Peer Support Services in the Behavioral Healthcare Workforce: State of the Field

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Objective: This article examines how the history and philosophy of peer support services has shaped current mental health and substance use service delivery systems. The growth of peer-run and recovery community organizations in the changing health care environment are discussed, including issues related to workforce development, funding, relevant policies, and opportunities for expansion. These initiatives are designed to increase access to recovery-promoting services. *Methods:* We conducted an environmental scan and analysis of peer support services within the behavioral health care field in the United States, with particular attention to initiatives of the Substance Abuse and Mental Health Services Administration. Published manuscripts, policy statements, and reports were reviewed. *Findings:* There is abundant and growing literature illustrating how peer support services have become an integral component of behavioral health care systems in many states. Peer support services have the potential to increase access to recovery-oriented services for people with mental and substance use disorders served by the public behavioral health care system. Numerous initiatives in various states are being undertaken to build this workforce. *Conclusions and Implications for Practice:* Workforce and financing challenges exist, yet opportunities, including among others those made possible by the Affordable Care Act, will continue to strengthen the peer support workforce within behavioral health service delivery systems.

Keywords: peer support, mental health, recovery, Affordable Care Act, peers

History of Peer Support Services

In the mid-1970s, the emergence of self-help and advocacy organizations, whose members included people with lived experiences of mental disorders and substance use disorders (SUDs), created a more conducive climate for growth of the peer support model (Davidson, Chinman, Sells, & Rowe, 2006). Peer support services took the form of self-help groups, consumer- or peer-operated services, and other organizations where peers supported each other (Grant, Reinhart, Wituk, & Meissen, 2012; Salzer, 2010). The earliest known peer support and advocacy organization in mental health was the Alleged Lunatic Friends Society, begun in England around 1845 by John Perceval, a tireless advocate for reform (Podvoll, 2003). Peer support service models continued to develop through the efforts of Dr. Abraham Low in Chicago, who in 1937 established Recovery Incorporated in an effort to help people make the adjustment from the hospital to community settings through mutual support and encouragement (Low, 1991). Now called Recovery International, the organization has provided their tools and self-help training to over one million people worldwide (Recovery International, 2016).

An early peer advocate and author, Judi Chamberlin, in her seminal work *On Our Own,* suggested that peers direct the course of their own care (Chamberlin, 1978). Chamberlin's work led to a model of empowerment and self-direction, which ultimately became the foundation for recovery-oriented programs and subsequently for mental health systems transformation efforts that have taken hold within the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA; U.S. Department of Health & Human Services, 2015a). Systems transformation efforts and a paradigm shift toward recovery gained added traction through two influential reports issued by the U.S. Surgeon General, which summarized advances in understanding mental health, the centrality of mental health to overall health and well-being, the importance of a focus on recovery, remaining disparities, and other gaps in the access to care (President's New Freedom Commission on Mental Health, 2003; U.S. Department of Health & Human Services, 1999).

Philosophy, Delivery, and Benefits of Peer Support Services

Peer support is rooted in the idea that people who share similar experiences can offer help, empathy, validation, information, and hope for another person pursing recovery (Dennis, 2003). SAMHSA defines *peers* as persons in recovery from mental disorders or SUDs, or, in the case of family peer support, a family member of a person living with a behavioral health condition (U.S. Department of Health & Human Services, 2015b). *Peer support* in the mental health field has been defined by several authors (e.g.,

Chinman et al., 2014; Salzer, 2010) and can largely be seen as a process of giving and receiving support, founded on the key principles of respect, shared responsibility, and mutuality (Mead, 2003; Solomon, 2004). Salzer (2010, p. 169) described the peer support relationship as that which involves an "intentional relationship between individuals with mutually perceived similarities based on personal characteristics and experiences," while Chinman and colleagues state that peer support services "assist in developing coping and problem-solving strategies for illness self-management; draw on lived experiences and empathy to promote hope, insights, skills; help engage in treatment, access community supports, [to] establish a satisfying life" (Chinman et al., 2014, p. 430). While peer support services for chronic medical conditions such as cancer, diabetes, and asthma have been widely accepted (Carlson, Rapp, & McDiarmid, 2001), in behavioral health, peer support seems to present more complex issues that may have impeded its growth.

Peer providers are defined by SAMHSA as "a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience" (U.S. Department of Health & Human Services, 2015c).[1] Individuals providing peer support services use their lived experiences to inform their work, to provide benefits to people in recovery and behavioral health programs, and for their own recovery. Over the past decade, peer support services have grown to become an integral component of the behavioral health care system, which is evolving toward a recovery-oriented system and which aims to integrate mental health and substance use services into an individualized, person-centered framework (Kaplan, 2008; Sheedy & Whitter, 2009).

A review of qualitative research emphasizes that peer-delivered services should be supportive rather than directive and that reciprocity and empathic human relationships are central components (Miyamoto & Sono, 2012). Blanche, Filson, and Penny (2012) further clarified the core principles and values of peer support as being voluntary, nonjudgmental, empathic, respectful, requiring honest and direct communication, mutual responsibility, power-sharing, and reciprocity. The role of peer support specialists varies widely by setting, service model, credentials, and field (Allen, Radke, & Parks, 2010). Peers may serve as a certified and paid provider or as a volunteer. They may be called peer support specialist, peer mentor or counselor, recovery support specialist, recovery coach, client liaison, peer bridger, family support navigators, or a number of other terms used to describe such roles (Allen, Radke, & Parks, 2010; Cronise, Teixeira, Rogers, & Harrington, 2016).

In the substance use arena, peer support services are often referred to as recovery coaching and are defined as the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term SUD recovery (Laudet & Humphreys, 2013). This support is provided by individuals who have the experiential knowledge (Borkman, 1999) to assist others in initiating and maintaining recovery and in enhancing the quality of their personal and family lives (White, 2009). In the mid-20th century, The Alliance Project emerged as a powerful voice for advocacy and raising awareness, leading to the 2011 Recovery Summit that founded *Faces and Voices of Recovery* (Faces and Voices of Recovery, 2013). Because substance use services are gradually adopting a recovery-oriented system of care framework, there is growing emphasis on incorporating various forms of peer support that are tailored to individuals' recovery stages, needs, and chosen recovery pathway—with a goal of promoting and a better life (Clark, 2007; Clark, 2008).

The literature has historically divided service settings for peer specialists into different categories. In mental health, peer support services have been described as generally occurring in three different service settings: (a) naturally occurring mutual support groups; (b) consumer-run services; and (c) clinical and rehabilitative settings that employ peers as providers (Davidson et al., 1999; Salzer, Schwenk, & Brusilovskiy, 2010; Cronise et al., 2016). In the substance use field, peer support specialists (known as recovery coaches) generally provide peer support services within three distinct program models: (a) the clinical model, where the recovery coach is typically an addictions counselor who supports clients before, after, and during addiction treatment; (b) the community development model such as recovery community organizations, where the community is an important part of recovery and the recovery coach is an active member of the community; and (c) the business model, where independent for-profit entities employ recovery coaches to deliver fee-for-service recovery support services (White, 2010). The continuing growth and expansion of peer-provided support has created a gap in our understanding of these evolving roles and service delivery settings. For example, peers are integrated into care teams in new settings, such as emergency departments (Migdole et al., 2011) and state psychiatric hospitals (Unger, Pfaltzgraf, & Nikkel, 2010). Furthermore, peers are delivering wellness coaching services to help individuals in their pursuit of individually chosen health and wellness goals (Swarbrick, Murphy, Zechner, Spagnolo, & Gill, 2011). Clearly, the settings in which peer specialists provide support range greatly from mental health outpatient and inpatient facilities, jails and prisons, substance use treatment services, recovery communities and consumer-run programs, hospitals and patient-centered medical homes, community health centers, and more (Cronise et al., 2016; Salzer et al., 2013).

In addition to the growing information about settings, roles, and job titles for peer specialists, numerous benefits of peer support services have been documented. Despite methodological challenges in conducting research on peer-delivered services, Chinman and colleagues (2014) observed in a literature review of their effectiveness, that:

> across the service types, improvements have been shown in the following outcomes: reduced inpatient service use; improved relationship with providers; better engagement with care; higher levels of empowerment; higher levels of patient activation; and higher levels of hopefulness for recovery. (p. 439)

These conclusions suggest that peer support services are a means to support recovery after treatment and to help people attain other goals such as employment, education, housing, and social relations (Laudet & Humphreys, 2013).

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[1] The term peer support specialist is used to denote a person with a lived experience who provides support to another person in recovery. We recognize that although this may be the most commonly used job title, often it is used interchangeably with other terms such as peer supporter, peer specialist, and so on. This range of job titles is described later in the article.

SAMHSA's Role in Systems Reform for Peer Services

In 2011, SAMHSA and a host of partners in the behavioral health care community and other fields developed a working definition of recovery that captures the essential, common experiences of those recovering from mental disorders and SUDs, along with the foremost guiding principles that support the recovery definition (U.S. Department of Health & Human Services, 2015a). These guiding principles and definitions lay the groundwork that has and will continue to guide the development of the peer specialist workforce.

To further promote a more recovery-oriented system with peer support specialists as an integral component, SAMHSA has facilitated the development of programs, including statewide consumer networks, which now exist in nearly every state and are designed to enhance mental health consumer-run and -controlled organizations. These consumer networks promote service system capacity and infrastructure development that is consumer-driven, recovery-focused, and resiliency-oriented (U.S. Department of Health & Human Services, 2015d). The growth of peer support services models and practices have also been facilitated by grant programs that have promoted activities such as developing partnerships with families, young adults and peers in addiction recovery, the development of peer support values and standards, and trauma-informed peer support. In addition, SAMHSA currently funds four national consumer and consumer/supporter technical assistance centers to foster self-help, recovery-oriented approaches to services, systems transformation, and to provide mental health information to others (U.S. Department of Health & Human Services, 2015d).

Workforce Challenges

In 2007, the Centers for Medicare and Medicaid Services (CMS, 2007) stipulated that "peer support providers must complete training and certification as *defined by the State*" (p. 3), which may have inadvertently led to variation in training programs across the country. The authors' scan suggests that no single national training and certification process exists for peer support specialists. Instead, there is a patchwork of state, private, and nonprofit training and certification programs, and no national standards defining core competencies of peer support specialists currently exist. Nor is there a national consensus about what those core competencies, training, and certification requirements should be. This lack of consensus about competencies and training is further compounded by the fact, as described earlier, that peer support specialists work in a broad range of settings, perform a wide range of tasks, and hold many different job titles (Cronise et al., 2016; Salzer et al., 2010). This is exemplified by the results of a 2010 national survey of certified peer specialists, in which 291 respondents reported 105 different job titles (Salzer et al., 2010), with the most common being "certified peer specialist," "peer support specialist," and "certified peer support specialist."

Recognizing the increased importance and varied roles that peers hold in recovery-oriented behavioral health systems, SAMHSA engaged diverse stakeholders nationally to identify the core competencies needed by people who deliver peer support in a wide range of behavioral health services and peer-run and recovery community organizations. These competencies reflect an array of abilities and offer guidance to state, local, and credentialing organizations on the delivery of peer support services. Core compe-

tencies can guide service delivery and promote best practices in peer support. Furthermore, they can be used as a framework for peer training programs, assist in developing standards for certification, and inform job descriptions. Supervisors can use these competencies to appraise peer specialists' job performance, and peers will be able to assess their own work performance and set goals for continued skill and knowledge development (U.S. Department of Health & Human Services, 2015b). Development and promulgation of these core competencies is another important step in the continued advancement of the peer specialist workforce in mental health.

It is important to note that within the substance use field, a distinction is often made between treatment and mutual aid. Treatment typically involves professional providers such as physicians and others, while mutual aid is thought of as nonclinical, peer support. As a result of this distinction, peers have not been fully integrated into the SUDs continuum of care (White, 2010). The literature on workforce issues facing peer support specialists focuses largely on peer specialists in mental health services, neglecting the peer workforce in SUDs. Furthermore, in contrast to the mental health field, there is a strong focus on the community of peers as a source of support—rather than the individual recovery coach—and a strong ethic of volunteerism (White, 2010). In 2011, Faces and Voices of Recovery initiated the process of gaining stakeholder feedback about the need for and development of an accreditation process resulting in the creation of the Council on Accreditation for Peer Recovery Support Services in 2013 which is the first national accrediting body for peer recovery support in the substance use field (Peers for Progress, 2014). The purpose of accrediting recovery programs and organizations, rather than certifying individuals, was to capitalize on organizations' and programs' ability to provide oversight and delivery of wide array of peer services and activities (Burden, Hill, & Zastrowny, 2012).

Factors Predicting Job Satisfaction Among Peer Specialists

Generally, peer specialists report high satisfaction with their job duties and work environment (Chang, Mueller, Resnick, Osatuke, & Eisen, 2016; Cronise et al., 2016; Johnson et al., 2014). However, peer support specialists, along with professional and administrative staff within programs employing peer specialists, identify various challenges and barriers. A review of the literature suggests that much of the responsibility for maintaining successful employment as a peer support specialist falls to the workers themselves (e.g., advocating for oneself in the face of discrimination, requesting reasonable accommodations; Bluebird, 2004; Singer, 2011). Peer support specialists may experience discrimination from non-peer staff with respect to their ability to work in different environments and express concerns over low pay compared with their colleagues (Allen, Radke, & Parks, 2010; Cronise et al., 2016). Role conflict and ambiguity, as well as boundary issues, are also seen as ongoing challenges (Carlson et al., 2001; Gates, Mandiberg, & Akabas, 2010; Moran, Russinova, Gidugu, & Gagne, 2013). Often, a lack of clear job descriptions and resulting role confusion has resulted in uncertainty about how much of their lived experiences to share (Alberta, Ploski, & Carlson, 2012). Pay equity is critical because the peer support workforce has histori-

cally been paid relatively low wages (Creamer et al., 2012; Cronise et al., 2016).

Effective integration of peer support services and specialists requires consideration of the work role, unique needs of the worker, and the overall workplace environment. Because of differences between more medically-oriented clinical approaches and recovery-oriented approaches in treatment settings, integrating peers into the workforce can be challenging (Moran et al., 2013). Integrating peer providers is a process that evolves over time and does not end with hiring (Moll, Holmes, Geronimo, & Sherman, 2009). Both SAMHSA and the Department of Veterans Affairs are leading efforts to integrate greater numbers of peers into the workforce (U.S. Department of Health & Human Services, 2013; White House, Office of the Press Secretary, 2014).

Continuing Efforts by SAMHSA to Address Peer Specialist Workforce Issues

SAMHSA continues to build resilience and recovery-oriented services by developing, promoting, and disseminating effective policies and practices to support the development and expansion of addiction and mental health recovery support initiatives and strategies (U.S. Department of Health & Human Services, 2015a). Examples of these efforts include the sponsorship of national symposia to build a shared understanding of the diverse current and future peer provider workforce in behavioral health through a framework of peer core competencies and provider practice guidelines. In 2014, SAMHSA conducted three "Policy Academies" designed to bring key leaders from states, tribes, and territories together for training and technical assistance to develop, expand, or enhance recovery-oriented systems and services. Policy Academy participants received expert facilitation, technical consultation, and other support to help their team develop and implement outcome-focused Action Plans in their jurisdiction. SAMHSA has also supported 20 states with training and technical assistance to expand recovery support efforts. Examples of state-specific impacts include increased peer roles in recovery-oriented systems, increased numbers of trainings and certified peers specialists, increased reimbursable peer delivered support services, and the involvement of state agencies to support and promote financing peer support services (Center for Social Innovations, 2014).

Financing Challenges and Opportunities

Georgia was among the first states to implement peer specialist services in 1999 and became the first state to identify peer support services as a Medicaid-fundable service in 2001(Sabin & Daniels, 2003; Salzer et al., 2010). In 2007, CMS published a letter to State Medicaid Directors that defined reimbursable peer support services as "an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders" (p. 1). This memorandum designated peer support as a billable service and outlined the minimum requirements needing to be addressed as well as the Medicaid funding states could use to support peer services. As of 2014, there are 36 states that bill Medicaid for mental health peer support services and at least 11 states that are able to bill for peer support in SUD or co-occurring conditions (Kaufman, Brooks, Bellinger, Steinley-Bumgarner, &

Stevens-Manser, 2014). Furthermore, efforts were also made available in other sectors of health, including the Department of Veterans Affairs who launched the largest-ever national effort to promote and adopt peer support in 2012 (Department of Veterans Affairs, 2013). By 2015, the number of peer support specialists for veterans increased from 91 in the base year to over 1,000 across the United States (Davidson, 2015).

States and peer-run/recovery community organizations are increasingly taking creative approaches to financing peer services. As described previously, Medicaid has been a major source of funding for peer support services since 2007, and various states include peer support under their Medicaid program using the following authorities: Section, 1905(a)(13), 1915(b) Waiver Authority, 1915(c) Waiver Authority, and Section, 1915(i) Deficit Reduction Act Authority (CMS, 2007). In addition, behavioral health managed care organizations (MCOs), are increasing opportunities to fund peer support services, mostly in mental health but increasingly for substance use and/or co-occurring disorders (Sabin & Daniels, 2003).

Fewer funding sources for peer-delivered recovery support services in addictions exist, and many Recovery Community Organizations struggle to be financially sustainable. Most recovery coach training programs in addictions require trainees to fund their own training (Gagne, Olivet, & Davis, 2012). SAMHSA has been a major source of funding, enabling states and community organizations to provide peer-delivered recovery support services for individuals with SUDs, via the Access to Recovery (ATR) and Recovery Community Services Program (RCSP) initiatives, respectively. States have also used general funds and dollars from the Substance Abuse Prevention and Treatment (SAPT) Block Grants to support peer services (U.S. Department of Health & Human Services, 2011).

Influence of the Affordable Care Act (ACA)

With the passage and implementation of the ACA, Medicaid expansion, and parity for mental health and substance use services (defined as "essential benefits"), the U.S. health care system is undergoing a transformation toward a more integrated, person-centered model of care. The ACA includes provisions to address the needs of people with multiple, complex, chronic conditions, such as serious mental illness, SUDs, and co-occurring disorders, including patient-centered health homes and Accountable Care Organizations (National Council for Community Behavioral Healthcare, 2011). Peer providers roles and scope are expected to expand to meet the demands created by ACA's emphasis on the integration of primary and behavioral health. To provide support for people with behavioral health and complex medical conditions, peers are providing services and supports as whole health coaches (Tucker et al., 2013) and peer wellness coaches (Swarbrick et al., 2011; Swarbrick, 2013). It is expected that the demand for peer support specialists will increase as Medicaid expands, as more states offer peer support as a Medicaid-reimbursable service, and as peer roles related to patient-centered medical homes and community health workers grow (Peers for Progress, 2012). Current shortages in the behavioral health workforce, together with growing demand as Medicaid expands under the ACA, may make it increasingly difficult to access care.

In addition, the ACA uses and defines the term "community health worker" to describe a role that can be provided by peer support specialists in a variety of settings (H. R. 3590-11th Congress: Patients Protection and Affordable Care Act 2009). The National Peer Support Collaborative Learning Network (NPSCLN) recognized that peer support has been effective in improving quality of care, lowering health care costs, and reducing disparities. The NPSCLN identified a number of opportunities within state and local governments to fund programs related to community health workers, thus presenting prospects for peer support leaders to work collaboratively in the their states and local communities on the planning process. *Faces and Voices of Recovery* also noted that ACA provisions encourage people to manage their own health and provide an opportunity for individuals to actively engage in decisions about their recovery, principles and values that are consonant with peer support (Faces and Voices of Recovery, 2013).

Recognizing the significant role that peer support services will play in the transformation created by the ACA, SAMHSA has been assisting states to integrate peer providers in service delivery systems in ways that are compatible with this new legislation. SAMHSA has provided states with training and technical assistance for health reform education to increase access to health care and build the capacity of peer-run and recovery community organizations nationwide. In addition to these state-level efforts, other similar efforts have been awarded to peer-run and recovery community organizations to promote peer delivered supports for people in recovery from mental health and substance use conditions (Center for Social Innovations, 2014). In 2012, Medicaid approved Georgia as the first state to offer whole health and wellness peer support services provided by certified peer specialists (Canady, 2013). Peer support specialists help other peers to effectively deal with chronic health and behavioral health conditions. Michigan has been utilizing Certified Peer Support Specialists (CPSS) within Federally Qualified Health Centers (FQHC) to assist people with behavioral health issues and at least one physical health condition; services that can be underwritten by Medicaid along with other funding. The CPSS help with self-management of chronic conditions, providing health and wellness services and assistance navigating various health systems (Canady, 2013). CMS services also require that new "health home" applications include peer support services (U.S. Department of Health & Human Services, 2012).

Summary

Much has been accomplished yet much remains to be addressed to successfully integrate peer support services into the behavioral health workforce. Peer specialists offer unique supports to people in recovery by using their lived experience and stories to guide, support, and inform others while building authentic relationships. The role of peer specialists varies widely by setting, service model, credentials, and field; roles range from providing services in mental health outpatient and inpatient care, substance use treatment services, recovery communities and consumer-run programs, hospitals and patient-centered medical homes, to community health centers and others. These roles and settings will continue to expand under the ACA.

Today, SAMHSA and many others in the mental health field understand the value and unique contributions that peer specialists

can make in promoting recovery. Studies of peer delivered services indicate they can improve relationships with providers, increase engagement with services, increase patient activation and hopefulness for recovery. These findings show promise for achieving other goals such as employment, education, and social relationships (Chinman et al., 2014; Laudet & Humphreys, 2013; Pitt et al., 2013). Given the value of peer support services and the potential for peer support to effect recovery, addressing challenges and taking advantage of opportunities such as the ACA are critical and will require attention to both workforce and funding issues.

This environmental scan and analysis found that while the Medicaid can be used to reimburse peer provided services to date, not all states have Medicaid reimbursable peer services. The ACA provides states the opportunity to fund peer services in integrated primary and behavioral health care settings. One of the largest workforce challenges is the integration of peers into clinical or medical settings. Therefore, to maximize funding sources for peer services through sources such as the ACA, we must address the challenges of role clarity, job descriptions, supervision and training of peers entering the workforce. SAMHSA's peer core competencies can facilitate consistency in training, supervision and the creation of job/role expectations for peer specialists and as a launching point for states or organizations as they develop criteria for peer provided services. But continued attention must be paid to national standards for training and certification of peer specialists.

The ACA, Medicaid, and other funding options have provided the vehicles for states like Georgia and Michigan, as examples, to increase opportunities and improve outcomes for people living with mental illness through peer support. Such programs can improve access to recovery-oriented services as they overcome the challenges in embracing future opportunities. New roles such as community health workers, peer wellness coaches, peer whole health coaches, and peer navigators are also promising opportunities to expand the peer workforce, address workforce shortages, and impact the outcomes of people with behavioral health conditions that also experience complex physical health conditions. These new roles, coupled with expanded access to trained peer specialists across systems, together should increase access to recovery-promoting services for individuals with mental health needs and SUDs.

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