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RESEARCH ARTICLE

Emerging Roles for Peer Providers in Mental Health and Substance Use Disorders

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Introduction: The purpose of this study was to identify and assess states with best practices in peer provider workforce development and employment. A growing body of research demonstrates that peer providers with lived experience contribute positively to the treatment and recovery of individuals with behavioral health needs. Increased employment opportunities have led to policy concerns about training, certification, roles, and reimbursement for peer provider services.

Methods: A case study approach included a national panel of subject matter experts who suggested best practice states. Researchers conducted 3- to 5-day site visits in four states: Arizona, Georgia, Texas, and Pennsylvania. Data collection included document review and interviews with state policymakers, directors of training and certification bodies, peer providers, and other staff in mental health and substance use treatment and recovery organizations. Data collection and analysis were performed in 2015.

Results: Peer providers work in a variety of settings, including psychiatric hospitals, clinics, jails and prisons, and supportive housing. A favorable policy environment along with individual champions and consumer advocacy organizations were positively associated with robust programs. Medicaid billing for peer services was an essential source of revenue in both Medicaid expansion and non-expansion states. States' peer provider training and certification requirements varied. Issues of stigma remain. Peer providers are low-wage workers with limited opportunity for career growth and may require workplace accommodations to maintain their recovery.

Conclusions: Peer providers are a rapidly growing workforce with considerable promise to help alleviate behavioral health workforce shortages by supporting consumers in attaining and maintaining long-term recovery.

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INTRODUCTION

Peer providers are individuals who provide services in behavioral health settings—both mental health and substance use disorders (SUDs) treatment—based on their own experience of recovery from mental illness or addiction and skills obtained from formal peer provider training.[1] They are part of the transformation of behavioral health care into a "recovery-oriented" model of care. Traditional mental health care focuses on treatment and control of symptoms of mental illness and

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addiction with services primarily provided by licensed professionals. By contrast, the recovery model focuses on maintaining long-term recovery past acute crises.[2] Key components of this model include empowering and involving consumers of behavioral health services in shaping their own care and the integration of peer providers into the workforce supporting recovery and resilience.[3,4]

In 1999, Georgia was the first state in the nation to include mental health peer providers in its Medicaid plan as a billable provider type.[5] In 2007, the Centers for Medicare & Medicaid Services issued a letter to state Medicaid directors authorizing them to bill Medicaid for peer provider services under particular conditions, including the establishment of statewide training and certification and supervision of peer providers by "competent mental health professional(s)."[6] By 2016, a total of 42 states and the District of Columbia had adopted statewide certification and training for peer providers and Medicaid reimbursement for mental health peer support.[7] Only 11 states have provisions for Medicaid billing for SUD peer support.[8] In 2015, there were an estimated 25,417 certified mental health peer support specialists in the U.S.[9] There are no similar nationwide numbers available for SUD peer providers.

The Centers for Medicare & Medicaid Services rationale for authorizing Medicaid billing for peer support cited studies that established peer support as "an evidence-based mental health model of care."[6] Peer providers are thought to be effective because their lived experience allows them to establish a rapport with consumers. This rapport includes promoting belief in the recovery process and demonstrated success in self-efficacy and management of one's own recovery.[10] Findings from numerous RCTs suggested the potential for peer providers to improve outcomes, including reducing hospitalizations, enhancing self-efficacy and quality of life, and increasing patient activation.[10–16]

Despite the spread of peer provider programs, the integration of peer providers into traditional settings still faces challenges of poorly defined roles, client–staff boundary issues, lack of workplace accommodations, variation in training and work experience, and workplace stigma.[17–23] Peer providers often receive lower pay than comparable non-peer staff and experience limited career mobility.[24–26]

This paper contributes to the literature on peer providers with in-depth research and identification of best practices in utilization of the peer provider workforce based on 194 interviews conducted in four states. The authors make policy recommendations for future employment of peer providers in behavioral health settings.

METHODS

Researchers used a comparative case study design to examine four states with best practices in peer provider employment, via comprehensive site visits to study peer providers in mental health and SUD settings.

An expert panel was convened telephonically in February 2015 to provide guidance in selecting states for the case studies. The expert panel consensus was that Arizona, Georgia, Texas, and Pennsylvania were among the leading states in the employment and training of peer providers and thus were selected for the case studies. Researchers contacted state officials, certification boards, training organizations, and provider organizations in these four states to gather preliminary information about their peer provider models. Some key informants and provider organizations were suggested by panelists whereas others were suggested by state behavioral health departments and web searches.

Three- to 5-day site visits were scheduled in 2015 with four to nine organizations per state. During site visits, teams of two to four researchers toured facilities and conducted semi-structured interviews with individuals in training and certification bodies, state agencies, and provider organizations. Interviewees included policymakers, training and certification specialists, peer providers, supervisors, and managers in peer-run, recovery-focused, and traditional treatment settings. In-person visits enhanced rapport with interviewees and allowed researchers to observe the sites and communities in which interviewees worked. A total of 194 individuals at 29 organizations were interviewed. At least two researchers attended each interview and took detailed notes. Background information, such as staffing counts, billing and reimbursement information, job descriptions, and program brochures, was also collected.

In 2015, interview notes were coded for key themes by state using Atlas.ti software, version 8. Themes were compared across the four states for similarities and differences. All members of the research team participated in the coding and development of the key themes.

The IRB at the University of California, San Francisco, approved this study. All research participants consented to participation.

RESULTS

Several key themes in the four study states have implications for the growth of peer provider employment nationwide: roles and job descriptions in various employment settings; training and certification approaches; billing and reimbursement for peer providers; workforce and career development; and maintaining recovery, addressing boundaries, and stigma.

Diverse Employment Settings and Roles

Across the four states, peer providers were employed in a variety of settings and sectors, including non- and for-profit organizations and government agencies. Some organizations were peer run and staffed. Clinical settings included mental health clinics, detox and rehabilitation centers, crisis stabilization units, and psychiatric

hospitals. Non-clinical settings included peer-run respites, community centers, supportive housing, and sobering houses. Many peer providers spent most of their time meeting with consumers in the community or at a facility, such as a jail, prison, or probation center; mental health, family, or drug court; or hospital or primary care clinic. Typical job duties included leading wellness groups, teaching classes, case management, and one-on-one services, including referrals to housing, jobs, and other resources; financial counseling; wellness coaching; accompanying consumers to appointments; and emotional support provided in-person or telephonically. Documentation accounted for a significant portion of time for peer providers in Medicaid-billable positions.

Examples from each of the states illustrate the variety of peer provider roles and settings. Pennsylvania had a number of forensic peer provider programs, including one deployed by a private organization providing peer support re-entry services in local Pennsylvania county jails. Texas had a robust peer provider program inside some of its state psychiatric hospitals, including support groups, art activities, and one-on-one peer support. Arizona had peer providers working with tribal organizations and on reservations with a focus on stigma reduction and outreach. Georgia created a certification for Whole Health and Wellness Coaches who assist mental health consumers in setting and maintaining health and wellness goals, accessing resources, and managing stress in coordination with a nurse or primary care provider.

Training and Certification Approaches

In order to include peer providers in a state Medicaid plan, there must be a state-approved training and certification program.[6] The four states chose different approaches to approving curricula and exams, certification, and selecting training vendors.

Georgia and Texas each selected a single training vendor for mental health peer providers and used a customized version of the Appalachian Consulting Group curriculum. Georgia had a single vendor for training SUD peer providers (Table 1). This approach provided statewide consistency in training and curricula, but sometimes limited access to training. By contrast, Pennsylvania designated two training vendors for mental health; Pennsylvania and Texas designated multiple vendors for SUD peer providers, specifying core competencies (Pennsylvania) or a single curriculum (Texas) for all vendors. Arizona had multiple authorized training vendors and did not distinguish between mental health and SUD peer providers in training and certification. However, each organization's curriculum, competency exam, and exam scoring methodology had to be reviewed and approved by the state. Some interviewees reported that multiple training vendors fostered healthy competition, innovation, and greater access, whereas others felt it created a lack of consistency in screening and training standards.

Training hours varied across states, ranging from 40 to 75 hours. In Texas, SUD peer provider certification curricula and examinations are aligned with standards developed by the International Certification & Reciprocity Consortium, which provides limited reciprocity across states and greater oversight and accountability within states.

Peer providers were enthusiastic about the training they had received and the networking opportunities it provided, but felt they needed ongoing training in documentation.

Funding Mechanisms for Peer Support

Funding mechanisms for peer support evolved from a reliance on grant funding to increasing use of Medicaid billing and Medicaid managed care contracts. Medicaid reimbursement created a new funding stream to support peer support services and helped expand the workforce in organizations eligible to bill Medicaid for peer providers. In Medicaid expansion states, Medicaid payments were reported to cover much of the cost of employing peer providers. In non-Medicaid expansion states, funding for peer support was more reliant on state general revenues and state and federal grants.

There was state variation in billing for SUD peer provider services. Georgia and Arizona billed Medicaid for SUD peer providers. Neither Pennsylvania nor Texas could do so because SUD peer providers were not included in their state Medicaid plans. Interviewees in Pennsylvania and Texas credited the lack of growth in their SUD peer provider workforce to this non-inclusion, although some Medicaid MCOs in these states contracted with employers of peer providers, providing a payment mechanism for SUD peer support.

Interviewees reported that Medicaid billing requires extensive documentation. Many reported difficulties, with some peer providers' lack of computer experience and knowledge of billing terminology with incorrect documentation leading to negative financial ramifications. Peer providers reported concerns about the impact of time-consuming documentation on their relationships with consumers. Some peer-run organizations chose not to bill Medicaid for peer support because of concerns that documentation and clinical supervision requirements might compromise their philosophy of peer support, which is rooted in mutuality.

Workforce and Career Development

All four states had some type of policy mandating the hiring of peer providers. In Arizona and Georgia, this was

Table 1. State Comparison: Training and Certification

Category	Arizona	Georgia	Pennsylvania	Texas
Mental health				
Title	Peer Support Specialist	Certified Peer Specialist	Certified Peer Support Specialists	Certified Peer Specialist
Year statewide certification instituted	2012	2001	2007	2009–2010
No. of peer providers certified 2016[a]	2,524[b]	1,700	4,389	750
No. of authorized training vendors	16[b,c]	1	2	1
Training hours	Varies	40	75	43
Substance use disorders				
Title	Peer Recovery Specialist	Certified Addiction Recovery Empowerment Specialists	Certified Recovery Specialist	Peer Recovery Support Specialists
Year statewide certification instituted	2012	2011	2008	2012
No. of peer providers certified 2015	2,524[b]	310	535	460
No. of authorized training vendors	21[b,c]	1	6	180
Training hours	Varies	40	54	46

[a]Because accurate data were not available from state sources, authors utilized information from Wolf J, Jones N, Rosen C. The national peer career development project state certification survey results. September 2016.
[b]Arizona does not differentiate between mental health and substance use disorder in training and certification.
[c]Arizona now has 21 vendors. Updated information on number of vendors can be found in Kaufman L, Kuhn W, Stevens Manser S. University of Texas at Austin. Peer specialist training and certification programs: a national overview. 2016.
No., number.

the result of class action lawsuits; in Texas and Pennsylvania it was a policy developed through a behavioral health care transformation initiative (Table 2). Interviewees reported that hiring mandates increased peer provider employment in traditional behavioral health settings, but that these organizations needed to prepare staff and supervisors to integrate peer support successfully. For example, Pennsylvania's Office of Mental Health and Substance Abuse Services provided outreach and technical assistance in order to help organizations develop a welcoming environment for peer providers.

Peer providers' wages were reported to be low in all of the states. As the demand for peer providers increased, some organizations were adjusting pay and benefits in order to retain staff. Low wages were compounded by the part-time nature of much peer provider employment. Peer providers reported working part-time for the following reasons: (1) out of choice because of their own recovery issues; (2) to not exceed thresholds for disability benefits; (3) the perception that employers did not want to pay benefits available to full-time workers; and (4) lack of available full-time positions.

Career advancement opportunities for peer providers were generally limited to advancement to supervisor. One large Arizona organization and Texas state psychiatric hospitals had multistep career ladders, but these were exceptions. A few employers supported career advancement by providing tuition support for degree programs. State policies played a role in promoting career advancement for peer providers. Pennsylvania added the certified peer specialist category as a civil service classification, developed a certified peer specialist supervisor category that recognized different combinations of experience and education, and provided supervisor training. Texas's three-tiered peer specialist classification in its state hospital system was expected to be adopted by local Mental Health Authorities in the future. The Arizona Department of Health Services/Division of Behavioral Health funded Arizona State University to develop a Peer Career Advancement Academy to provide additional training to advance certified peer providers' careers.

Maintaining Recovery and Addressing Boundaries and Stigma

A critical component of the peer provider role is having adequate time and resources to maintain one's own recovery. Peer support requires a balance of empathy and self-disclosure while maintaining professional boundaries with consumers. This requires skillful negotiation by individuals who are themselves in recovery and may experience relapse. This component was highly emphasized in all the training programs. Some employers

Table 2. State Comparison: Factors Impacting Billing and Hiring

Category	Arizona	Georgia	Pennsylvania	Texas
Medicaid expansion state	Yes	No	Yes	No
Year CMS authorized billing for MH peer providers	2007	1999	2007	NA
Year CMS authorized billing for SUD peer providers	2007	2012	–	–
Average peer specialist salary by HHS/SAMHSA region 2015[a]	$15.27	$14.83	$14.72	$15.69
Common billing codes	H0038[b] H0038 HQ[c] H2016[d]	H0038[b] H0038 HQ[c] H0025[e]	H0038[b] H0038 GT[f]	H2017[g] H2014[h]
Source of peer hiring mandate	Lawsuit: *Arnold v. Sarn*	Lawsuit: The Civil Rights of Institutionalized Persons Act (CRIPA) of 1980	Pennsylvania Office of Mental Health and Substance Abuse Services: BH transformation initiatives	Texas State Department of Health Services: Texas Recovery Initiative
Description of hiring mandate	State must provide peer and family support services	Most state-funded behavioral health agencies required to hire at least 2 FTE peer providers	Each county is required to make peer support available as part of its mental health services	22 SUD recovery agencies receiving grants must hire peer providers

[a]Daniels A, Ashenden P, Goodale L, Stevens T. National survey of compensation among peer support specialists. www.leaders4health.org. The College for Behavioral Health Leadership. Published January 2016.
[b]Peer support, one-on-one.
[c]Peer support, group.
[d]Comprehensive community support services (peer support)—3 or more hours in duration.
[e]Behavioral health prevention education service (whole health and wellness coaching).
[f]Peer support, telephonic.
[g]Psychosocial rehabilitation services.
[h]Skills training and development.
BH, behavioral health; FTE, full-time equivalent; CMS, Centers for Medicare & Medicaid Services; FTE, full-time equivalent; HHS, Department of Health and Human Services; MH, mental health; NA, not applicable; SAMHSA, Substance Abuse and Mental Health Services Administration; SUD, substance use disorder.

responded to this need for accommodations in leave of absence policies and the peer supervision process. One-to-one or group supervision was provided to peer providers in all of the sites visited. It included checking in on one's recovery, additional training such as documentation, and client updates. However, several human resources interviewees reported that peer support staff required no more accommodations than any other staff.

The perception of stigma is an important issue in the peer provider role according to many interviewees. Peer providers in peer-run organizations reported less difficulty with stigma. Stigma may include labeling, stereotyping, and discrimination internalized or experienced.[27] Problems with acceptance and stigma were reportedly more common when peer providers needed to interact with non-peer staff in clinical and forensic settings. Some non–peer-run organizations required staff and leadership to attend training on the peer provider role in order to address issues of stigma before introducing peers.

DISCUSSION

The growth of peer provider employment is related to increased acceptance of the recovery model of care and enhanced focus on empowering consumers to manage their own recovery. Job growth in the four case study states was driven by a number of factors, including strong consumer advocacy groups and champions within state government; increased insurance coverage because of Medicaid expansion under the Affordable Care Act (in Pennsylvania and Arizona); behavioral health workforce shortages; Substance Abuse and Mental Health Services Administration grant programs[8]; class action lawsuits; and hiring mandates.

The relationship between certification, training, and employment growth is unclear. Although a recent study estimated that the number of mental health peer provider certifications grew in the U.S.,[9] there is little research on how many are employed. Better tracking of the employment of peer providers would assist in workforce planning across states. Tracking could be done through licensing boards, by state agencies, or in partnership with external research organizations, such as universities.

Certification encourages standardization and professionalism that may enhance peer provider status and wages and ensure higher quality care. However, some peer provider advocates have concerns that certification and professionalization might harm the essence of peer provision and limit entry into the field. This concern is discussed in previous research.[19,28]

Differing training and certification standards across states mean that peer providers cannot easily transfer their credentials to another state. Twenty-five states offer reciprocity through the International Certification & Reciprocity Consortium, which is largely used for SUD peer providers. Mental Health America has recently announced a National Certified Peer Specialist Certification designed to exceed standards in public behavioral health and open career pathways in the private sector.[29]

Medicaid payment plays a large role in peer provider employment. Only three U.S. states have not yet adopted the statewide certification and training protocols necessary to bill Medicaid for peer support.[7,9] Medicaid expansion was reported as a factor in increasing peer provider employment in Pennsylvania and Arizona. The uncertain future of state Medicaid programs likely has an important impact on the employment of peer providers.

The use of peer support in forensic settings is particularly promising as many incarcerated individuals also have mental illness or SUDs or both. Innovative partnerships like that between Pennsylvania's Office of Mental Health and Substance Abuse Services and the Department of Corrections, in which prison inmates are trained and certified as peer providers eligible for civil service employment on release,[30] and the private program visited that utilized peer providers to work with inmates in Pennsylvania county jails, should be explored by other states. State and county regulations barring employment of those with criminal records and that disallow ex-offenders from entering jails and prisons make it difficult to implement forensic programs. States that have found a successful model of hiring individuals with a history of criminal convictions may be helpful to other states that experience barriers.

Although employment is part of recovery for many with lived experience, the quality of peer provider positions is diminished by low wages,[31] workplace stigma, and few career advancement opportunities. Some employers are actively addressing these issues by developing career ladders and dedicating resources to staff and leadership training on the role of peer providers. In states that were early adopters of peer provider programs, state-level organizations led trainings on organizational transformation prior to the introduction of peer providers into traditional behavioral healthcare workplaces. Despite these efforts, researchers heard from many interviewees that stigma in the peer provider role continues. This may be partially because of a misunderstanding of the peer provider role and partially fear of encroachment of traditional provider roles. These encroachment concerns are similar to those reported for other growing non-licensed roles, such as community health workers[32] and medical assistants.[33]

Although there are studies of the efficacy of peer providers, much of this research has been limited by small sample sizes and other methodologic issues.[34–37] There is even less research on SUD peer providers.[8] Additional research may be helpful to better understand both workforce issues and peer provider impact on behavioral health outcomes.

Limitations

This study focuses on four states that are frontrunners in peer provider employment. Each state has a different cultural and policy environment and some findings may not be generalizable. Data on states and organizations is self-reported and could not always be independently verified. Peer providers working in states with less developed peer provider policies may have different experiences than those in these four states.

CONCLUSIONS

Peer provision is a rapidly growing occupation with considerable promise to help alleviate the behavioral healthcare workforce shortage by supporting consumers in maintaining long-term recovery. Peer providers can aid organizations in establishing rapport with consumers, sensitizing treatment staff to consumer needs, and encouraging a recovery-oriented culture that allows for self-disclosure and self-care for all staff. Growth of the peer provider profession can be facilitated by continued improvement of training and certification, addressing wages and benefits, tracking of long-term employment outcomes, facilitation of documentation skills, revision of regulations that create barriers to practice, and education of behavioral health leaders in the capacity of peer providers to help those with mental health and SUD treatment needs.

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