Peer Providers in Mental Health and Substance Use Disorders: Emerging Roles, Training, Certification, and Payment

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Research Objective: Peer providers are individuals with lived experience who are hired to provide direct support to those in mental health (MH) or substance use disorder (SUD) recovery. A growing body of research demonstrates that peer providers can contribute positively to the treatment and recovery of individuals with behavioral health care needs. Our objectives were to identify and assess best practices in peer support including the policy environment, training and certification requirements, funding, employment, roles of peer providers, and challenges and barriers in providing peer support services.

Study Design: Case study approach including semi-structured interviews and thematic analysis. We conducted 3-5 day site visits to 4 US states identified as leaders in this area and interviewed key staff and leaders in MH and SUD treatment and recovery organizations.

Study Population: We interviewed a total of 193 key informants across 4 US states and collected available data on numbers certified and employed.

Principal Findings: A variety of factors are important to the optimal use of peer providers. A policy environment favorable to peer support is critical, along with individual champions and consumer advocacy organizations to lead the development of robust peer workforces. In some US states peer providers have been mandated by judicial decisions. The ability to bill the state's Medicaid program for peer services is an essential source of revenue. Peer provider training and certification requirements vary by state, as do methods for satisfying billing requirements. Peer employers cited challenges in training peers to document services for billing. Consumer-run organizations expressed difficulty meeting billing requirements while retaining a "recovery based" model of care. Peer providers work in a variety of roles and settings, including psychiatric hospitals, crisis centers, forensic settings, public housing, and peer provider-run recovery organizations. While peer providers are often seen as valuable members of care teams, remaining stigma towards mental illness and addiction poses a barrier to integrating peer providers' recovery based approach into traditional treatment models. Additionally, peers tend to receive low wages and experience difficulty advancing in their career without formal education.

Conclusions: Peer providers are an essential workforce in promoting MH and SUD recovery. However, significant policy and workplace barriers remain to integrating them into behavioral health treatment.

Implications for Policy or Practice: Data on peer providers' employment and roles should be consistently collected by state agencies or partner organizations, and policies should ensure that reimbursement requirements do not undermine the unique features of peer providers that make them effective in supporting recovery. In order to better retain peer providers, standardized training and certification should be established to create job mobility and improve coordination of co-occurring behavioral health conditions. Employers should be sensitive to peer providers' needs for sustainable earnings, benefits, and workplace accommodations.