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

Research Report

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

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December 17, 2015

This research was conducted through a Cooperative Agreement with the Health Resources and Services Administration (HRSA), and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Opinions and recommendations do not necessarily represent those of HRSA, SAMHSA, or other government agency.

Please cite as: Chapman, S., Blash, L., Chan, K. Mayer, K. and Spetz, J. (2015). Peer Providers in the Behavioral Health Workforce: Arizona. San Francisco, CA: UCSF Health Workforce Research Center on Long-Term Care.

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

Executive Summary

This case study explores Arizona's development and implementation of a peer provider workforce in mental health (MH). Peer providers are individuals hired to provide direct support to those undertaking 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.*"

The main focus of this case study was MH, but because peer support certification in Arizona covers SUD as well, both are referenced.

More background information on this topic can be found in the related report, [*The Peer Provider Workforce in Behavioral Health: A Landscape Analysis*](#).

Methods

Arizona was identified as a leading state in the employment of peer providers in MH through a literature review and the input of a national panel of experts convened in February 2015. We contacted Arizona state officials, certification boards, training organizations, and provider organizations to better understand the state's service model, and to identify organizations to interview during a site visit that lasted 3 days. During the site visit, we visited 3 organizations, at which we interviewed staff and administrators; we also interviewed 3 state-level policy makers. Where feasible, we collected administrative data from peer provider sites.

Findings

- **Training and Certification:** Arizona's model for training and certifying peer support specialists is unique in that it recognizes multiple curricula and training models, and integrates SUD and MH under one basic certification.
 - As of June, 2015, 1,132 Peer/Recovery Support Specialists (P/RSS) were certified in Arizona.
- **Employment:** As of June 2015 1,123 P/RSS were employed.
 - Wages ranged from \$9 to \$15 per hour for basic peer support.

- **Funding for Peer Support Programs:** The majority of public behavioral health services in Arizona are covered by Medicaid under a “carve out.”
 - Arizona has a statewide Medicaid managed care program. Peer support services are Medicaid-billable through the agency for which the P/RSS works.
- **Models of Care:** Most of Arizona’s public behavioral health services are provided by contracted private for-profit and non-profit organizations, including both licensed treatment agencies and non-licensed community service agencies. Some of the latter are peer-run. These organizations employ a unique mix of providers, often including licensed clinical social workers, nurses, naturopaths, psychologists, emergency medical technicians, and P/RSS. Their services can include support groups, housing and housing support, detoxification services, respite, one-on-one coaching, and more.
- **Roles and Acceptance by Colleagues:** SUD and MH P/RSS appear to be well-integrated into both peer-run and treatment organizations and fill diverse roles, including wellness coaches, outreach specialists, warm-line operators, housing navigators, crisis support specialists, and supervisors of peer teams.
 - Beyond the P/RSS role, many provider organizations include staff with lived experience at all levels of the organization.
- **Impacts on Colleagues and Roles in Organization:** P/RSS and non-P/RSS staff alike expressed appreciation for the peer-based model of care and noted benefits to employees and organizations resulting from this model, including increased sensitivity to consumer needs and greater consumer engagement, as well as improved consumer outcomes such as a reduction in unnecessary visits to the emergency room, decreased psychiatric hospitalizations, and increased housing independence.
- **Training/Knowledge Gaps Identified:** Documentation for billing provided a training challenge for P/RSS, especially for those with limited recent job experience due to illness or incarceration.
- **Implications for Integration with Primary Care:** Although Arizona has recently changed its Medicaid Waiver to integrate behavioral and physical health, the integration of P/RSS as wellness coaches appears to be in its early phases.

Conclusions

Arizona has a large and well-established peer workforce. Key factors of Arizona’s model include:

1. The inclusion of all behavioral health under a statewide Medicaid managed care system.
2. The inclusion of both licensed treatment organizations and community-based and peer-run organizations in a recovery oriented framework.
3. The integration of MH and SUD services overall and in the provision of a unified peer certification.
4. The encouragement of innovation and competition by providing flexible standards for agencies to develop their own P/RSS curricula and training programs.
5. The ongoing inclusion of community stakeholders in deliberations concerning service provision and training standards.

Arizona has been successful in changing the culture of MH and SUD treatment agencies by adopting a recovery-oriented framework and creating an environment that encourages the employment of P/RSS in service provision. The continued expansion of Medicaid coverage has provided the resources necessary for a robust behavioral health care system as well as the financial incentive to hire P/RSS. Advocates harbor concerns that the embrace of Medicaid, with all of its benefits, will change the nature of peer support and cause it to lose some of the key elements of mutuality that make it effective. Arizona has attempted to counter the pressure for professionalization of peer roles by supporting peer-based organizations as a part of the mix of service providers.

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

Background and Policy Framework

This case study explores Arizona's development and implementation of a peer provider workforce in mental health (MH) and substance use disorders (SUD). 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."*¹ More background information on this topic can be found in the related report, [*The Peer Provider Workforce in Behavioral Health: A Landscape Analysis*](#).

Arizona has a large and established peer support workforce—the result of grassroots activism, a class action lawsuit, and successful statewide policy development of training, certification, and Medicaid billing.

Arizona adopted a recovery-oriented system of care (ROSC) framework for behavioral health in 2000. SAMHSA defines a ROSC as "a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities".^{2, 3} Recovery refers to the period after treatment when individuals need continued support to maintain wellness.

This shift allowed the state to fund behavioral health service provision in recovery-based community settings as well as in traditional (office) treatment settings.⁴ A major part of this new system was family and peer support providers. Organizations such as *Recovery Innovations* began training and employing peer providers with funding from various sources such as the St. Luke's Health Initiative, SAMHSA grants, and Regional Behavioral Health Authority (RBHA) community investment funds.⁵

A major facilitator in funding and expansion of recovery and peer support services was *Arnold v. Sarn*, a 1981 class action lawsuit brought against the state of Arizona by advocates on behalf of persons with serious mental illnesses (SMIs), who had been de-institutionalized without subsequent provisions made for their care. The 1989 Arizona Supreme Court judgment affirmed that individuals with SMIs have a legal right to mental health treatment in their communities and required that the state begin implementing a "unified, cohesive, and well-integrated system of community health services" for those with SMIs, which would be audited for compliance.⁶

The case continued to be litigated until 2014 as periodic audits revealed that the state and its contractors were not fully implementing services as required by the ruling, including a 2004 audit noting “a lack of peer support services.”⁷ The final 2014 settlement required the State to provide supportive housing, assertive community treatment, supported employment, and *peer and family support* services.⁸ The 2014 settlement infused the state’s public health system with considerable new funding for behavioral health.⁸ This settlement, along with new funding available from Arizona’s adoption of Medicaid Expansion under the Affordable Care Act, are credited by many with providing the funding that finally allowed the state to carry through on its promise of comprehensive, community-based behavioral health care. Arizona has moved from being the state with the lowest per capita funding for mental health services in 1989 to number 10 in 2013.

Methods

Arizona was identified as a leading state in the employment of peer providers in MH through a literature review and the input of a national panel of experts convened in February 2015. We contacted Arizona state officials, certification boards, training organizations, and provider organizations to better understand the state’s service model, and to identify organizations to interview during a 3-day site visit. During the site visit, we visited 3 organizations, at which we interviewed staff and administrators. We also interviewed 3 state-level policy makers. Where feasible, we collected administrative data from peer provider sites.

Training and Certification

In 2005, Arizona convened a stakeholder workgroup made up of peer providers, clinical providers, and advocates to develop statewide standards and core competencies for peer support.⁴ In 2007, the Center for Medicare and Medicaid Services (CMS) authorized peer support services as Medicaid-billable services for certified peer providers. In order to access Medicaid billing, Arizona instituted statewide certification for peer support in 2012.

As previously noted, a number of organizations had already been training and employing peer providers prior to statewide certification. To expedite the process of certifying previously trained and working peers, a statewide exam was created and administered for a short period of time to allow certification of existing peer providers.

Peer providers may be called either Peer Support Specialists (PSS) or Recovery Support Specialists (RSS). The P/RSS certification is essentially the same for MH

and SUD. Although training providers may focus more on one or the other, both topics must be covered due to the high rate of co-occurring disorders.

To apply for certification, a person must self-identify as a “peer,” complete a Peer Support Employment Training Program approved by the Arizona Division of Behavioral Health Services (DBHS), and pass the associated competency exam with a minimum score of 80%. Approximately 1,132 P/RSS were certified as of June, 2015. P/RSS are not required to complete continuing education units (CEUs) and there is no time limit or expiration for certification. However, state officials noted that efforts are underway to enact continuing education requirements and assure access to continuing education in the future.

In 2015, 16 different agencies were DBHS-authorized to train and certify P/RSS. Each agency has its own curriculum, which must meet curriculum standards set by the state. For an organization’s training to count for certification, its curriculum, competency exam, and exam scoring methodology have to be reviewed and approved by DBHS. A state representative indicated that the acceptance of different curricula and training programs allows a diversity of recovery philosophies and cultures to have equal status within the system of care, and encourages competition and innovation. This competition is encouraged by state policy, which bans monopolies. The state representative noted, “Our model is not having a standard program; it is having program standards.”

Peer provider training programs are accredited by the DBHS in collaboration with regional behavioral health authorities (RBHAs).⁹ Programs and policy are reviewed every 3 years. Most of the approved training organizations are provider organizations.

Peer Employment

Approximately 1,123 certified peer providers were employed as of mid-2015. Peer support specialists are employed throughout the behavioral health system, including jails, hospitals, emergency rooms, and in both treatment and non-clinical community services agencies. There are not yet any peer provider programs within the state prison system’s behavioral health program.

According to statistics kept by the state, the average statewide length of employment of peer providers is 856 days. Wages range from \$9 to \$15 per hour for basic peer support. There is no requirement that peer providers be certified to be employed, but certification is required to bill Medicaid.

Funding for Peer Support Programs

Arizona's Medicaid system was instituted in 1982 under a Social Security Act Section 1115 research and demonstration waiver, which exempts the state from specific provisions of the Act.¹⁰ The resulting Arizona Health Care Cost Containment System (AHCCCS) was the nation's first statewide public managed care system.¹⁰ The majority of Arizona's public behavioral health services (88%), including peer support, are covered by Medicaid.^{10, 11}

In Arizona, peer support is billed in 15-minute increments by the licensed agency. Medicaid billing codes include the following:

- H0038 (Self-help / Peer Services by certified peer specialist)
- H0038HQ (Self-help / Peer Services in a group setting)
- H2016 per diem rate (Comprehensive community support services)

Behavioral health services are "carved out" from the managed care contracts and covered by the AZ DBHS via subcontracts with a set of 3 (North, South, and Greater Phoenix) community-based RBHAs and 4 Tribal Regional Behavioral Health Authorities (TRBHAs) that receive capitated payments.¹¹ The RBHAs/TRBHAs administer managed care delivery systems covering Medicaid-eligible individuals in their regions and receive state funding to provide services for some persons with SMIs who are not Medicaid eligible. The RBHAs/TRBHAs contract with agencies, both clinical and community-based, for behavioral health treatment and recovery services.

Models of Care

Most of Arizona's public behavioral health system is composed of contracted private companies, which include for-profit and not-for-profit agencies. Some agencies are treatment-oriented, and have licensed clinical providers on staff, and others are considered "community service agencies," or CSAs. The CSAs receive Medicaid and Block grant funds, but are not licensed and do not do intake or conduct assessments. Their role is to provide rehabilitation and support services that enhance those provided by licensed agencies.⁴

CSAs, some of which are peer-run,ⁱ are often dependent on licensed clinics to send them referrals. Licensed treatment agencies have also invested in training and

ⁱ Peer-run organizations are owned, administratively controlled, and operated by mental health consumers.

employing peer support specialists. This may serve as a disincentive to referring these services out to peer-run organizations.¹²

Arizona organizations employing peer support specialists in MH and SUD provide a wide array of population-specific services, including specialized services for Veterans, transition-age youth, the homeless, those who are deaf and hard of hearing, Native Americans, and Latinos. All organizations visited for this study operated training programs for P/RSS certification. One organization, *Recovery Innovations*, also contracts for P/RSS training and direct services in several other states.

Roles

We found that P/RSS are employed in many different roles in Arizona. Organizations visited for this study provided detailed job descriptions for a number of peer provider roles, demonstrating that peer providers are employed in a variety of capacities and that their responsibilities are well-defined and integral. Examples of job titles we found in the organizations we visited include: warm-line operator, community outreach specialist, community support specialist, housing navigator, crisis navigator, job coach, peer employment specialist, VA support navigator, wellness coach, and whole health peer. Settings include transitional and permanent housing, wellness centers, warm lines, medical respite centers, primary care clinics, detox centers, hospitals, jails, mobile crisis teams, and in the community.

In most settings and roles, P/RSS worked with licensed staff such as licensed clinical social workers (LCSWs), emergency medical technicians (EMTs) and triage registered nurses (RNs). They also worked with staff at collaborating organizations, such as law enforcement and hospital staff. In some roles, P/RSS encountered primarily other P/RSS and supervisors, but nearly everyone interviewed reported needing to work with interdisciplinary teams at some level.

State regulations require that peer support staff be supervised by either a behavioral health professional (psychiatrist, RN, marriage and family therapist (MFT), LCSW, etc.) or a behavioral health technician (BHT) who has received training on supervision of peers. The latter designation is neither licensed nor certified, and is based on a combination of work experience and education.¹³ The flexibility of the BHT category can serve as a career step for P/RSS to become supervisors.

While lived experience with mental illness and/or substance use disorders was required for peer support positions at the agencies we visited, many other staff,

including supervisors and managerial staff, also had lived experience. Some agencies required peer support certification for positions that were not involved in frontline service provision, such as integrated operations manager, administrative claims manager, or director of program services, to ensure that staff understood the principles of peer support that were central to the organization's mission.

Acceptance by Colleagues in Organizations

Agencies we visited employed a sizable number of peer support staff (ranging from 75 to more than 300). Interviewees at these organizations reported that anywhere from 25% to 99% of their staff were "peers" (persons with lived experience), regardless of job title. One was a non-clinical peer-run organization. Two were not peer-run and provided clinical services, but also employed large numbers of P/RSS. All of the organizations we visited had employed peer support staff for more than 10 years.

While many articles in the academic literature on peer support focus on the challenge of integrating peer providers into clinical behavioral health settings, for some organizations we visited, the challenge was incorporating licensed clinicians, many without lived experience, into a work place that was peer-centered. Administrators spoke of preferences for clinical staff (LCSWs, clinical psychologists, counselors, etc.) with lived experience, and of trying to acclimatize these staff to a peer-centered environment.

Impact on Colleagues and Roles in Organization

All interviewees, including administrators, felt positive about the peer-based model in which they worked, listing a number of benefits. Peer support was cited as central to organizational mission. Non-peer staff recounted instances in which peer support specialists were able to identify issues that they would have missed, enhancing their ability to support consumers in need. In many treatment situations, peers are the first providers patients see, not clinicians.⁴ Peer support providers can model recovery, effectively engage people seeking services, and calm those in crisis. One interviewee noted that her agency received very high consumer satisfaction ratings, even in programs where consumers were brought to treatment centers involuntarily. She credited this to the work of peers within those programs.

Most agency representatives indicated that peer support staff required no more accommodation than any other staff, noting that peer support staff had a much lower turnover than clinical staff. However, one interviewee noted that life challenges could complicate supervision and retention of peer providers, with up to

70% of peer staff on her team being out on medical leave on some days. Another noted that the challenges some P/RSS faced were not directly related to their mental health issues, but more related to their economic situation, including chronic illness and lack of transportation. One interviewee noted, “The challenge is to provide excellent service while caring for the people we employ.” Overall, peer support staff felt that they were accepted, valued, and supported in their organizations, noting an organizational emphasis on self-care for all employees. One organization offered an extended wellness benefit of \$300 annually that staff were required to use. This emphasis on self-care, including benefits and organizational acceptance and support for relapse/health crises for all employees, was cited by some interviewees as a reason for low turnover rates.

Training/Knowledge Gaps Identified

P/RSS interviewed were very positive about the training they received to become certified. Some of the biggest challenges identified by interviewees had to do with documentation required to bill Medicaid. Agency staff noted the need to develop ongoing training for peer support staff and other frontline staff on computer systems and record-keeping. Peers themselves noted documentation for billing as a key component of their jobs. Trainers noted that for some students this was their first job, or first job after a long absence, which had ramifications for basic job skills such as computer literacy and expectations.

Professional Development and Career Aspirations

All organizations noted that they promoted from within, and that people with lived experience were employed at every level of the organization. One supervisor noted, “We promote from within more than we hire from outside.” In addition, some P/RSS noted that they were former clients of their employing organizations and that this was a first job after incarceration or hospitalization, providing a path back into employment for them. One organization had a multi-step career ladder for P/RSS with a significant pay raise between steps. Several other P/RSS interviewees noted that they were pursuing college degrees.

Implications for Integration with Primary Care

In December 2014, CMS approved Arizona’s request to amend its Section 1115 Medicaid waiver to integrate behavioral and primary care for individuals with SMIs.¹⁴ However, although administrators noted high rates of comorbidity in the SMI population, the integration of peer support services with physical health services appeared rudimentary at the time of our visit.

One organization had built a primary care clinic on its campus, which it hoped to find funding to staff with clinicians and peer support. One organization had peer health and wellness coaches who worked with a naturopathic doctor on staff to check vitals, teach nutrition, and otherwise help with consumer wellness plans. Another had developed a course for training whole health peers to work on hospital-to-community transitions and had peers employed in clinics serving the homeless.

Implications for Policy

Arizona's peer support workforce grew out of a consumer movement, facilitated by a pivotal class action lawsuit and the state's Medicaid policies. Arizona has a statewide Medicaid managed care program, has accepted Medicaid expansion, and the majority of the state's behavioral health funding now comes from Medicaid.¹⁵ The recently settled *Arnold v. Sarn* case mandates increases in peer support and other services, providing for a robust behavioral health system with multiple complementary resources.

Arizona has fostered the growth of the peer support workforce, first through adopting a recovery-oriented system of care, and then by developing training standards and certification that allow agencies to bill Medicaid for certified peer providers -- further incentivizing the employment of P/RSS.

Arizona involved family and peer support providers, as well as other stakeholders, in developing the statewide training standards for P/RSS. It has devolved P/RSS training and certification processes to a diversity of agencies, encouraging innovation and competition in P/RSS training programs, within certain guidelines.

Another significant component of Arizona's model is the integration of SUD and MH services, in terms of overall administration (both are managed under the same division), coverage under the state's Medicaid managed care program, and certification, which allows P/RSS to focus on either area or address co-occurring disorders.

Interviews with provider agencies suggest that peer providers are well-integrated into both peer-run and treatment agencies and play important roles. Some peer-run organizations may feel pressure to become licensed and incorporate clinical staff in order to do their own intake and referrals, as well as to bill Medicaid. Some observers are concerned that Medicaid billing requirements will destroy the special essence of peer provision by placing it under the "medical model" of care and diminishing the emphasis on lived experience and mutuality. Policy makers in



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Arizona have continued to explore strategies to retain and support peer-run organizations as an important element of the state's behavioral health provision.

Arizona Sites visited

- Recovery Innovations and Recovery Opportunity Center — Phoenix
- NAZCARE – Prescott and Cottonwood
- Community Bridges — Mesa
- Arizona Department of Health Services, Office of Individual and Family Affairs

Acronyms Used in this Report

AHCCCS - Arizona Health Care Cost Containment System

ACT – Assertive Community Treatment

BHT – Behavioral Health Technician

CMS - Centers for Medicare and Medicaid Services

CEU – Continuing Education Unit

CSA – Community Service Agency

DBHS - Division of Behavioral Health Services

MH – mental health

SMI – serious mental illness

SUD – substance use disorder

PSS – Peer Support Specialist

P/RSS – Peer Support Specialist or Recovery Support Specialist

RBHA – Regional Behavioral Health Authority

TRBHA – Tribal Regional Behavioral Health Authority

RSS – Recovery Support Specialist

VA – Veterans’ Administration

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