POLICY BRIEF

Peers in the Behavioral Health Workforce: A Qualitative Assessment of Workforce Contributions

Project Team

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Background

Peer support providers, or individuals trained to use their lived experience with mental illness and/or substance use disorders to help others in recovery, are increasingly used in behavioral health treatment, but research evaluating their impact on client outcomes remains mixed.[1] Prior studies to determine the effectiveness of peer providers, or peers, in behavioral health service delivery identify inconsistent training requirements and role definition as barriers to assessing their value.[2] This second year of a two-year study, conducted jointly by the Behavioral Health Workforce Research Center (BHWRC) at the University of Michigan and the University of California-San Francisco Health Workforce Research Center on Long-Term Care (UCSF-HWRC), sought to assess the effectiveness of peers in helping behavioral health clients achieve and maintain recovery. Findings of this study build on a 2020 systematic review of literature on the efficacy of peers in behavioral health treatment.

Methods

A systematic review of literature was conducted during year 1 of the project.[3] These findings informed development of phase two of the project that included key informant interviews and collection of fiscal data. The interview guides included items about role definition, employment history, training, collaboration across provider types, and workforce acceptance of peers. A staffing and financial data request form was created for use with Human Resources and Billing key informants to collect information about organizational costs associated with peer services. A summary of fiscal data is discussed in a separate brief. The financial data collection strategy utilized a 2018 study assessing utilization and economic contribution of psychiatric mental health nurse practitioners as a model.[4]

Organizations offering peer-provided services were identified through a review of the National Mental Health Services Survey (N-MHSS) and the National Survey of Substance Abuse Treatment Services (N-SSATS) results, word-of-mouth references, and general web searches. Introductory calls with organization staff yielded a sample of key informants comprising peers, peer supervisors, managers, clinical directors, billing, and human resources staff. Semi-structured interviews were conducted from March through July 2021. Transcripts were transcribed through Scribie services and thematically coded by two researchers. This study qualified for IRB Category 2 Exempt Certification by both institutions.

Findings

Forty-seven key informants from 9 organizations that bill Medicaid for peer services across Arizona, Georgia, Michigan, Pennsylvania, and Ohio, and 1 key informant from a non-Medicaid participatory Colorado organization, participated in interviews. Seven organizations were nonprofits; 4 of the 10 were consumer-run. Identified populations frequently served by organizations were adult individuals in recovery from a mental health and/or substance use disorder diagnosis, individuals with a serious mental illness (SMI), formerly incarcerated individuals, persons experiencing trauma, and low-income and uninsured populations. Several organizations provide integrated behavioral and physical health services, with most offering referrals to specialized treatment. All 10 organizations offered peer support services via telehealth modalities at the time of interviews, often in response to the COVID-19 pandemic, with methods of care delivery including text-only, audio-only (phone), and audio/video (Zoom, Duo, Google, FaceTime). Professional role titles held by key informants are provided in Table 1.

Table 1: Key Informant Professional Titles

Key Informant Roles	Total Key Informants
Peer	11
Program or Department Director	7
Chief Executive Officer (CEO) or President	6
Manager	6
Program Manager	4
Supervisor	4
Chief Financial Officer (CFO)	3
Chief Operating Officer (COO) or Director of Operations	3
Clinical Director	3
Director of Human Resources (HR)	3
Counselor or Therapist	2
Program Specialist	1

A commonality across key informants was the fluidity of described roles at all levels, with one peer key informant describing herself as a “jack of all trades… open to help every program [run].” Emotional and instrumental support provided individually and in groups were the hallmark of peer-provided services, with multiple peers describing their provided services as “meeting others where they are” and “walking alongside them in their recovery.”

The majority of organizations employed between 2 and 10 peers, with the total number of peers employed ranging from 2 to 148. Titles held by peers were Certified Peer Specialist (7); Recovery Coach (2); Certified Peer Recovery Coach (1); Community Peer Supporter (1); Peer Supporter; Peer Advocate (1); and Recovery Support Specialist; some key informants held more than one peer support title. Length of time in the current peer role ranged from 3 months to 7 years for an average tenure of 2.4 years. The majority of organizations required peers to complete training and be certified upon hire, with career advancement opportunities as a benefit of certification. Key informants serving in a non-peer role overwhelmingly advocated for the value of peer services, with few reported instances of stigma against peers within organizations. Collaboration between peers and other clinicians was common across organizations, with many key informants lauding peers’ ability to build rapport with clients:

> *One of the most amazing things about our peers is that transparency in their title alone, they are a peer support specialist, that means that I have lived experience. And so you don't have those barriers of, "Well, how do you know how I feel?" Well, part of the peer experience is sharing their story and sharing the relevant story. So when the client says, "I'm tired of going in the hospital" a peer can say, "I know. I've been in the hospital 10 times myself and here's how I got to the point that I am." I think they inspire hope in our clients. 'Cause our clients might look at us as a clinician and say, "Yeah, it's nice, you're sitting in your chair and... " Where with that peer, they can kind of see themselves in that [...] and say, "Wow. I think I wanna be a peer someday."*

Despite the reported value of peer services, most organizations did not track or evaluate the cost effectiveness of peer services or their effect on client outcomes based on limited funding for evaluation. Medicaid was the primary reported funding source, with block grants as a common secondary funding source used to counterbalance low reimbursement rates. Some key informants noted the lack of peer service coverage by Medicare and private insurance companies as a potential barrier for behavioral health organizations to hiring peers. Key informants serving in executive and administrative roles corroborated the reported low pay and reimbursement rates for peer services, with the COVID-19 pandemic and ensuing reductions in service as a catalyst for some peers leaving the workforce. Peers unanimously expressed a high level of satisfaction with their role in supporting others in their recovery, while expressing low pay rates and long hours as challenges. One peer stated:

> *"It's a very rewarding job, but it's also very demanding. You know, if I have a peer that has a crisis, I'm available... I mean most of the time I'm accessible to 28 people for $12 an hour. It makes it hard. [...] It's quite a sacrifice."*

Conclusion

Differing organizational staffing and frequency of peer service provision varied widely at the time of key informant interviews due to the COVID-19 pandemic, introducing potential bias. Staffing shortages and ensuing organization recruitment challenges stemming from the pandemic also yielded a small sample size. Peer certification is required to bill Medicaid but not all organizations require peer staff to be certified, potentially resulting in exclusion of some peer organizations from the sample pool. However, evidence from key informants strongly supports peer services as an effective and valuable component of mental health and substance use disorder recovery. Despite the merit of peer services, reimbursement rates remain low, potentially dissuading peers from practicing in the long-term. Medicaid billing for peer services may motivate organizations to expand peer service availability, but without increased reimbursement rates, it is unlikely to prompt widespread adoption. Higher reimbursements rates, in conjunction with greater tracking and evaluation of peer-delivered service efficacy, are imperative for building the needed evidence to support large -scale incorporation of peers into behavioral health care.

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References

1. Chinman M, McCarthy S, Bachrach RL, Mitchell-Miland C, Schutt RK, Ellison M. Investigating the degree of reliable change among persons assigned to receive mental health peer specialist services. *Psychiatr Serv*. 2018;69(12):1238-1244. doi:10.1176/appi.ps.201800118
2. Chinman M, George P, Dougherty RH, et al. Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatr Serv*. 2014;65(4):429-441. doi:10.1176/appi.ps.201300244
3. Gaiser MG, Buche JL, Wayment CC, et al. A systematic review of the roles and contributions of peer providers in the behavioral health workforce. *Am J Prev Med*. 2021;61(4):e203-e210. doi:10.1016/j.amepre.2021.03.025
4. Chapman SA, Phoenix BJ, Hahn TE, Strod DC. Utilization and economic contribution of psychiatric mental health nurse practitioners in public behavioral health services. *Am J Prev Med*. 2018;54(6 Suppl 3):S243-S249. doi:10.1016/j.amepre.2018.01.045