Research Report

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

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Executive Summary

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

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

Methods

Pennsylvania was identified as a leading state in the employment of peer providers in MH and SUD through a literature review and the input of a national panel of experts convened in February, 2015. We contacted Pennsylvania 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 in July, 2015. During the site visit, we visited 4 mental health (MH) and 2 substance use disorder (SUD) treatment and recovery organizations, at which we interviewed staff and administrators. We also interviewed 2 state-level policy makers, one representative from a statewide SUD certification board, and conducted one phone interview with a training and advocacy organization representative. Where feasible, we collected administrative data from peer provider sites.

Findings

- **Training and Certification:** Pennsylvania has had certification for MH peer providers since 2006 and for SUD peer providers since 2008.
  - As of October, 2015, there were over 4,200 MH Certified Peer Support Specialists (CPSs) in Pennsylvania.

- o As of August, 2015, there were 535 SUD certified recovery specialists (CRSs) in Pennsylvania.
- **Employment:** According to an online survey conducted in 2010 by a coalition of state and non-profit organizations, 83% of new CPS trainees were employed, most commonly in residential settings and psychiatric rehabilitation centers. CRSs were reportedly most commonly employed by treatment agencies.
  - o Wages reported by sites we visited in 2015 ranged from $12 to $16 per hour.
  - o CPSs worked a varying number of hours at the sites we visited in 2015, while CRSs primarily worked full-time.
- **Funding for Peer Support Programs:** Pennsylvania is transitioning individuals in its Medical Assistance program to its Medicaid Managed Care program, HealthChoices, in 2015.
  - o MH peer support services are Medicaid-billable due to a 2007 State Plan amendment under rehabilitative services.
  - o SUD peer support services are not yet included in the State Plan and are funded through a variety of local and state grants as well as billing to HealthChoices behavioral health managed care plans.
- **Models of Care:** Pennsylvania's behavioral health system is a county system.
  - o County governments have their own mental health and developmental disabilities offices, and their own single-county authorities for SUD.
  - o Most direct services are provided by private community agencies contracted with the counties and licensed by the Commonwealth of Pennsylvania; these direct service organizations employ peer providers.
  - o Some MH and SUD organizations are peer-run.
- **Roles and Settings:** CPSs and CRSs work in both clinical and non-clinical organizations.
  - o Many CPSs and CRSs work one-on-one with consumers in the community at offsite venues.
  - o A growing number of peer providers, particularly CPSs, work as forensic peers assisting incarcerated individuals with serious mental illnesses to achieve wellness and transition into the community upon release.
  - o Some CPSs and CRSs work in intensive case management, career development, staff warm lines, conduct consumer and family

satisfaction surveys, mentor peers, or assist with independent living skills, and provide education and outreach to the broader community

- **Acceptance by Colleagues:** CPSs and CRSs reported feeling accepted in their organizations.
  - o MH organizations in particular had developed accommodations for peer providers, including generous leave policies, flexible hours, and documentation training and input strategies. CPSs indicated a sense of welcome and acceptance in their roles.
- **Impact on Colleagues and Roles in Organization:** Incorporating peer providers helped shift MH and SUD organizations into a "recovery-oriented" model of care. Peer providers enhance rapport with those seeking care. Some organizations were involved in formal evaluation studies that substantiated improvements in patient outcomes resulting from peer support programs.
- **Training/Knowledge Gaps Identified:** Documentation for billing provides a training challenge for some CPSs and CRSs, especially for those with limited education. Other needs identified included training in motivational interviewing, co-occurring disorders, and goal setting.
- **Implications for Integration with Primary Care:** Although Pennsylvania is exploring integration at the state level, integration is not yet widespread. Some providers visited for this study are making preliminary preparations via partnering with primary care providers, providing wellness services, and investigating health record systems.

Conclusions

Pennsylvania has a large and well-established mental health peer provider workforce statewide, and a smaller substance use disorder peer provider workforce in some regions of the state. Key success factors include:

1. The inclusion of MH peer providers in the State Plan as a Medicaid-billable service.
2. A flexible system for peer provider supervision, with state-provided supervisor training, which allows for MH peer providers' career progression.
3. Adopting a recovery-oriented framework for behavioral health and creating an environment that encourages the employment of CPSs in each county. This effort has been successful for CRSs in some counties.

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

Background and Policy Framework

This case study explores Pennsylvania'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*.

In 2003, Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) initiated a transformation of its public mental health system to become a recovery-oriented system of care. Peer support was identified as an important component of this transformation, as identified in the 2005 document, *A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults*.[2] As a result, Pennsylvania has a large and established peer support workforce.

Methods

Pennsylvania was identified as a leading state in the employment of peer providers in MH and SUD through a literature review and the input of a national panel of experts convened in February, 2015. We contacted Pennsylvania 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 in July, 2015. During the site visit, we visited 4 mental health (MH) and 2 substance use disorder (SUD) treatment and recovery organizations, at which we interviewed staff and administrators. We also interviewed 2 state-level policy makers, and one representative from a statewide SUD certification board. Where feasible, we collected administrative data from peer provider sites.

Mental Health

- The idea for developing a statewide certified peer support workforce arose from the application process for SAMHSA's Mental Health Transformation State Incentive Grant (MHTSIG). A group from the Pennsylvania Office of

Mental Health and Substance Abuse Services (OMHSAS) convened in 2003 and reviewed the research and brainstormed on what kind of project would have the greatest impact on the state in terms of mental health system transformation. Peer support services were envisioned as an important component and were included in the proposal.

- In 2004, Pennsylvania received a 3-year $300,000 grant from SAMHSA. This grant funded the Pennsylvania Peer Specialist Initiative (PSI) including 3 components for peer support in mental health services: 1) developing a State Plan amendment for the service, 2) developing standards, and 3) developing a training and curriculum for peer providers.

The training organization chosen for the pilot initiative was the Mental Health Association of Southeastern Pennsylvania (MHASP).[3] MHASP is a peer-run, nonprofit corporation that provides advocacy, direct support, training and education, information and referral, and technical assistance to persons with mental illnesses and their families.[4]

Representatives from OMHSAS traveled the state to provide outreach and technical assistance to develop a welcoming environment for peer providers. They also developed public announcements of the training opportunity to distribute across the state, initially in the counties selected for the pilot initiative.

In 2007, the Center for Medicare and Medicaid Services (CMS) authorized Pennsylvania's State Plan amendment to add peer support services as Medicaid-billable under rehabilitative services. All of Pennsylvania's 67 counties are required to make peer support available as part of their mental health services.[5] The decision was made to retain another trainer, Recovery Innovations of Arizona, in addition to MHASP, in order to speed the spread of the initiative and provide competition and choice.[6]

In 2008, Pennsylvania added the CPS category as a civil service classification.[5] Also in 2008, OMHSAS worked with University of Pennsylvania partners to develop curriculum and training for a new category, the Certified Older Adult Peer Specialist (COAPS), an enhancement that entails three extra days of training. OMHSAS has continued to expand this role, including the provision of a special training program in wellness coaching for COAPS in 2013.[3]

Finally, starting in 2011 Pennsylvania established an innovative forensic peer support program training prisoners in 6 state prisons to serve as CPSs.[7] This partnership between OMHSAS and the Pennsylvania Department of Corrections has trained and certified approximately 500 CPSs *within* the prison system as of September, 2015 according to state representatives.

Substance Use Disorders

SUD peer support programs have not expanded as rapidly as peer support programs in mental health, largely because SUD peer support has not yet been added to the Medicaid State Plan as a billable service. While there are several thousand peer providers in mental health, there are only a few hundred in substance use disorders. SUD peers are concentrated in regional pockets throughout the state, as their development has largely been driven by county funding.

Statewide certification for peer providers in SUD is available through the independent Pennsylvania Certification Board (PCB). The Certified Recovery Specialist (CRS) credential became available through the PCB in 2008.

Training and Certification

Mental Health Peer Training and Certification

As noted previously, Pennsylvania's first class of Certified Peer Support Specialists (CPSs) graduated in 2006. In 2007, the Center for Medicare and Medicaid Services (CMS) authorized peer support services as Medicaid-billable in response to Pennsylvania's application for a State Plan amendment.

In order to become a CPS, an applicant must have received mental health services for a serious mental illness (SMI), have at least a high school diploma or a GED, and have maintained a job or volunteer position for 12 months or have earned 24 post-secondary education credits within the past 3 years.[8] The applicant must attend one of the approved training programs, and must achieve at least 80% correct on a certification exam.

The state's 2 approved trainers are MHASP's Institute for Recovery and Community Integration and Recovery Innovations of Pennsylvania's Recovery Opportunities Center. The basic standards for training, based on core competencies developed by a state working group, include a 10-day, 75-hour curriculum, but the curricula and exams are unique to each vendor. The vendors issue certificates to trainees and maintain files on certificates granted. In order to maintain certification, CPSs must have 18 hours of continuing education per year, and Continuing Education Units (CEUs) are tracked by employers. Due to a 2010 memorandum of understanding between OMHSAS and the Office of Vocational Rehabilitation (OVR), a substantial portion of the tuition of approved CPS candidates who are OVR eligible is covered by OVR.[3]

As of October, 2015, there are an estimated 4,200 individuals in Pennsylvania who have been trained and certified as CPSs.[9]

Substance Use Disorders Peer Training and Certification

The certification and designation process for SUD certified recovery specialists (CRSs) is handled through the Pennsylvania Certification Board (PCB). Statewide CRS certification was instituted 2008. Although the PCB is a member of the International Credentialing and Reciprocity Consortium (IC&RC), its CRS certification is distinct from IC&RC's peer recovery credential.

In order to apply for certification, applicants must have at least a high school education or GED, complete an approved course of training, and pass an exam. There are 6 approved training vendors in the state. CRSs training requires about 54 hours of education on topics such as understanding addiction, communication, stigma, vision of recovery, ethics, and confidentiality. To maintain certification, CRSs must acquire 30 hours of approved continuing education per 2-year cycle.

As of August 2015, there were 535 CRSs in Pennsylvania.

Peer Employment

Statistics on the overall employment of CPSs are not available. According to an OMHSAS representative, there were 149 agencies licensed to provide MH peer support services in 2015. According to a survey of CPSs conducted in 2010 by a coalition of state agency and advocacy groups, 83% of surveyed CPS trainees were working after their initial training.[10] The most commonly-reported employment settings were residential settings (20.5%), psychiatric rehabilitation centers (13%), case management (12.3%), drop-in centers (10.3%) and consumer-run organizations (9.6%).[10] CPSs were also employed in state and community hospitals, intensive outpatient programs, peer mentoring programs, warm lines, supported employment programs, veteran programs, family court, survey teams administering consumer and family satisfaction surveys,[i] Assertive Community Treatment teams, and advocacy organizations.[10] In addition, CPSs are increasingly employed in forensic settings in Pennsylvania such as state prisons, and OMHSAS has partnered with various institutions to promote training in this field.

Interviewees reported that CPSs earn $12 to $16 per hour, often depending on county reimbursement rates. The hours worked by peers at 2 organizations we

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[i] Not all service are Medicaid billable.

visited ranged from part-time to full-time depending on the employer needs and capacity of CPSs. For example, some CPSs who receive disability cannot work more than a certain number of hours per week and retain their benefits. Other CPSs noted that there was a limit to the number of hours they felt they could work according to their own wellness needs.

CRSs are hired by SUD treatment organizations and recovery community organizations. While it is likely that treatment organizations are the predominant employer, statistics on the overall number and employment settings of CRSs are not tracked. Interviews with employers suggest that the wage range for CRSs is similar to that of CPSs. At both organizations we visited, CRS positions were full-time.

Funding for Peer Support Programs

According to the Kaiser Family Foundation, Pennsylvania ranks fifth in the nation in state mental health spending at $287.17 per capita.[11] Pennsylvania is an Affordable Care Act Medicaid Expansion State. The state is transitioning its Medicaid system to a Medicaid expansion plan and individuals in the state's Medical Assistance Program (Medicaid) will be enrolled in the state's Medicaid managed care program, HealthChoices, in 2015.[12] Through HealthChoices, Pennsylvania contracts with 5 behavioral health plans (managed care organizations or MCOs) to manage care for beneficiaries.[13]

Funding for Mental Health Peer Support Programs

In 2007, Pennsylvania's State Plan amendment to add peer support to its Medicaid plan as a billable service was approved. Peer support is billed in 15-minute increments. The Medicaid billing code for peer support is H0038 (Self-help / Peer Services by certified peer specialist).[14]

According to a 2007 Medical Assistance Bulletin from OMHSAS, peer support may be provided by "an agency that provides only peer support services, or by a psychiatric outpatient clinic, partial hospitalization program, crisis intervention provider, resource coordination provider, intensive case management provider, or, in HealthChoices counties, psychiatric rehabilitation providers."[14] Provider agencies must be licensed by the Department of Public Welfare. In addition, peer support services may be delivered by subcontract between a licensed provider agency and an agency or program that is not an approved peer support provider, with authorization from the Department.[14]

Forensic peer support programs may receive support from the Department of Corrections, including funds from the Bureau of Justice Assistance Second Chance Act Comprehensive Statewide Adult Recidivism Reduction Program. Agencies working with veterans receive funding from the Veterans Administration.

Funding for Substance Use Disorders Peer Support Programs

Administration for drug and alcohol programs is shared by the Bureau of Drug and Alcohol Programs (BDAP) and OMHSAS. BDAP, which is in the Department of Health, administers block grants and state funds to counties for SUD prevention and treatment, while OMHSAS, which is in the Department of Public Welfare, manages Medical Assistance services for the treatment of substance use disorders and distributes some of the funding to counties.[5]

CRSs are not yet covered in the Pennsylvania Medicaid State Plan, and some interviewees cited this as a barrier to uniformity and standardization of CRS services throughout the state. Instead, peer support programs are funded through a variety of grants and HealthChoices. According to a 2010 report from OMHSAS, an important feature of HealthChoices is that it allows for supplemental services not specified in the Medicaid State Plan, including the services of CRSs.[5]

Other sources of funding for SUD peer support services include various state and county funds, federal grants such as the Center for Substance Abuse Treatment's (CSAT) Recovery Community Services Program (RCSP), private foundation funding, patient self-payment, and other revenues. Organizations visited also mentioned receiving reinvestment funds, which are Medicaid managed care treatment funds that are not expended during a given fiscal year.

Models of Care

Pennsylvania is a commonwealth with 67 counties. County governments have their own mental health and developmental disabilities department or office that plans, funds, administers, and monitors services provided by contractors. These offices assess eligibility and make referrals, but most direct services are provided by private community agencies licensed by the Commonwealth of Pennsylvania.[15]

Substance abuse services are administered through Single County Authorities (SCAs). As with county mental health, the SCAs assess eligibility for funding and need for treatment or other services and makes referrals to provider organizations.[16]

Models of Care: Mental Health

We visited four MH provider organizations for this study. One was a private for-profit stand-alone peer support organization, which includes a growing forensic component and offers technical assistance to other agencies developing peer support programs. One was one of the oldest peer-run groups in the state providing direct services at multiple sites and a training institute for CPSs. One was primarily focused on developmental disabilities, but provided peer support for those dual-diagnosed with mental illness. One was a multi-site non-profit comprehensive outpatient treatment center with a community residential rehabilitation center.

Roles

CPSs work both alone with consumers and in teams. In many instances, CPSs work on mobile teams, meeting alone with consumers in their homes or other community settings, or in prisons and jails. CPSs also work in teams with other CPSs, as well as with case managers, supervisors, psychiatrists, recovery coaches, outpatient directors, and other staff. In one organization, CPSs work with consumers to set an agenda for self-directed care by creating a budget and plan for services and supports.[17] At another site, CPSs who had been dual-diagnosed with developmental disabilities and mental illnesses worked with other dual-diagnosed individuals on socialization and independent living skills. At one site, CPSs provided employment placement and career readiness training. Leading groups was seldom identified as a job duty at the sites we visited.

Acceptance by Colleagues in Organization

Agencies we visited employed anywhere from a few peer support staff to a very large number, ranging from 4% to 80% of all staff. At one peer-run organization interviewees reported that many employees had lived experience whether or not they were providing peer support.

Most CPSs interviewed for this study reported acceptance at their organizations, and some expressed a sense of relief at having employment that did not require them to hide their status. One CPS observed, "When I approach, their minds seem to be open. I am not always wrong and they are [not always] right. I can express negativity and instead of it being a red mark on my record, it is okay to feel that way." CPSs described open relationships with immediate supervisors. Supervisors in turn spoke of their own efforts to lay the groundwork for that acceptance. One noted that they'd had particular difficulty getting mental health professionals to accept the value of CPSs. Another noted that it was important to educate other staff

prior to introducing CPSs, and to hire very qualified CPSs to make a good impression on the organization from the start.

Organizations had developed accommodations to retain peer support staff. While many CPSs reported working full-time hours, one organization allowed CPSs to determine how many hours they wanted to work per week. Newly hired CPSs began with a part-time caseload because, as one supervisor noted, wanting to work full-time and being able to work full-time while in recovery were 2 different things. Staff were also often offered a leave of absence, separate from Family or Medical leave, without having to reapply for additional time. One administrator reported that about 20% of their CPS workforce had been on leave over the prior year, with approximately half of that being for self-care. Two interviewees also mentioned the need to work on clearance issues to hire CPSs with criminal backgrounds, which was especially an issue for forensic programs where having lived experience with the criminal justice system makes a person uniquely qualified for the job. Supervisors needed to be attentive to when a staff member was having a bad day, "When you have a mental health challenge it is hard to focus and be present. I can tell when that is going on and they do not understand something because they can't focus ..."

Impact on Colleagues and Roles in Organization

Some supervisors noted that incorporating peer support staff met considerable resistance when the idea was first introduced. However, some could see a change in their organizations and in the broader culture of some parts of the state with a greater embrace of recovery and "peer culture". CPSs noted that therapists and other team members might seek their opinion on cases because of the CPSs' rapport with consumers.

One interviewee mentioned that CPSs brought a "passion that drives the organization." Another interviewee commented on how hiring former clients was beneficial because it gave other consumers a sense that they could recover and obtain a job because they knew that the CPS had been a former patient.

Evaluation research conducted at some sites helped establish the importance of peer provision to the organization and collaborators. For example, one site was able to document that peer supports resulted in a recidivism rate of 23.6% compared with the expected recidivism rate of 50% for offenders with SMIs within 385 days.[18]

Training/Knowledge Gaps Identified

In addition to the initial CPS training that peer providers receive, they also receive training from their county mental health office or the state on various topics such as documentation, CPS supervision, supported employment, forensic work, and specialized trainings for the deaf and for those with developmental disabilities.

CPS reported that their initial CPS training was useful and engaging, but "it just prepares you to start, you have to have the experience" to fully understand the job. Many reported enjoying the networking opportunities at county mental health trainings, and the chance to compare and contrast job experiences.

Some interviewees had criticisms of the overall training structure. A few noted that the different curricula and screening processes used by the two training vendors meant that staff were not equally prepared when they started work. "They *do* come out empowered and encouraged—but there is no preparation in these trainings for billing regulations or rules—they need training on all aspects of Medicaid billing rules." Another observed that the state trainings on documentation were difficult for some CPSs with limited educational backgrounds, and it was challenging for a person with little more than a GED to write a good Medicaid contact note.

Documentation was an important issue at several agencies, taking up to a third of the work time according to one CPS. One organization had worked out a unique interface for documentation that allowed their peer support staff to prepare notes more easily. Some agencies also offered in-house training on specific topics like documentation, computer skills, compliance, safety scenarios, or forensic work.

Professional Development and Career Aspirations

CPSs reported a somewhat limited internal career ladder, with the next step primarily being the role of CPS supervisor. State regulations require that peer support staff be supervised by either a mental health professional who has completed approved CPS supervisory training, or a person with a bachelor's degree and 2 years of direct mental health care experience (including peer support), or a person with a high school degree or GED, 4 years of direct mental health care experience, and CPS supervisory training.[19]

In terms of professional development, most CPSs interviewed reported numerous training opportunities. At one site, the organization paid for CEU classes. At another, CPSs reported that the county sponsored a peer networking group and a

number of trainings they could take free of cost. Some CPSs were enrolled in secondary education programs.

Models of Care: Substance Use Disorders

We visited 2 recovery community organizations (RCOs) and also interviewed representatives of the Pennsylvania Certification Board (PCB) and the Pennsylvania Recovery Organizations–Alliance (PRO-A), a statewide advocacy group representing the recovery community and supporting recovery community organizations.[ii] Neither provider organization was a clinical treatment agency and both followed a recovery management model. As one interviewee noted, "The hard stuff happens when you're out of treatment and (back) in the community."

Provider organizations we visited provided a variety of services in many settings. One organization ran most of its services out of recovery community centers— houses and offices that provided a space for recovery community groups to meet, classes and scheduled events focusing on recovery, peer support services to help prevent relapse and sustain recovery, and other services. Another focused on providing peer support services, including buprenorphine (medication used to treat opioid addiction) care coordination, therapeutic recovery housing, life skills classes, vocational assistance, and social and education events for the recovery community. One organization was an approved trainer of CRSs.

Roles

CRSs described their typical tasks and roles as including intensive case management, attending sessions of drug court with individuals, working with drug court staff to coordinate resources, visiting rehabilitation facilities to connect with individuals before they are discharged in order to connect them to recovery resources, providing family intervention, operating a help line, conducting focus groups and surveys of client satisfaction with treatment centers for the county, making presentations on the peer role and recovery to outside organizations, running support groups and orientation sessions, working one-on-one with individuals to develop a recovery plan, assisting individuals' transitions from

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[ii] A recovery community organization (RCO) is an independent, non-profit organization led and governed by representatives of local communities of recovery. These organizations organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services (P-BRSS).[20]

incarceration into the community, and assisting with accessing resources such as housing and employment.

Acceptance by and Impact on Colleagues in the Organization

Within their organizations, CRSs felt accepted. As one said, "This agency feels like it's built around the CRS; it's part of our mission so I feel they really recognize the importance of the CRS role."

Although many CRSs reported that most of their time was spent one-on-one with peers, they also needed to be able to interact with many different types of people at collaborating organizations. This might include licensed providers at treatment organizations and rehabilitation centers, probation officers, judges, drug court coordinators, public defenders and defense attorneys at drug courts, and staff at vocational programs.

One administrator recounted how initial interactions between peer providers and treatment organizations were rocky. Providers did not understand peer support and thought the Recovery Community Organization (RCO) as going to "steal" their clients. The staff at one treatment agency finally came to appreciate the role of the CRS when, due to overload, it had to refer clients to other organizations and found that peer support helped with their recovery outcomes. This convinced other providers to overcome their reluctance and partner with this RCO.

Interviewees felt that CRSs were able to reach out to program participants in a way that clinical staff could not: "We make sure they're getting their treatment but we don't necessarily know how recovery impacts their goals so we bring in a CRS to work with them…The CRS (program) is a wonderful service for people because hearing it from somebody who has walked the walk kind of works better."

Training/Knowledge Gaps Identified

Documentation was an issue for the organizations we visited. There were 5 different behavioral health plans, each with different rules for how services were to be documented and how referrals could be made. Supervisors and trainers spoke of the struggle of training staff to document properly, especially with the diversity of plans. One interviewee said, "To expect someone who has a high school diploma and 2 years of recovery to do all of this, it's insane."

One CRS felt that the CRS training about boundaries, privacy, and confidentiality was very good, but the training could have done more on organizational skills,

motivational interviewing, and — especially — documentation. Another CRS also noted that they were somewhat underprepared to deal with co-occurring disorders.

Professional Development and Career Aspirations

While there is no specific data on CRS employment, some interviewees expressed concerns about job opportunities for certified CRSs due to the fluctuating and regional nature of funding sources. CRSs and supervisors noted that there was some room for advancement to the supervisor level if positions opened up, but opportunities were not extensive, partially due to organization size and also due to education requirements. However, supervisors and organizations provided training opportunities and encouraged staff to seek additional education and training opportunities.

Implications for Integration with Primary Care

We observed a limited amount of integration with primary care, although state representatives mentioned growing interest in this topic. One agency had co-located services with a primary care clinic, which includes a dental provider and a pharmacy. This agency also had a program for consumers that included personalized wellness planning and support. At another site, there were some efforts at medical monitoring, outreach to homeless veterans, and some nursing support. Neither program appeared to include CPS involvement. Interviewees cited different EHR systems, outcomes measures, and work cultures as barriers to integration.

Implications for Policy

Pennsylvania has trained and certified perhaps the largest number of mental health peer providers of any state in the U.S. Pennsylvania has fostered the growth of this workforce by requiring that counties provide peer support and providing a mechanism to bill Medicaid for these services. Because the state has Medicaid expansion under the ACA, this workforce is likely to grow to address demand. The State has also developed a CPS supervisor category that recognizes different combinations of experience and education, and provides supervisor training that allows staff with a GED or high school degree to advance. Finally, the Office of Vocational Rehabilitation now covers some of the costs of training CPSs in collaboration with OMHSAS.

The state and vendors have continued to innovate with ambitious mental health peer support programs such as forensic peer support with both incarcerated and

formerly incarcerated CPSs, a pilot of self-directed care for persons with SMIs, and the Certified Older Adult Peer Specialist (COAPs) program. Organizations implementing these and other peer support innovations have worked with university researchers to evaluate outcomes and have produced results that have, in some cases, made them "best practice" models.

SUD is a separate system from MH with separate oversight, although there is some collaboration between the two. Interviewees indicated that because SUD peer provider services (CRSs) are not Medicaid billable, the use of CRSs is not as widespread and is subject to fluctuating funding streams by region. Some pockets of the state, such as the Philadelphia area, have strong recovery-oriented systems in place and others do not.[21] Advocates continue to negotiate with the state to have CRSs added to the State Plan, citing workforce shortages in behavioral health and high rates of substance use disorders.

The state of Pennsylvania is notable for its innovative use of peer providers and strong advocacy in both MH and SUD as well as for the large number of peer providers trained and certified. In MH, Pennsylvania is well recognized for its long history and widespread use of peers. Pennsylvania is continuing to innovate and expand its use of peer providers and address challenges such as funding opportunities and career development.

Pennsylvania Sites Visited

- The Council of Southeast Pennsylvania, Inc.; Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT) — Doylestown
- Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) – Harrisburg
- Mental Health Association of Southeast Pennsylvania (MHASP) – Philadelphia and Upper Darby
- Indian Creek Foundation – Souderton
- Creative Health Services — Pottstown
- The RASE Project – Harrisburg
- Pennsylvania Certification Board – Harrisburg
- PeerStar, LLC — Concordville
- PROA – phone interview

Acronyms Used in this Report

ACT – Assertive Community Treatment

BDAP - Bureau of Drug and Alcohol Programs

CSAT - Center for Substance Abuse Treatments

CMS - Centers for Medicare and Medicaid Services

COAPS - Certified Older Adult Peer Specialist

CEU – Continuing Education Unit

CPS – Certified Peer Specialist

CRS – Certified Recovery Specialist

IC&RC - International Credentialing and Reciprocity Consortium

MCO - managed care organizations

MH – mental health

MHASP - Mental Health Association of Southeastern Pennsylvania

MHTSIG - Mental Health Transformation State Incentive Grant

OMHSAS - Office of Mental Health and Substance Abuse Services

OVR - Office of Vocational Rehabilitation

PRO-A - Pennsylvania Recovery Organizations – Alliance

PCB - Pennsylvania Certification Board

PSI - Peer Specialist Initiative

RCOs - recovery community organizations

RCSP - Recovery Community Services Program

SAMHSA - The Substance Abuse and Mental Health Services Administration

SCA - Single County Authorities

SMI – serious mental illness

SPA - State Plan amendment

SUD – substance use disorder

VA – Veterans Administration

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