CENTER FOR HEALTH WORKFORCE STUDIES
UNIVERSITY of WASHINGTON

OCCUPATIONAL PROFILE: CERTIFIED PEER COUNSELORS

Support from others who have lived experience with a mental health or substance use disorder (SUD) has become an important behavioral health (BH) service. The occupation of peer counselor fills this role on BH teams. Peer counselors create bridges between consumers of health services and their providers, and can increase treatment engagement and adherence by creating personal, sustained relationships with patients or clients. In BH settings, peer counselors can directly help persons with behavioral health conditions establish positive health management techniques that promote well-being and recovery.

In Washington state, only peer counselors who identify as having lived experience with mental health challenges (or is the caregiver of a child with mental health system involvement) and who are certified by the Division of Behavioral Health and Recovery (DBHR) and credentialed by the Department of Health (DOH) can have their services reimbursed through Medicaid funds. Other peer counselors in Washington, such as those with SUD or criminal justice system lived experiences alone, are not eligible for reimbursement with Medicaid funds, but they can provide services and can be paid by other funding sources (grants, donations, or volunteerism). It is more difficult to enumerate and describe the peer counselors who are not certified or credentialed through DBHR. This profile will describe both general peer counselor roles and the pathway to become credentialed as a DBHR-certified peer counselor (DBHR-CPC).

TABLE 1. Washington State Division of Behavioral Health and Recovery Certified Peer Counselors, 2017

With address in:	
Washington	2,358 (99.4%)
Oregon	5 (0.2%)
Idaho	4 (0.2%)
Other	5 (0.2%)
Total	2,372

Data sources: Washington State Office of Financial Management

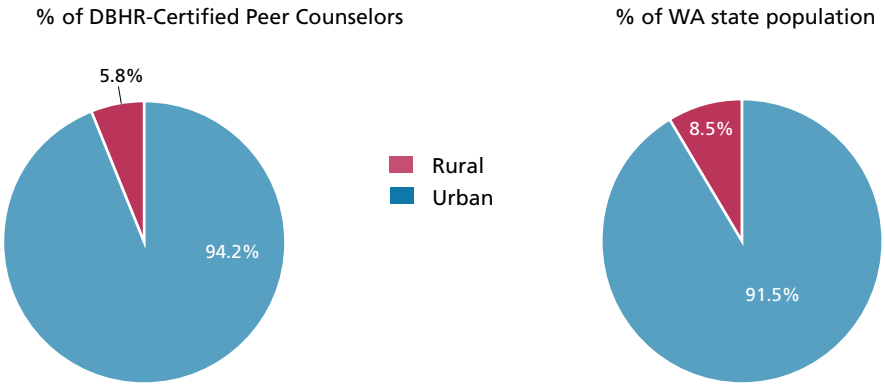
Size, Distribution, and Demographics of Supply of DBHR-Certified Peer Counselors

In April 2017, there were 2,372 DBHR-CPCs who held an active Washington state certification, 99.4% of which had addresses in Washington (Table 1).

Education and Training

Many organizations provide peer support training for people with mental illness or substance use disorders (SUD), and there is no single accepted curriculum to train these peer counselors. While non-DBHR certified peer counselors may be providing services in Washington, this section is focused on DBHR-CPCs whose services can be reimbursed with Medicaid funds.

Figure 1: Rural/Urban Distribution of Division of Behavioral Health and Recovery Certified Peer Counselors and the General Population in Washington



Data sources: 2016 Washington State Office of Financial Management county population data; Washington State Department of Health, 2017 Health Professions Licensing Data System.

The training to become a DBHR-CPC in Washington is managed by the Office of Consumer Partnerships.(Washington State Department of Social & Health Services, January 2017) To be eligible for the standard DBHR-CPC training, one must:

- Be a consumer of mental health services, and be in mental health recovery (self-assessed) for at least one year, and be willing to share that personal story and skills

- Be 18 years of age or older
- Have a high school diploma or equivalent, or be granted an exception
- Demonstrate proficiency in reading comprehension and writing skills
- Demonstrate qualities of leadership

The education requirement for becoming a DBHR-CPC is a high school diploma or equivalent. (Washington State Department of Social and Health Services, January 2017) A recent national survey of peer counselors, however, reported that 46.0% of respondents had some college or an associate degree, and 39.4% had a bachelor's degree or beyond.(Cronise, Teixeira, Rogers, & Harrington, 2016)

TABLE 2. Distribution of DBHR-Certified Peer Counselors in Washington by Accountable Community of Health, 2017

DBHR-Certified Peer Counselors	N	Population	Rate per 100,000
Statewide*	2,346	7,183,700	32.7
By Accountable Community of Health (ACH)†			
Pierce County	518	844,490	61.3
North Sound	253	1,206,900	21.0
King County	538	2,105,100	25.6
Better Health Together	207	587,770	35.2
Cascade Pacific Action Alliance	267	614,750	43.4
Greater Columbia	128	710,850	18.0
Southwest Washington	242	493,780	49.0
Olympic Community of Health	76	367,090	20.7
North Central	117	252,970	46.3

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

* DBHR-Certified Peer Counselors with Washington State certification address only.

† Counties in multi-county ACH's are Whatcom, Skagit, Snohomish, San Juan, Island (North Sound), Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams (Better Health Together), Grays Harbor, Mason, Thurston, Pacific Lewis, Wahkiakum, Cowlitz (Cascade Pacific Action Alliance), Whitman, Asotin, Garfield, Columbia, Walla Walla, Franklin, Benton, Kittitas, Yakima (Greater Columbia), Clark, Skamania, Klickitat (Southwest Washington), Clallam, Jefferson, Kitsap (Olympic Community of Health), Okanogan, Chelan, Douglas, Grant (North Central).

CPC applicants are required to complete an online training as a prerequisite to applying to attend an in-person training session. The online program is a 10-12 hour course administered by the Behavioral Health Workforce Collaborative at Washington State University.

On completion of the online training, applicants submit an application packet and the prerequisite course certificate of completion to be considered for in-person training. There are usually waitlists, and applicants are selected to attend based on criteria such as current employment in a Medicaid-funded mental health agency, regional priorities, and application scoring. If selected, applicants attend an in-person classroom training session offered by DBHR or regional behavioral health organizations (BHOs). State CPC trainings occur twice per year, once in the east and once in the west of the state. Regional trainings number about 12 per year and may be restricted to BHO residents only. DBHR plans to increase the number of certifications by 15-20% in 2018 (from approximately 350 to 410 individuals trained annually) by increasing the number of trainings and the capacity per training.[1]

The in-person training involves about 40 hours spent studying the peer counselor manual, participating in individual and group training activities, and completing skill checks which must be satisfactorily passed. (Washington State Department of Social and Health Services, 2017) The CPC test is administered by Washington State University at the end of the in-person training or shortly afterwards in a nearby location. The test includes multiple choice and oral sections. Applicants have up to five attempts to pass the test before being certified. On passing, applicants receive a letter from DBHR confirming certification requirements have been met.

The curriculum used in the in-person training was prepared by the Washington Institute for Mental Health Research and Training. (Washington Institute for Mental Health Research & Training, 2009) It describes the public mental health system and the role of the DBHR-CPC, and focuses on recovery principles and core skills including communication, telling one's story, ethics, goal setting, documentation, and working in groups. Training is largely focused on trauma-informed practices and cross-cultural partnerships.

[1]Patricia Marshall, Washington State Department of Social and Health Services Peer Support Program Manager, personal communication, October 30, 2017

There are also family and youth specialty trainings as well as trainings in Spanish. In 2018, DBHR will be adding SUD peer counselor training for targeted SUD recovery support as part of the State Targeted Response to the Opioid Crisis Grant ("Opioid STR") efforts. (Washington State Department of Social and Health Services, March 2017) The training and testing are free to the trainees, and food and board are provided for state-level trainings. Program administration costs are supported by grants (Mental Health Block Grant [adults], Opioid STR Grant [SUD]), T.R. Litigation settlement funds (T.R. v. DREYFUS, 2013), and regional Behavioral Health Organization (BHO) funds.

Credentialing

Once certified, potential employers may require that the DBHR-CPC become credentialed as an Agency Affiliated Counselor (AAC) if the agency provides Medicaid billable services. AACs may only work in approved facilities (see WAC 246-810-016), and must notify the Department of Health within 30 days if they leave or change agencies.(Washington State Legislature, 2011) They may not provide counseling services except through their agency of employment. Prior criminal history may be a barrier to employment as a DBHR-CPC in some agencies, or in getting an agency affiliated counselor license, but would not prevent a person from becoming a DBHR-CPC.

The services which AACs may provide include screening of functional impairment, and guidance in life situations and skill development. However, AAC service provision is limited by the functional impairment of the patient. If the patient's impairment meets certain criteria, the AAC is legally required to refer to a licensed mental health professional or medical provider, or attain written refusal from the patient to participate in the referral. Even with written refusal, AACs may not be a sole treatment provider for individuals with serious functional impairment.

Practice Characteristics

While Medicaid reimbursement opportunities in Washington are limited to DBHR-CPCs who acquire the AAC credential, peer counselors trained in other programs may also provide services. For example, across the nation, peer counselors work in myriad roles and settings.(Blash, Chan, & Chapman, 2015; Cronise, Teixeira, Rogers, & Harrington, 2016) Peer counselors serve as recovery navigator/coaches, case managers, outreach coordinators, family support, and health and wellness coaches, to name a few. They may provide activities which promote recovery, self-advocacy, community living skills, and support formation. Peer counselor services may be provided individually or in groups, in-person or by telephone.

Peer counselors can be used in community mental health centers, rehabilitation centers, hospitals, schools, adult and juvenile justice systems, the foster care system, and other settings. They may also work in community settings and non-profits, on crisis lines, and in peer-run recovery organizations. Peer counselors may provide a bridge for those leaving inpatient or incarceration facilities and transitioning back into the community. As AACs, their services can be paid for in approved agencies.

Employment of peer counselors may improve an agency's credibility with its consumers, provide informal perspective and quality control, and provide first-hand insights into treatment limitations, appropriateness, and outcomes.(Blash, Chan, & Chapman, 2015)

The U.S. Bureau of Labor Statistics does not collect data specifically on peer support specialists, but counts them among community health workers. In Washington, the annual mean wage for community health workers was $39,980 in May 2016.[2] The 10th percentile mean annual wage was $24,780 and the 90th percentile mean annual wage was $60,830.

Relevant Skills Needed for Behavioral Health – Primary Care Integration:

Research literature on emerging roles of peer counselors provides examples of where peer counselors may serve on teams with traditional mental health and substance use treatment providers, such as with assertive community treatment (ACT) teams, crisis stabilization units, mobile crisis teams, medication-assisted recovery services (MARS), and peer-bridger programs.

Peer counselors may become their agency's community resource expert in topics like housing, employment, and parenting/childcare. They often possess valued skills such as training in motivational interviewing, WRAP (Wellness Recovery Action Plan), trauma informed

[2]Estimates do not include self-employed workers.

care, life skills, dialectical-behavioral therapy and other modalities. They can model strength-based language within the agency.

There is a perceived lack of internal support for peer counselors within agencies, and this may result in higher turnover.(Gates & Akabas, 2007) Agencies may not understand how best to use peer counselors, and stigma or differing treatment philosophies can create barriers to acceptance and respect on the integrated team. Providing a supervisor who is a certified peer counselor and providing internal meetings of the peer counselor employees may help support their connectedness to their agency.(Silver & Nemec, 2016) Clearly defined roles and job descriptions, as well as boundaries, can improve the work environment for peer counselors. Investing in continuing education, particularly in community settings, is also a positive way for agencies to demonstrate support.(Gates & Akabas, 2007)

Demand

Data on the demand for peer counselors in behavioral health is lacking.(Blash, Chan, & Chapman, 2015) Behavioral health workforce shortages and the provision of Medicaid billable services may increase the appeal for their use.(Blash, Chan, & Chapman, 2015; Cronise, Teixeira, Rogers, & Harrington, 2016; Myrick & Del Vecchio, 2016; Silver & Nemec, 2016) Further research is recommended on the number of peer providers trained, employed, and who advance in the field.

Washington's "early warning" system of health workforce demand changes, the Washington Health Workforce Sentinel Network, allows employers to report workforce shifts and high-priority needs.(Workforce Training & Education Coordinating Board, 2017) Some sentinels in behavioral health clinics report exceptionally long vacancies for peer counselors. The most commonly reported barriers to hiring are lack of funding, salary constraints, and finding qualified and professional candidates.

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TECHNICAL NOTES

1. Washington State DBHR-Certified Peer Counselors data are from the Washington State Office of Financial Management. All analyses include DBHR-Certified Peer Counselors ages 18 – 75 years with active credential status and expiration of credential >= 2017.
2. Washington population data are from the Washington State Office of Financial Management, 2016 data.
3. Rural/urban status determined using Rural Urban Commuting Area (RUCA) taxonomy.(U.S. Department of Agriculture) and practitioner's license public address ZIP code.

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University of Washington • School of Medicine • Box 354982 • Seattle WA 98195-4982
phone: (206) 685-0402 • fax: (206) 616-4768 • http://depts.washington.edu/uwchws/