacy

- While the majority of published studies indicate positive outcomes for peer support programs such as increased sense of activation and empowerment among consumers, decreased rates of hospitalization, and increased medication adherence—recent meta-analyses call into question the rigor of this research.

### Policy and Financial Infrastructure for Peer Support

- The Affordable Care Act's (ACA) behavioral health parity requirement, along with a shortage of traditional clinical providers, has created precedence for increased federal and state funding for peer providers.
- A Center for Medicaid Services (CMS) ruling in 2007 authorized peer support services as Medicaid billable services. Approximately 36 states now offer the ability to bill Medicaid for mental health peer support services, while approximately a third of those have similar provisions for SUD peer support.
- Other than Medicaid funding, organizations employing peer providers have depended on state and local funding, and federal block grants.

### Training and Certification

- Approximately 40 states have statewide certification for mental health peer support specialists, and up to a third have statewide certification for SUD peer recovery coaches.
- Training requirements and certification standards for peer support specialists vary widely by state and organization in terms of the number of hours of training required (from 30 to over 100), amount of work and/or volunteer experience required (0 to over 500 hours), and curriculum used for training.<sup>3</sup>

### **Peer Provider Workforce Concerns**

As peer providers achieve a higher profile and greater legitimacy in the behavioral health workforce, there are concerns that standardization and professionalization of the role might jeopardize the special components of peer support that speak to lived experience. Some behavioral health organizations, particularly peer-led initiatives, prefer not to bill Medicaid for peer support services, fearing a compromise of organizational values. There is some concern about the financial sustainability of peer-run organizations that prefer not to bill Medicaid as this becomes an increasingly important source of funding for behavioral health services.

The benefits to professional standardization include expansion of peer roles, greater capacity to serve people in need, increased acceptance of consumer perspectives in behavioral health treatment, and paid employment for a population that has frequently found employment prospects extremely poor. However, some researchers note that peer providers often receive lower compensation and poorer benefits than other staff in behavioral health services with comparable qualifications. Some researchers and advocates note that the cost savings attributed to peer support should come from improvements in the quality of care and decrease in utilization rates, and not from the exploitation of peer support staff.

There is ongoing discussion about the differences and similarities between peer support and recovery in mental health as compared to substance use disorders, and about how to address certification, training, and service provision of these two often siloed fields. While many individuals experience co-occurring disorders, mental health and substance use disorder recovery

organizations have different cultures and different philosophies of care and recovery.

While many studies have concluded that peer support services result in outcomes that are equal to or better than the same services provided by professionals without lived experience, recent literature reviews have noted weaknesses in this research, including a lack of robust comparison groups, risk of bias, and insufficient consistency between peer roles and settings studied. This has led some researchers to question whether traditional measures such as hospitalization rates, decreases in symptoms, adherence, and treatment costs are the most appropriate outcomes to use to track improvement, or whether measures such as hope, empowerment, and integration into the community are more relevant to recovery.

### ***Outstanding Research Questions***

Peer provider certification and employment data are difficult to track. It is not clear how many peer providers have been certified on a national level. It is also unclear how many of those who become certified obtain and maintain employment or advance in the field.

It is not known what reimbursement methods best support a peer support workforce or the emerging recovery-oriented system of care, as opposed to a treatment-oriented system of care. Further research should explore the impacts of health care reform, Medicaid expansion, and managed care on (1) the number of peer providers employed, (2) the viability and mission of peer-run organizations, and (3) the culture of treatment organizations employing peers.

There is a need for more rigorous research on the efficacy of peer providers. More rigorous research that better specifies types of peer support programs, comparison groups, patient populations, and outcomes may help establish which peer support interventions provide the most benefit. Some interventions merit further research, e.g., emerging interventions including forensic peer support and the integration of peer whole-health and wellness coaches into primary care, and established interventions, e.g., peer-run respite services. In addition, more research on the efficacy of peer recovery coaches would help to clarify the impact of these workers in the field of SUD recovery.

## **The Peer Provider Workforce in Behavioral Health: A Landscape Analysis**

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### **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, formally defines a peer provider—otherwise 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 resilience.”*<sup>1</sup> The key distinction between peer providers and traditional providers is the ability to draw from lived experience and experiential knowledge.<sup>2</sup>

Peer providers are part of a relatively new movement to transform behavioral health care into a “recovery-oriented” system.<sup>4</sup> As many advocates have noted, traditional mental health care and substance abuse treatment have been 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 mental 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. Peer providers are part of the movement toward recovery-oriented systems of care.

### **Purpose**

The purpose of this report is two-fold. We first describe the history and context for the development of peer providers in mental health and substance use disorder (SUD) recovery. We then present a national landscape analysis derived from the peer-reviewed and grey literatures on policy, billing, training, and certification; roles and responsibilities; employment settings; integration within traditional treatment systems; and efficacy of peer providers in mental health and SUD recovery.

## **Methods**

### Search Strategy

We conducted a literature search for materials on peer support providers, broadly defined. We started with a general Web-based search to find reports from government and private agencies and peer-reviewed journal articles. We also conducted targeted searches in the following databases: PubMed, CINAHL, PsycINFO, Scopus, Google Scholar, and Social Services Abstracts. We reviewed the bibliographies of promising articles and reports and were referred to published and unpublished reports by subject matter experts.

### Search Terms

Initial search terms included: peer support specialist, peer provider, peer recovery coach, peer support specialist, SUD peer support specialist, peer workforce certification, peer specialist, peer coach, peer recovery coach, peer provider, consumer-run, peer-run, consumer-led, and peer-led. Additional terms such as "Medicaid", "billing", "evidence", "respite\*", "warm line\*", "forensic", and "Assertive Community Treatment" were used to focus on specific areas of interest.

### Search Results

We found over 490 English-language articles, reports, and presentations produced between 1988 and 2015 relevant to peer support services in mental health and SUDs. These references were loaded into an Endnote database.

Two researchers reviewed abstracts to categorize papers according to which research questions they addressed. These coded topics included:

1. Peer Provider Roles, Organizational Settings, and Models of Care
2. Integration of Peer Providers into Traditional Care
3. Evidence of Efficacy of Peer Support
4. Billing, Reimbursement, and Sources of Funding for Peer Support Programs
5. Training and Certification for Peer Support

Papers deemed most relevant to these topics were reviewed in depth to inform this landscape analysis and to aid in the development of research

protocols for case study research on these topics. We cite 163 of these documents in this report.

## **Findings**

### ***History and Context for Implementing Peer Support Services***

In 2013, nearly 1 in 5 (18.5%) adults in the US experienced some form of mental illness<sup>5</sup> and 4.2% had been diagnosed with a serious mental illness. Just over half of those with serious mental illnesses received treatment (58.7%).<sup>5</sup> Data from 2013 show that 8.6% of Americans needed treatment for a problem related to drug or alcohol use, but only 0.9% received treatment in a specialty facility.<sup>6</sup> Stigma and documented shortages of behavioral health practitioners make it difficult for many to seek and receive care, especially in low-income and rural communities. Beyond the need for treatment, persons suffering from episodes of addiction or mental illness often require ongoing support and encouragement to recover and re-engage with their lives and communities. Strategies to increase workforce capacity, including developing resources for self-management and deployment of a trained peer support workforce, are important for addressing the unmet demand for behavioral health services.<sup>7</sup>

Informal peer support has long been a part of the recovery process for people suffering from mental illness and/or addiction. Peer support for addiction recovery has a long history of mutual-aid and peer-based recovery support groups that came about either as supplements to or substitutes for professional care. White's 1998 publication<sup>8</sup> details the United States' history of recovery addiction programs, from indigenous Native American movements to more formalized models of peer support, such as Alcoholics Anonymous. Today, peer providers are central to a variety of mutual-aid societies, including religious, spiritual, and secular organizations, as well as those targeting specific age groups, families, ethnicities, sexual orientation, gender, and more.<sup>9</sup> A vast network of groups throughout the country participates in peer-led SUD recovery advocacy and support. These groups are commonly referred to as recovery community organizations (RCOs).<sup>10</sup>

Peer providers working in mental health have a more recent history, with similar themes involving individuals with lived experience offering recovery support when professional treatment was seen as insufficient or even detrimental. Emerging from the philosophy of the organized civil rights

movements of the 1960s and 1970s, as well as the de-institutionalization of patients from large state mental hospitals, growth of the consumer-survivor movement was a reaction to the often coercive mental health care provided in traditional treatment settings of the time.<sup>11</sup> Former psychiatric patients began to organize against the traditional “medical” model of mental health treatment, advocating for peer-run services based on self-help, mutual support, and the then-radical idea that “recovery” from mental illness was possible.<sup>12</sup> Recognition of the value of the perspective of individuals with lived experience in mental health services led to the expansion of drop-in centers and consumer-run organizations throughout the 1980s. By the 1990s, academic literature began to include studies on the potential benefits of incorporating consumer case managers into traditional care: benefits that included decreased rates of hospitalization and improvements in quality of life. These changes indicated shifting attitudes about mental illness and greater acceptance of the recovery model of care.<sup>13-15</sup> The President’s New Freedom Commission report, released in 2003, proposed a set of goals intended to transform the nation’s mental health system into a recovery-oriented system of care (ROSC), embedding in policy these changing ideas about mental illness and recovery.

The New Freedom Commission’s recommendations and the growing recognition of the ROSC as an alternative to an illness-oriented (or “medical”) model of care has resulted in policy support for “professionalizing” peer provider roles. Some advocates assert that incorporating a strong peer provider workforce into behavioral health care teams is an essential component of building recovery-oriented systems of care.<sup>16</sup> Federal and state agencies have released guidelines for the implementation of ROSCs at the state, regional, and county level. SAMHSA’s Access to Recovery (ATR) Initiative provided funding for peer support and the Center for Substance Abuse Treatment’s (CSAT) Recovery Community Services Program has funded policy discussions on the implementation of ROSC.<sup>17</sup>

A further expansion and validation of the peer support specialist role came in 2005, when the Department of Veterans Affairs began to fund a number of new positions for veterans with lived experience of mental illness to provide support services to other veterans with serious mental illnesses.<sup>18</sup> By 2015, this number had increased from the original 91 positions to over 1,000 nationwide.<sup>19</sup>

The Affordable Care Act (ACA) includes mental health and substance use disorder services in its 10 categories of essential health benefits, enforcing “parity” protections that require insurance coverage of these services to be on par with coverage of medical and surgical services.<sup>20</sup> Peer providers are seen as an effective solution to addressing the severe workforce shortages that challenge the fulfillment of this ACA objective, along with having the potential to prevent hospitalizations and consequently lower health care costs.<sup>21</sup>

The ACA also offers the potential for the expansion of peer providers’ scope of practice by emphasizing the integration of primary and behavioral health care. An ACA provision allows state Medicaid programs to be billed for home and community services for people with co-occurring disorders; previously, states would have had to apply for a waiver.<sup>22</sup> As a result, peer providers are increasingly being employed to help patients manage both physical and behavioral health, acting as whole health coaches who offer support beyond mental health and SUD conditions.<sup>23</sup> This helps fulfill an unmet need for individuals living with mental illness or addiction: a population known to be at increased risk for untreated chronic medical conditions due to lifestyle factors, poverty, and the side effects of psychiatric medication and/or alcohol and illegal drugs.<sup>24</sup> In 2012, Georgia became the first state to have Medicaid-recognized whole health and wellness peer support provided by certified peer specialists.<sup>25</sup>

### ***Peer Provider Support Roles, Organizational Settings, and Models of Care***

Peer providers assume a variety of roles and work in a wide range of settings. We found over 70 reports and articles discussing one or multiple roles played by peer providers, and 14 articles that focused on the settings and programs in which peer providers work and their integration into those settings. In this section, we describe commonly held peer provider roles and employment settings. We also describe the challenges associated with the integration of peer providers into traditional mental health and substance use disorder programs, and potential solutions to those challenges.

Roles and settings often overlap in the literature, and two reports provided useful categorizations. A report to the Tennessee Department of Mental Health provides a comprehensive compendium of peer roles by model of care setting, and literature associated with each, as part of an exploration of best practices in incorporating peer providers into the mental health workforce.<sup>26</sup>

A 2012 SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) report<sup>27</sup> provides a summary of these roles and settings, using the results of an expert panel discussion to frame the challenges and opportunities facing behavioral health organizations as they attempt to integrate peer providers into the workforce in meaningful roles. Some of these settings and roles are discussed in more detail below.

### Titles and Roles

In mental health, peer providers are commonly called peer support specialists or certified peer specialists (CPS). Peer providers in substance use disorders are often called peer recovery coaches (PRC) or peer recovery support specialists (PRSS), but may also be CPSs, depending on the training and licensing structure of the state in which they work.<sup>28,29</sup> The following section draws on a large number of articles, reports, slide presentations, and Web sites to describe in detail some common roles for peer providers:

1. **Outreach Specialist:** Outreach specialists attempt to engage those with mental illnesses and/or substance use disorders, including the homeless, in order to provide them access to recovery support and/or treatment.<sup>30</sup> This may entail visiting public places that people with addictions or mental illnesses frequent.
2. **Telephone Support Specialist:** Telephone support specialists are trained to provide support as well as referral information to persons with mental illnesses or substance use disorders. Telephone support specialists typically work on “warm lines” providing compassionate listening and problem-solving support after hours when psychiatric and other care is not available.<sup>31-33</sup> Warm lines are often part of other peer-run services or institutions such as peer-run respite centers, although not all warm lines are peer-run.
3. **Peer Educator:** Peer educators may lead classes in self-directed recovery such as Wellness Recovery Action Plan (WRAP) and SUD recovery education, as well as stress management, anger management, and other topics. They also may facilitate support groups and provide one-on-one counseling.<sup>34</sup>
4. **Resident Counselor:** Peer providers may serve in supportive living facilities providing one-on-one peer support to residents in mental health or SUD recovery or in peer-run sober living houses.<sup>35,36</sup> This

- may include helping residents develop and maintain recovery plans and goals. They may also work on activities and community integration for residents in board and care housing, including assistance to access recreation activities or to utilize public transportation.<sup>37</sup>
5. **Forensic Peer Specialist:** MH or SUD peer providers with a history of criminal activity may be employed to help incarcerated individuals transition back into the community from jails, prisons, and probation programs.<sup>27,38</sup> Forensic peer providers work with incarcerated individuals prior to release to engage in treatment and support and prepare for re-entry. They can help link newly discharged people with housing, vocational and educational opportunities, and community service, and assist consumers with maintaining adherence to conditions of supervision.<sup>39</sup>
  6. **Peer Evaluator:** The peer provider may be engaged by a research group specifically developed to assist consumers in completing the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey.<sup>40</sup> The MHSIP is a program of the Center for Mental Health Services intended to improve the quality of mental health program and service delivery. The Adult Consumer Survey measures issues relevant to consumers of publicly funded mental health services, including access, quality, outcomes, satisfaction, and participation in treatment planning.
  7. **Employment/Job Coach:** Peer providers may work as employment specialists providing job counseling and placement assistance to others in recovery, sometimes also negotiating with employers for placements.<sup>41,42</sup>

**8. Peer Navigators and Peer Whole Health and Wellness Coaches:** Peer providers may serve as health and wellness coaches helping other consumers learn to self-manage chronic diseases common to those with mental illnesses, or to maintain healthy eating and exercise regimens. Coaches often work with primary care providers to assist individuals with goal-setting, physical health management, and access to resources.<sup>23,24</sup>

Settings and Models of Care

Box 1 summarizes some of the settings in which SUD and MH peer providers might work. However, the concept “setting” may encompass more than the physical location or function of the organization or program.

White categorizes SUD peer support service venues into, “1) self-supported or publicly-funded recovery community organizations, 2) publicly funded addiction treatment programs or allied service organizations, 3) private addiction treatment programs, and 4) private organizations that once specialized in conducting pre-treatment interventions on a fee basis and are now expanding their services to include post-treatment monitoring and support.”<sup>9</sup>

The SAMHSA BRSS TACS report acknowledges that distinguishing features of settings include organizational structure and governance.<sup>27</sup> Some peer providers work in peer-run settings: mutual support programs and consumer-operated services, where the peer is

**Box 1. Employment settings for peer providers<sup>†</sup>**

- Churches
- Community recovery centers / Drop-in centers
- Court diversion programs
- Detoxification clinics
- Emergency rooms
- Employment support services
- Federally qualified health centers / primary care clinics
- Health care agencies
- Home health services
- Hospitals (inpatient psychiatric)
- Jails and prisons (forensic programs)
- Mobile crisis units
- Peer evaluation services / research
- Peer run respite center
- Rehabilitation programs
- Residential support (housing services)
- Veterans’ Services

<sup>†</sup>Sources: Gagne, C., Olivet, J. and Davis, L. (2012). Equipping Behavioral Health Systems & Authorities to Promote Peer Specialist/Peer Recovery Coaching

the dominant provider for individuals seeking services. Some of these peer-run settings are:

1. **Peer-Run Respite:** Peer providers play an important role in helping to operate respite centers that serve as an alternative to psychiatric incarceration. Usually located in a house in a residential neighborhood, they provide a safe environment for people experiencing a psychiatric crisis. Researchers such as Ostrow have noted that the efficacy of these centers is not well-researched.<sup>43,44</sup>
2. **Drop-In Centers/Peer-Run Self-Help Centers:** There are a large number of research articles on consumer-operated self-help centers (COSHC). Swarbrick defines these centers as “freestanding, located in the community, and accessible to individuals 18 years of age and over who are diagnosed with a mental illness and have received/are receiving mental health services.”<sup>45-48</sup> These centers, which are peer-run and operated, are intended as places where consumers can socialize, learn new skills, join self-help support groups and advocacy groups, and enjoy recreational activities.<sup>47</sup> These centers are intended to serve as a complement to traditional treatment-oriented mental health services *or* as an alternative. Swarbrick observes that they are empowerment- and autonomy-focused rather than focused on “alleviating problems and reducing symptoms.”<sup>46</sup>
3. **Recovery Community Centers:** The RCC is a peer-led organization that may provide a range of services for those affected by substance use disorders. First developed in 2004 by the Connecticut Community for Addiction, this community-based model has grown over the years to include recovery coaching and telephonic support, as well as orientation to recovery, support groups, recovery-oriented classes and social events, employment services, relapse prevention/early intervention, access to treatment, etc. While the majority of services may be volunteer-delivered, there are roles for paid staff.<sup>49-51</sup>

Other peer providers work in more traditional treatment settings, such as hospitals, inpatient and outpatient treatment centers, community behavioral health, and home health services, often in interdisciplinary teams with licensed health care professionals and practitioners and other non-peer staff. Peer providers are starting to become integrated into settings outside of behavioral health such as primary care and emergency rooms, and in jails,

prisons, and courts. Some models of care and settings in which peers provide services as part of teams or in tandem with traditional mental health and substance use treatment providers include:

1. **Assertive Community Treatment Teams:** Peer providers are increasingly found in traditional mental health as members of Assertive Community Treatment (ACT) or other intensive case management teams. ACT is an evidence-based practice entailing a team approach to providing round-the-clock, as-needed care to consumers with severe and persistent mental illness and difficulty with daily functioning. According to a SAMHSA toolkit, "At a minimum, an ACT team has a psychiatrist, 2 nurses, 2 substance abuse specialists, and 2 supported employment specialists. Teams also employ social workers, and individuals with backgrounds in psychiatric rehabilitation," and they are increasingly expected to have consumers on the team, either as peer support specialists, or in any other role for which they are qualified.<sup>52</sup> We found 10 articles assessing the role of peer providers on ACT teams, including ways peer providers were integrated into teams, and innovative models of utilizing peer support on ACT teams.<sup>53-61</sup>
2. **Crisis Stabilization Units:** Crisis stabilization is defined as "a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness."<sup>62</sup> Peer providers often provide peer-to-peer support, or lead support groups in these temporary residential settings alongside licensed mental health professionals including, for example, psychiatrists and nurses.
3. **Mobile Crisis Teams:** Peer providers may work on mobile crisis teams providing mobile mental health crisis assessment, intervention, and stabilization. According to the New York City Department of Health and Mental Hygiene, "A mobile crisis team is an interdisciplinary team of mental health professionals (e.g., nurses, social workers, psychiatrists, psychologists, mental health technicians, addiction specialists, peer counselors). They respond to

persons in the community, usually visiting them at home, although their mandate allows them to make contact at other locations.”<sup>63</sup>

4. **Medication-Assisted Recovery Services (MARS) programs:**

One relatively new setting for SUD peer providers is in medication-assisted treatment programs for those recovering from addiction to opioids. The MARS program trains peer recovery coaches to assist people in “medication assisted recovery” (rather than just “treatment”).<sup>64</sup>

5. **Peer-Bridger Programs:** In these programs, peer support starts in the hospital, where a peer provider works with the hospitalized person to begin recovery and plan for discharge, which includes obtaining housing, employment, and benefits. Post-discharge, the peer provider works with the person in his or her community to retain connection with mental and physical health resources, social support, and social services.<sup>65</sup> This may include one-on-one or group work.<sup>66</sup> The peer bridger may work for the hospital or may be employed by an outside organization and deployed in the hospital.<sup>67</sup>

*Integration of Peer Providers into Traditional Care*

The employment and integration of peer providers into traditional (treatment-based) care teams has led to a shift in care team structures, which has brought about transitional challenges as organizations strive to incorporate individuals with lived experience into a professional role. It is in these more traditional employment settings that friction between a recovery-oriented model of care and the traditional treatment-oriented model may occur.<sup>68</sup> Approximately 22 journal articles addressed the issue of peer provider integration into the behavioral health workforce.

Authors found that the integration of peer support into more traditional care sites may face challenges such as poorly defined roles or job descriptions, client-staff member boundary issues, lack of clear confidentiality policies and practices, lack of support/accommodation for peer providers, initial lack of technical preparation and professional work experience, and workplace discrimination and stigma.<sup>27,30,35,69-72</sup> As a result, some peer providers reported a lower level of acceptance among colleagues, resulting in more interpersonal contact and identification with clients.<sup>73</sup> Peer providers may

receive lower pay and less stable employment than comparable non-peer staff.<sup>74-76</sup>

Even in peer-run organizations, there are reported challenges with creating workplace structure, establishing roles and boundaries between staff members and between staff and consumers, and managing interpersonal conflict between staff with mental illnesses in different phases of recovery.<sup>68</sup> There are several strategies offered in the literature to enhance integration of peer providers into the care team. These include clear job and role delineation for peer providers and all other staff,<sup>69</sup> including written job descriptions for peer and non-peer staff.<sup>70</sup> Some sites have adopted training for colleagues and particularly supervisors to understand roles and integrate peer support specialists into the team.<sup>69,70,77</sup> Other strategies include ensuring equal compensation for peers and non-peers in comparable positions, establishing clear policies and practices around information-sharing and confidentiality, providing adequate supervision for all staff, and developing adequate orientation, professional development, and career advancement opportunities for peer support staff.<sup>1,75</sup> These human resources policies and supervisory expectations may be effective in improving the perception of peer providers among coworkers, thereby streamlining team operations and transforming lived experience from a source of stigma into a source of empowerment.<sup>13,56,70,72,78</sup> Gates and Akabas (2007) also note that leadership must provide clear messaging about the importance and centrality of the peer role to the agency mission rather than as an “add-on.”<sup>70</sup> Organizational outcomes of well-defined integration of peer providers include increased referrals to peer services, effective collaboration on treatment teams, and stronger support for peers from other staff.<sup>79,80</sup>

### ***Evidence of Efficacy of Peer Support***

Peer provider services are acknowledged by the Center for Medicare and Medicaid Services as an evidence-based practice.<sup>81</sup> This has been the rationale for authorizing states to bill Medicaid for peer support services.

The efficacy of peer providers in mental health and, to a lesser extent, SUD services has been extensively evaluated through published randomized controlled trials, qualitative studies, and meta-analyses of previously published literature.<sup>55,82-85</sup> There are over 50 peer-reviewed articles that evaluate the effectiveness of peer providers in different settings. We found 25 that were randomized controlled trials.<sup>14,15,58,73,86-106</sup> Several meta-

analyses<sup>55,60,74,84,85,107-114</sup> provided useful summaries of the efficacy or non-efficacy of peer support.

Studies have explored the impact of utilizing peer providers in place of traditional mental health or SUD clinicians on various measures, including symptom severity, hospital/treatment readmissions, length of hospitalization, use of emergency department services, medication and medical appointment adherence; treatment completion, past-month abstinence, functioning level, quality of life, self-perceived recovery, cost effectiveness, patient satisfaction, and other measures. The diversity of measures illustrates one of the key debates in the literature: the selection of relevant measures on which to evaluate the potential contributions of peer support.

### *Efficacy of Peer Supports in Mental Health*

Three of the early studies on effectiveness of peer providers in mental health were conducted in the 1990s by Solomon and Draine. Researchers randomly assigned individuals to case management teams, some of which had a member with lived experience acting in a traditional case manager role, otherwise known as the consumer case manager.<sup>14,73,115</sup> Case management teams with a consumer case manager were just as effective as teams with non-consumer case managers in maintaining the stability of severely mentally ill patients over the span of two years, and no difference was found in the strength of alliance between the mentally disabled with their consumer or non-consumer treatment teams.<sup>16</sup> Other randomized controlled trials also found that patients with consumer case managers or care teams had fewer hospitalizations, fewer inpatient days, greater improvements in quality of life, and qualitative differences in the culture of care.<sup>116-119</sup>

As peer support roles have expanded beyond that of case manager, randomized controlled trials have confirmed the potential for peer providers to change treatment patterns and improve outcomes in a psychiatric treatment setting.<sup>88,93,97,103,120</sup> The use of peer providers as whole-health and wellness coaches and as patient navigators for individuals with serious mental illness and physical comorbidities has been documented as being effective in improving treatment engagement and health outcomes.<sup>121-125</sup> Consumer-managed residential programs have been found to be a positive alternative to psychiatric facilities, yielding greater patient improvements in psychopathology and service satisfaction.<sup>97</sup> Other recent studies support the

idea that peer support can alter treatment patterns to reduce the cost of care. Peer interventions have been found to increase the use of primary care over emergency services,<sup>123</sup> reduce psychiatric re-hospitalizations,<sup>88,120</sup> and make patients more active in treatment.<sup>103</sup>

As noted above, a number of studies have concluded that various peer support programs appear to result in significantly lower utilization rates, which could result in cost savings. However, a recent study by Landers and Zhou (2014)<sup>126</sup> using insurance claims data found that incorporating peer support services increased costs to Medicaid. Those utilizing peer support services in Georgia used more services overall and were more likely to experience a crisis stabilization episode, but less likely to experience psychiatric hospitalization. The authors noted that peer support specialists encourage consumers to seek appropriate services, so the care-seeking behavior of these patients might have a positive impact in the long run, despite initial high cost.

Qualitative and observational studies of peer provider services have observed differences in the patient experience and “culture” of care between peer-based organizations and traditional treatment organizations, as well as between teams within an organization based on composition.

In their ethnographic study of peer support at a mental health peer-run organization in New York City, Austin et al.<sup>127</sup> studied how peer support influenced recovery, noting peer support was effective because it helped consumers (mental health clients) move beyond the patient role into one of empowerment.

In an observational time-series study comparing 2 Assertive Community Treatment teams, one staffed entirely by peer providers and one with no peer provider members, Paulson et al.<sup>116</sup> found little difference in time allocation to job tasks. However, culture, expressiveness, and boundary setting between the groups differed radically. The team that did not include peer providers was more adept at setting boundaries with clients, less expressive in general, and more authoritarian. The peer provider team was more collaborative and expressive and more flexible with time spent with consumers. The peer provider team also had much higher turnover and absenteeism rates.

In a similar vein, a comparison of consumer rankings of peer-run hospital diversion services and non-peer-run acute inpatient programs found that consumers perceived peer-run programs as more client-centered and less restrictive, yielding overall higher satisfaction ratings.<sup>128</sup> Another largely observational study of Assertive Community Treatment (ACT) team members, including peer providers, found that the presence of peer providers encouraged greater trust from consumers, helped enhance empathy, and increased the overall respect of non-peer provider staff for peer provider colleagues.<sup>56</sup> Beyond improvements in treatment culture and physical outcomes for patients, peer providers have been found to be effective in providing supported socialization and long term reintegration into communities, both of which are vital components of recovery-oriented systems of care.<sup>129-132</sup> This improvement extends to the peer providers as well. Despite the obstacles to workplace integration, the employment of peer providers has been reported to result in recovery benefits for the peer providers themselves, largely due to the empowerment that comes from utilizing lived experience in a positive manner.<sup>75,133,134</sup>

Although results reported in individual studies are largely positive, 3 recent meta-analyses of the quantitative research on mental health peer supports provide a more nuanced picture, indicating that peer providers are not necessarily more effective than traditional providers in all domains. The authors of these meta-analyses note that much of the previous research lacks rigor. The meta-analyses cover overlapping, but not identical, groups of studies, including many listed previously in this paper. Pitt et al. (2013)<sup>55</sup> analyzed studies up to 2012; Lloyd-Evans, et al.<sup>85</sup> covered studies up to July 2013, and Chinman, George et al.<sup>82</sup> covered studies from 1995 to 2012.

The Cochrane review of 11 studies by Pitt et al. (2013) stands as an important critique of the existing research literature, citing many studies with unclear or high risk of bias due to poor randomization or lack of blinding of the outcome assessment.<sup>55</sup> The authors conclude that there is “low quality” evidence that including consumer-providers on the care team results in small reductions of clients’ use of crisis and emergency services, and also no evidence of harm from the use of consumer-providers.

A meta-analysis of 18 trials conducted by Lloyd-Evans et al. (2014)<sup>85</sup> reported similar findings. While there was some evidence that peer support was associated with positive effects on “measures of hope, recovery and

empowerment” at and beyond the end of the intervention, the authors did not find consistent evidence that peer support “was associated with positive effects on hospitalization, overall symptoms, or satisfaction with services.”<sup>85</sup> As in the Pitt et al. meta-analysis, the authors cite weaknesses in the included studies, including high risk of bias, incompletely reported outcomes, and a great deal of variation in participant characteristics and program content, which made it difficult to identify which factors in implementation might affect reported outcomes.

Finally, Chinman et al. (2014)<sup>82</sup> reviewed 20 studies, dividing peer support into 3 categories: peer providers added to traditional services, peer providers in existing clinical roles, and peer providers delivering structured curricula. As in the prior 2 reviews, the authors found that many studies could only be classified as “moderate” in rigor. However, the authors dispute the findings of the Pitt et al. review, noting that the Pitt et al. review excluded quasi-experimental trials and studies involving peer-delivered curricula, and did not differentiate between peer roles. Overall, Chinman et al. found that, compared with professional staff, peer providers were more effective than clinical professionals in reducing inpatient services use, improving patient relationships with traditional providers, engaging patients with care, and increasing levels of empowerment and optimism about recovery.

However, authors also noted that effectiveness varied by service type, and that effectiveness for peer providers in existing clinical roles was mixed. They recommended that better specification of peer role and service setting would help substantiate the contributions of peer support to recovery. In a later study, Chinman and authors (2015) note that another issue with the existing evidence base is that most studies have focused on hospitalization and symptoms rather than the full range of recovery domains such as empowerment, recovery, hope, social support, and quality of life—and most have not clearly addressed implementation barriers in programs studied.<sup>103</sup>

### *Efficacy of Peer Supports in SUD*

Studies of peer providers in SUD services are less common than in mental health. One recent review paper included 2 randomized controlled trials,<sup>87,106</sup> 4 quasi-experimental designs,<sup>135-138</sup> and 4 pre-post intervention designs.<sup>108</sup> The evidence from some of the more rigorous studies suggests a reduced risk of relapse for patients and a higher level of professional commitment

among counselors with lived experience.<sup>139</sup> Other included studies reported increased abstinence from heroin and cocaine among those seeing peer counselors trained in motivational interviewing,<sup>106</sup> significantly increased adherence to post-discharge SUD mental and medical health appointments among veterans at a VA hospital who had previously high SUD recidivism rates,<sup>87</sup> and increased rates of completion of substance abuse treatment and past-month abstinence among those receiving recovery-support services, including peer support, when coupled with SUD treatment as compared to those receiving social supports.<sup>137</sup> One study reported greater satisfaction with treatment among pregnant and postpartum crack cocaine users participating in peer recovery support compared with similar women in standard addiction treatment.<sup>138</sup> The authors of this SUD review drew conclusions similar to the authors of the mental health literature reviews: due to methodological weaknesses of the included studies, including lack of measurable outcomes, small samples, inadequate comparison groups, and differing populations and interventions, the evidence supporting the efficacy of peer supports in SUD could only be characterized as “moderate.”<sup>108</sup>

We found only one study that explored peer services for individuals with co-occurring mental health and SUD conditions. This study found that participants in “consumer-delivered services” were able to maintain longer periods of living in the community without re-hospitalization, and lower re-hospitalization rates overall, than a comparison group.<sup>135</sup>

### ***Policy and Financial Infrastructure for Peer Support***

There is little (if any) peer-reviewed literature pertaining specifically to the funding, billing, and reimbursement for peer support. We found 11 reports and articles that specifically addressed peer support and a variety of funding and billing mechanisms. We also found a number of general articles on financing of mental health and SUD programs. Nearly all literature we found on the topic of financing peer support services, and the cost-effectiveness of these services, pertains to mental health.

#### ***Sources of Funding for Mental Health Peer Support***

Most states use general funds to initiate and sustain peer support programs in conjunction with federal and foundation grants. Both SUD and mental

health peer support programs have a history of being supported by grant funding.

For mental health, O'Brien et al. (2008)<sup>140</sup> and others note the use of the Mental Health Block Grant and state allocations as prime sources of funding for mental health peer support. Medicaid has comprised an increasing amount of the funding for state mental health services administration over time, according to a 2010 report from SAMHSA—up from 16% in 1981 to 48% in 2007, replacing state general revenue funds as the largest single source of funding.<sup>141</sup> These increases occurred when states began using the Medicaid options of targeted case management and rehabilitation services to expand community mental health services. Local taxes, county taxes, and Medicare also provide a small amount of funding for community mental health.

#### Sources of Funding for SUD Peer Support

SUD peer support programs are especially dependent on grant funding because few states have state plan amendments or waivers that allow them to bill Medicaid for SUD peer recovery coaches' services. SUD treatment has generally been provided in different treatment settings than mental health treatment, and with different funding sources. Until recently, SUD funding has been primarily from state and local government sources, and some from private insurance or self-paying clients.<sup>142</sup>

In a 2008 report, White voiced concern over the decrease in insurance revenues for addiction treatment services and the resulting increased reliance on governmental grants, which constituted 80% of funding in 2008.<sup>16</sup> Noting that these funding streams evolved with an acute care rather than a long-term recovery management model, he questioned whether reimbursement methods would evolve to support the recovery model. While there is little research or consensus on what funding mechanisms best support the recovery model, he noted that payment models that "use proximal and distal recovery outcomes as a basis for baseline or enhanced reimbursement" (pay-for-performance) were under discussion, as were other models such as capitation.<sup>16</sup>

More recently, the 2010 Financing Recovery Support Services Report published by SAMHSA provides a comprehensive description of financing options used by states for SUD recovery services, including peer supports.<sup>143</sup>

These funding streams include state allocations, federal programs such as Access to Recovery (ATR), Substance Abuse Prevention and Treatment Block Grant (SAPT), Recovery Community Services Program (RCSP), and other funds such as state, federal, and Department of Justice Drug Court funding, Temporary Assistance for Needy Families (TANF), and private foundation funding. This funding mix may be changing as the Affordable Care Act requires behavioral health benefit parity with medical and surgical benefits and pay-for-performance modes of reimbursement, and as many states expand Medicaid eligibility.

A 2013 technical assistance brief produced by SAMHSA provides detailed guidance on the design and delivery of addictions peer recovery support services (PRSS). The authors note that community-based organizations in particular may need assistance in developing the infrastructure necessary to manage grants, contracts with MCOs, and to bill Medicaid for peer support services, including technology, billing, insurance, and reporting systems. The report profiles three states – Connecticut, Georgia, and Wisconsin – highlighting different strategies for funding peer recovery support systems. While only one of these states (Georgia) utilizes a statewide training and certification system, the authors note that the evolving system of behavioral health care, including the ACA and other market forces, may drive the need for services delivered by credentialed peer recovery coaches and/or accredited organizations.<sup>144</sup>

#### Medicaid Reimbursement of Services

In 2007, the Centers for Medicare & Medicaid Services (CMS) issued a letter to State Medicaid Directors authorizing them to bill Medicaid for mental health peer support services under particular conditions. The rationale for this authorization was a number of studies that established peer support as “an evidence-based mental health model of care”.<sup>81</sup>

Conditions required of providers in order to bill included:

1. **Supervision:** Peer support specialists must be supervised by a “competent mental health professional” with the “amount, duration and scope of supervision” defined by the specific State Practice Act.
2. **Care Coordination:** Peer support services must be coordinated with an individualized recovery plan with measurable goals as specified in the service plan and developed in conjunction with the consumer.
3. **Training and Certification:** Peer providers must complete training and certification as defined by the State. Peer providers must complete ongoing continuing education requirements to retain certification.<sup>81</sup>

In order to bill for peer support services, states must also meet requirements that apply to any Medicaid service, such as describing provider qualifications in detail and establishing utilization review and reimbursement methodologies. A later letter, issued in 2013, further clarifies that “Peer support services can be offered for mental illness and/or substance use disorders.” It further specifies that the peer-to-peer relationship includes the parents/legal guardians of Medicaid-eligible children.<sup>145</sup>

Peer support services can be provided as a distinct service via a number of Medicaid mechanisms, including changes to the state Medicaid plan and/or Medicaid waivers:

1. **State Plan Amendment (SPA):** The State Plan Amendment is an agreement between the state and federal government specifying how the state will administer its Medicaid program according to federal requirements. When the state wants to add or change its Medicaid services,<sup>1</sup> it amends its State Plan. The amendment must be approved by the Centers for Medicaid and Medicare Services (CMS).<sup>146</sup>
2. **The Rehabilitation Services Option:** Section 1905(a)(13) of the Social Security Act allows states to receive federal reimbursement for expanded services delivered in nontraditional settings, including in the community, the individual’s home or workplace, and by nontraditional providers, potentially peer providers, when rendered under the

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<sup>1</sup> Any service eligible for federal reimbursement under Medicaid law, not already outlined in the State Plan, can be implemented with a SPA.

- supervision of licensed mental health professionals. The Rehabilitation Services option can be used for evidence-based services that extend beyond clinical treatment to include those intended to help a person recover and acquire skills necessary for daily functioning.<sup>147</sup> This is an optional element of the state Medicaid plan.
3. **Medicaid Waiver:** the Medicaid Waiver allows a state to use Medicaid funding to cover services not specified<sup>2</sup> in its state plan or not otherwise eligible for Medicaid matching funds.<sup>146</sup> Again, these waivers must be approved by CMS. Waiver authority is outlined in the Social Security Act, including Section 1915(b)(3), which allows states to implement a managed care system for Medicaid beneficiaries<sup>148</sup>; Section 1915(c), which allows states to provide Home and Community-Based Services (HCBS) to people who require institutional level of care<sup>148</sup>; 1915(i) which allows provision of HCBS to adults with serious mental illness in lieu of them remaining long-term residents of in-patient facilities (May 13 joint letter); and Section 1115, which gives the Secretary of the U.S. Department of Health and Human Services the authority to approve experimental demonstration projects to transform service delivery practices to improve quality, health status, patient experience, coordination and cost-effectiveness, including whole-health wellness coaching programs.<sup>149</sup>

The National Association of State Mental Health Program Directors' (NASMHPD) Financing and Medicaid Division conducted a nationwide survey in 2010 to investigate how states had designed their peer support services programs and how they were using Medicaid to reimburse for those services. The results of this survey are summarized in Pillars of Peer Support 2.<sup>150</sup> At the time of the survey, 22 states reported that they had Medicaid reimbursement for peer support services. Half of these states had peer support services embedded in payment to another entity such as managed care organizations. Five received reimbursement for peer support services as

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<sup>2</sup> States could just write a SPA to add services not currently specified in their State Plan. A waiver is not really needed. However, a waiver could contain a package of services that include a combination of benefits allowable under federal law plus some that are not. California is doing this with the Drug Medi-Cal 1115 waiver. The difference is that when the waiver expires, rehab option services go away.

a distinct provider type, and 6 had both financing approaches.<sup>150</sup> Thirteen covered services through their State Plan, mostly under the provisions of Section 1905(a)(13) and one through a 1915(i)SPA. In summary, more than half of the states covered services through a state plan, primarily the rehabilitation option.<sup>143</sup>

A 2014 report produced by the University of Texas documented 36 states that bill Medicaid for mental health peer support services.<sup>3</sup> The report provides a state-by-state compendium of training and certification information. At least 11 states are able to bill Medicaid for SUD peer support, although for some that may be only for co-occurring conditions.<sup>3</sup> Another compendium of billing codes and mechanisms of family and youth mental health peer support programs was compiled and published by the Center for Healthcare Strategies in 2012. This report details how services are billed, under which CPT codes, and provides rates where known.<sup>146</sup>

Several reports not only discuss mechanisms of billing, but also provide case studies of how billing mechanisms are used to fund mental health peer support services in specific states.<sup>140,148,151</sup> A 2008 publication of Independent Living Research Utilization used Michigan, New Mexico, and Georgia to exemplify states using different financing strategies for services rendered by peer providers.<sup>140</sup> A 2008 report from the Truven Analytics Group uses Iowa, Georgia, and Wisconsin as examples of the use of different Medicaid authorities in the Social Security Act to cover peer support.<sup>148</sup> "State Plan Amendment Language Samples: Peer Support Specialists, Family Partners, Parent Partners, Peer Operated Centers and Whole Health Peer Coaches" by the California Institute for Mental Health et al. is a state-by-state compendium of state plan amendment language for peer support, including descriptions of billing codes and peer support qualifications by state.<sup>151</sup>

There is little available information on the extent of Medicaid billing by eligible organizations employing peer support specialists. However, one paper based on findings from the 2012 National Survey of Peer-Run Organizations, conducted by Ostrow et al., found that many peer-run organizations were reluctant to use Medicaid billing for peer support services.<sup>152</sup> This reluctance

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<sup>3</sup> The count above is derived from phone interviews and references in the University of Texas report.

was most strongly related to concern about compromising organizational values about peer support, which include a recovery rather than a medical model, and which prioritize mutuality, equality, and non-coercion over a hierarchical approach with “treatment” for an “illness” administered by professional clinicians.<sup>152</sup> Organization size was another important factor related to the capacity to process claims. Smaller organizations were less likely to consider billing Medicaid for peer support. The authors note that as Medicaid becomes an increasingly important source of funding for these services, organizations that cannot or will not develop infrastructure to bill for peer support services may not be sustainable.<sup>152</sup> The authors suggest a number of alternative billing mechanisms that might be more acceptable to these organizations, including self-directed care, or “money-follows-the-person,” which gives consumers direct control over service dollars to purchase goods and services, including peer support services.<sup>153</sup>

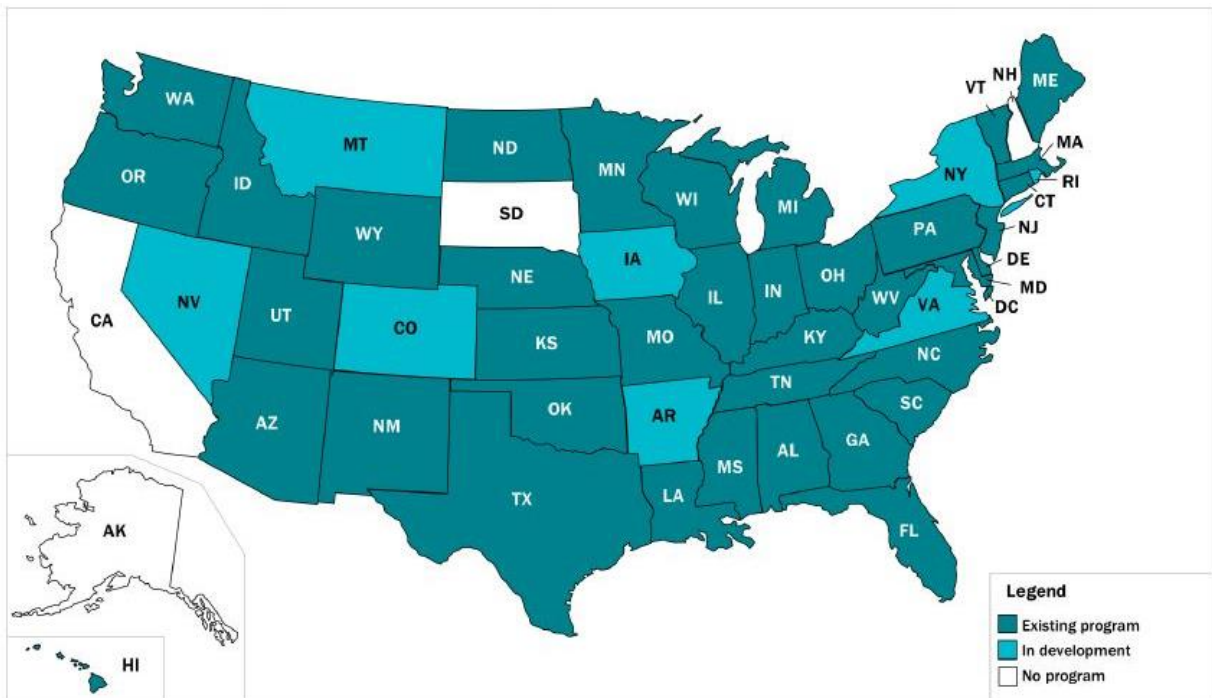


sometimes state-by-state. There were 7 journal articles and 4 reports documenting training and curricula for peer support specialists. Given recent trends to professionalize the peer provider role, many models of training and certification have been created by consumer or advocacy organizations as well as states. For Medicaid billing purposes, states must establish their own mechanism for training and certification standards of peer providers.<sup>81</sup> Approximately 40 states now have a state-wide certification process in place for mental health peer support specialists and 13 for SUD peer recovery coaches. These states have either created their own approved training and certification standards, or work with national training and certification organizations to establish peer support standards. As a part of the definition of a peer provider, certification often requires lived experience in mental illness and/or addiction. Training curricula follow many models, and require varying hours of coursework, continuing education credits, and examinations. Examples of curriculum modules include topics such as the recovery process, ethics, and cultural competency. Beyond basic peer provider certification, additional trainings have been developed to prepare peer trainers, teach whole health management, focus on populations with co-occurring disorders, and develop continuing education.

Training and Certification of Mental Health Peer Providers

A comprehensive overview of each state’s mental health training and certification standards has been compiled by the University of Texas, Austin’s Center for Social Work Research.<sup>3</sup> Figure 2 from that report illustrates how widely statewide mental health peer provider certification has been adopted.

**Figure 2. Map of Training and Certification for Mental Health Peer Provider Services by State**



Source: Kaufman, L., et al. (2014). Peer Specialist Training and Certification Programs: A National Overview, Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

Because of the capacity for states to bill Medicaid for peer providers in mental health, there has been robust interstate collaboration to establish standards for peer support. The first summit of the Pillars of Peer Support in 2009 assembled states that provided certification and training of peer providers. This meeting reported data on the number of peer providers in each state and the amount billed for Medicaid. Additionally, the summit created 25 Pillars of Peer Support as recommended guidelines for further implementation. These pillars call for a certification process that leads to

solid employment for peer providers and opportunities for workforce development.<sup>150</sup> Subsequent summits of the Pillars of Peer Support have published reports on the continued establishment of peer certification in the states, along with other topics surrounding the expansion of peer provider roles and employment.<sup>156</sup>

We found no data as to how many mental health peer providers have been either certified or employed nationwide since the 2009 Pillars of Peer Support report.<sup>150</sup> Some states have comprehensive and publicly available records, but others do not provide this information. Calls to state certification boards and state offices in spring of 2015 suggest that over 13,000 mental health peer providers have been certified, although we were only able to obtain information from 31 states.

### *Training and Certification of SUD Peer Providers*

Although certification of peer providers in SUD services has not been as firmly established, similar efforts have been initiated to train and certify SUD peer providers, as led by organizations such as Faces and Voices of Recovery (FAVOR), the International Credentialing and Reciprocity Consortium (IC&RC), and the National Association for Addiction Professionals (NAADAC).<sup>157</sup> FAVOR has advocated for the accreditation of peer recovery services among recovery community organizations and established recommended standards.<sup>158</sup> Currently, various independent certification boards and state or county health departments issue peer recovery certification through IC&RC or NAADAC.<sup>159,160</sup>

IC&RC boards in 11 states have adopted the peer recovery credentials, which specify completion of a 46-hour training program that includes 16 hours of ethical responsibility, 500 hours of work experience, 25 hours of supervision, passing a peer recovery exam, and 20 hours of continuing education units every two years.<sup>161</sup> IC&RC credentialing assures reciprocity between states and provides a level of accountability as IC&RC tracks complaints about those it certifies.

NAADAC, the Association for Addiction Professionals, also offers a Nationally Certified Peer Recovery Support Specialist (NCPRSS) certification requiring 125 hours of approved education, 1,000 hours of paid or volunteer work in the field, 1 year of recovery and passage of the CPRSS exam.<sup>157</sup>

## **Conclusion**

There is a considerable body of literature on peer support in mental health services, which includes many reports and publications that are not peer-reviewed, and a growing body of peer-reviewed studies on the implementation and efficacy of peer support.

### ***Peer Provider Roles, Organizational Settings, and Models of Care***

Peer providers work in a number of roles in a variety of settings, both treatment-based and non-clinical. The roles of peer providers have become more defined over time as they are incorporated into new and existing models of care. Research on the impact of peer support programs on the peer support specialists themselves,<sup>162</sup> as well as the effect of their inclusion on the workplace, is a growing area of study.

Numerous articles document ways that organizations have succeeded, or failed, to integrate peer providers into their workforce. However, the actual extent of peer provider employment is still unclear. Many states track the number of peer providers certified, but few track whether certification leads to employment in the field. This makes it difficult to know if training and certification as a peer provider opens a pathway to gainful employment for those with lived experience. Although turnover in peer provider jobs is reportedly high, we found limited evidence in the literature as to the trajectory of peer providers' careers.

In addition, peer providers may be paid less than other behavioral health staff and receive inadequate benefits. This may result in high rates of turnover and jeopardize the ability of peer providers to maintain their own health while providing support to others.

### ***Effectiveness of Peer Provider Programs***

There are a growing number of randomized controlled trials on the efficacy of mental health peer support programs in aiding recovery. Much of the literature suggests positive patient outcomes resulting from the inclusion of peer support, hence its inclusion as an "evidence-based practice" eligible for Medicaid reimbursement. However, a number of reviews of the literature conclude that the research on effectiveness has limitations, with methodological weaknesses including lack of randomization, minimal

categorization of different roles of peer providers, poor comparability of comparison and control groups, and lack of consistency across studied sites. Problems with variability in intervention – in terms of type of program, target population, intensity (dose), and duration – continue to challenge the research, as does overall specification of goals and objectives. There is relatively little research published on the effectiveness of SUD peer support.<sup>108</sup> There is also little, if any, research on the effectiveness of forensic peer providers<sup>32</sup> and peer respite services.<sup>28,29</sup>

### ***Policy and Financial Infrastructure for Peer Support***

There is a substantial grey literature on funding for mental health and substance use disorders programs in general, and on mechanisms to reimburse for peer support services in particular. Medicaid is a growing source of funding, especially for mental health services, and the authority to bill Medicaid for peer support along with the Affordable Care Act mandate for mental health parity may significantly improve prospects for peer provider employment. However, the current extent of Medicaid billing for peer support services is unknown: some organizations that could bill do not due to ideological and/or technical reasons.

Many researchers and advocates have speculated that the use of peer support providers would produce considerable cost savings to states and organizations due to both decreased utilization rates and the employment of lower-wage staff in service provision, but the empirical evidence for this is not yet well-established.

Certification for peer support specialists has led to a legitimization and professionalization of the role in many states and has opened the door for Medicaid reimbursement. How this will change the nature and quality of peer support is unclear, although many peer advocates have expressed concerns about losing the special qualities of “peerness” that make this role unique. As White notes, many federal funding sources were developed to support the “treatment” model of care; there is little good research on the role of different types of reimbursement in supporting the recovery model of care, which includes peer support.<sup>16</sup>

State government has an important role to play in developing and facilitating the adoption of recovery-oriented systems of care, including peer support. State policy can help create the infrastructure that provides for training and

statewide certification and, consequently, the option for Medicaid billing for peer providers' services. The ability to bill Medicaid for peer support, especially in Medicaid expansion states, may serve as an incentive to employers to hire peer providers.

There are several case study reports and compendia comparing states' uses of varying policy and billing mechanisms to foster mental health, and to a lesser extent, SUD peer support. Which systems are best for this purpose, and which measures indicate "success" are questions yet to be answered.



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## **Acronyms Used in this Report**

ACA - Affordable Care Act

ACT - Assertive Community Treatment

ATR - Access to Recovery

BRSS TACS - Bringing Recovery Supports to Scale Technical Assistance  
Center Strategy

CMS - Centers for Medicaid and Medicare Services

COSHC - Consumer-operated self-help centers

CPS - Certified Peer Specialist

CSAT - Center for Substance Abuse Treatment

FAVOR - Faces and Voices of Recovery

IC&RC - The International Credentialing and Reciprocity Consortium

MH - Mental Health

MHSIP - Mental Health Statistics Improvement Plan

NAADAC - National Association for Addiction Professionals

NASMHPD - The National Association of State Mental Health Program  
Directors'

NCPRSS - Nationally Certified Peer Recovery Support Specialist

PRC - Peer Recovery Coach

PRSS - Peer Recovery Support Specialist or Peer Recovery Support Services

RCO - Recovery Community Organization

RCSP - Recovery Community Services Program

ROSC - Recovery Oriented System of Care

SAMHSA - The Substance Abuse and Mental Health Services Administration



University of California  
San Francisco

SAPT - Substance Abuse Prevention and Treatment Block Grant

SPA - State Plan Amendment

SUD - Substance Use Disorder

TANF -Temporary Assistance for Needy Families

WRAP - Wellness Recovery Action Plan

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