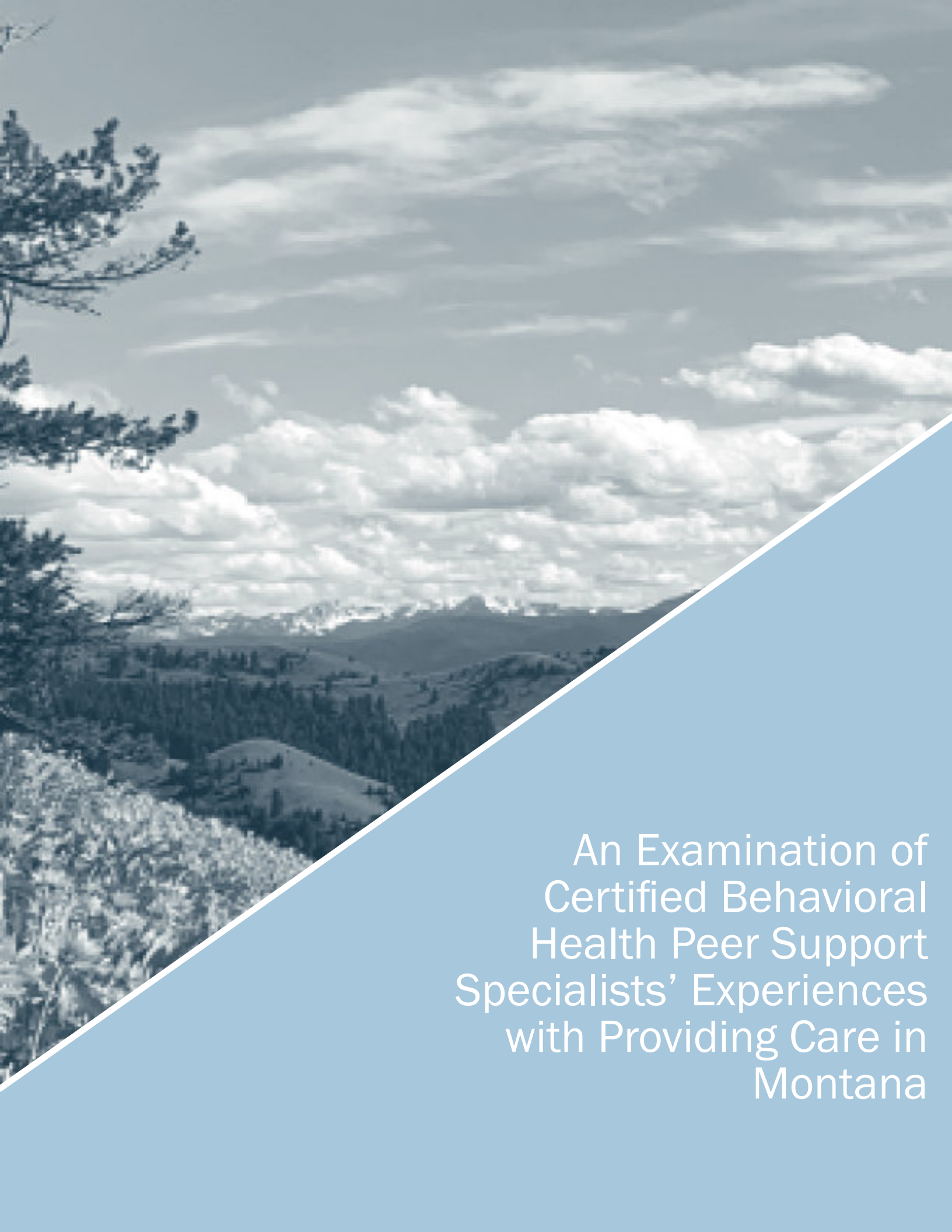

An Examination of Certified Behavioral Health Peer Support Specialists' Experiences with Providing Care in Montana

REPORT INFORMATION

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STUDY SUMMARY

In 2017 the Montana Board of Behavioral Health began certifying peer support specialists and in 2019 the Montana Legislature passed SB0030.01 which appropriated funding for Certified Behavioral Health Peer Support Specialists (CBHPSS) through the Montana Medicaid program (DPHHS 2020). These actions expanded the number of peers in Montana exponentially; however, many peers who completed trainings aimed at certification (PS101 and PS102) never complete the certification process, and some certified peers fail or neglect to renew their certifications.

The purpose of this study was to (1) understand the experiences of and the motivations for becoming a peer support specialist; (2) understand the factors that affect recruitment and retention; and (3) offer recommendations for strengthening this resource in Montana from the perspective of peer support specialists.

Altruism motivated most peer support specialists to pursue certification and employment as a peer support specialist. Peers described a sense of duty to help others during their recovery process, and defined PS 101 as an inspiration for pursuing that professional path.

Peers identified bureaucracy and bottlenecks within the Montana Board of Behavioral Health as the leading obstacle to attain the peer support certification. Once certified and employed, peers stated that inconsistent work responsibilities, low pay, and no benefits threaten retention. Peers also mentioned that burnout from working in behavioral health compelled peers to seek other employment opportunities. Alternatively, participants stated that clinical supervision meetings, and the relationships they formed with their clinical supervisors and other peers bolstered retention.

RECOMMENDATIONS

- Peers suggested offering a prerequisite to PS 101 that would screen out potentially unqualified candidates and increase retention through certification
- Peers recommended peer-to-peer assistance during the certification process for Continuing Education Units (CEUs)
- Eliminating or adjusting the clinical supervision requirement to apply for certification would boost retention because many peers lack connections to qualified supervisors before employment
- Expanding the types of health care settings that can offer peer support, or providing seed funding for independent peer support organizations to expand and contract with healthcare providers
- Increase the Medicaid reimbursement rate, so healthcare providers can pay CBHPSS more and offer better benefits
- Offer more CEU trainings on a wider array of topics
- Ensure that there is a shared understanding on the flexibility in supervision requirements for CBHPSS post the repeal of Montana Administrative Rule 24.219.916 in 2019

INTRODUCTION

On October 1, 2017 Montana's Board of Behavioral Health began certifying Behavioral Health Peer Support Specialists to use their personal experience with behavioral health disorders to provide support, mentoring, guidance, and advocacy to individuals diagnosed with behavioral health disorders. In 2019, the Montana Legislature passed SB0030.01 which appropriated funding for Certified Behavioral Health Peer Support Specialists (CBHPSS) through the Montana Medicaid program (DPHHS 2020). As of August 2020, Montana had 84 certified peer support professionals, a 95% increase in CBHPSS since July 2019 (DPHHS 2020). The Montana Peer Network (MPN) has utilized grant funds provided to Montana by SAMHSA in the State Targeted Response (STR) and State Opioid Response I and II (SOR) since 2017 to train about 400 peer support specialists using their Peer Support (PS) 101 and Peer Support (PS) 102 trainings.

This study was motivated by conversations with MPN leadership, Behavioral Health and Developmental Disabilities Division (BHDD) grant managers, and stakeholders interested in the success of CBHPSS across Montana. These conversations suggest that opportunities for CBHPSS are expanding across the state; however, many PS101 and PS102 graduates never complete the certification process, and some certified peers do not renew their certifications. Therefore, recruitment and retention challenges afflict expanding this position in Montana.

The purposes of this study are to:

- Document the experiences of and the motivations to become a CBHPSS
- Understand the factors that affect recruitment and retention
- Offer recommendations for strengthening this resource in Montana from the perspective of certified behavioral health peer support specialists

BACKGROUND

Previous research on peer support specialists largely focuses on the positive benefits clients gain from peer-to-peer relationships (Masih et al. 2021; Wayne et al. 2019). Studies show that patients working with peer recovery coaches experience reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience (Magidson et al. 2021; Reif et al. 2014; Staton et al. 2021). This study fills a gap in the literature by systematically documenting the experiences of the peers, important because peer support services increase access to treatment for low-income and minority populations by promoting treatment outside the clinical setting (Kleinman et al. 2020). This study aims to understand what motivates people to become peer recovery coaches and to identify any barriers to recruiting and retaining CBHPSS in Montana, with the explicit goal of strengthening the recovery landscape in Montana.

METHODOLOGY

SAMPLE

JG researchers primarily drew this study's sample from a list of Peer Support Specialists provided by the Montana Peer Network. To ensure diversity in study participants, the sample also included peers trained by the Mountain Plains Addiction Technology Transfer Center Network (ATTC). Researchers recruited every MPN and ATTC contact via email and telephone. Upon completion of an interview, participants were asked if they were willing to provide the name(s) of additional contact(s): administrators, clinical supervisors, and peers with familiarity with PS101. All study participants are based in Montana. Table 1 lists this study's participants.

Table 1: Type and number of participants

Participants	Number of Participants
Current CBHPSS	23
Former CBHPSS	3
Trained, Never Certified	7
Clinical Supervisors	9
Administrators	11
Total	53

DATA COLLECTION

Data were primarily collected using semi structured interviews, which allow the interviewer to ask all participants a standardized list of questions and then probe in areas unique to each participants' experience and perspective. All interview instruments and consent forms were reviewed by MPN leadership to ensure sensitivity, relevancy, and each instrument's validity. Observations were also a valuable part of the data collection strategy. JG researchers attended a peer conference where they met peers who participated in interviews, and a continuing education unit training where a researcher was able to network with peers, administrators, and clinical supervisors.

DATA ANALYSIS

JG researchers created a customized coding scheme that "deconstructs" and categorizes the data into codes: short words or phrases that allowed us to reduce, organize and summarize interview and visual data (Creswell 2007). JG researchers developed the coding structure after conversations with MPN leadership and documenting prominent patterns that emerged during interviews in the notetaking phase of data collection and analysis. By utilizing the insight gained from the "pre-coding," notetaking stage, we analyzed raw qualitative data through multiple levels of abstraction to reach assertions and conclusions presented in this report. The levels of abstraction began by coding the data in initial codes, most of which required subcodes to refine the data's meaning (Charmaz 2006). Next, JG researchers created and compared categories that illuminated higher-level and abstract constructs. By organizing the themes that emerge from each category (and subcategory) we coded to understand this

study's three primary objectives: (1) document the experiences of and the motivations for becoming a peer support specialist; (2) understand the factors that affect recruitment and retention; (3) offer recommendations for strengthening this resource in Montana from the perspective of peer support specialists.

JG researchers utilized the following two validity techniques: (1) intercoder agreement, whereby two JG researchers ensures the codes, subcodes, and categories developed by the researchers are assigned to the data consistently (Saladana 2013). First, codes were ascribed formal definitions and interviews were coded by two members of the research team. The researchers reconciled their differences, clarified each code's definition, and coded the data again to ensure reliability. The primary researcher responsible for data collection and analysis also utilized "member checking," in which former and new participants were contacted and invited into the analysis process (Creswell 2007; Stringer 1999). Member checking gives participants an opportunity to confirm or deny conclusions made during analysis, affords them a sense of ownership over the data analysis process, and ensures their voice is represented in the study's recommendations (Creswell 2007). JG Research and Evaluation utilizes NVivo qualitative software to code and analyze text-based data. Throughout the report, CBHPSS and PSS are used interchangeably.

FINDINGS

This study's primary research questions are used to organize the findings section.

DOCUMENT MOTIVATIONS FOR, AND EXPERIENCES OF, BECOMING A PEER SUPPORT SPECIALIST

ALTRUISM

Altruism is one of the primary motivators for people to enroll in PS101 and pursue certification. Peer supporters report a sense of duty to give back to those embarking on recovery and those experiencing behavioral health challenges. This peer supporter describes her motivations as, ". . . more altruistic. So, it's a foot in the door for a career. But if someone's going into this for the money, there's a lot easier avenues that they can be taking." Peer supporters have a sense of duty to help their fellow peer but also value the behavioral health model that has helped them in their own recovery. Another peer states, "I wanted to go back out and pay it forward and start to help people to figure out addiction before they go through all the trials and tribulations that I had to put myself through in order to be where I am today." Peers' desire to help people in recovery often originates from their struggles with recovery and a desire to positively affect others' recovery journeys.

PS 101

Peers state that enrolling in PS101 was an opportunity to increase their knowledge about recovery in general, and gain information about their own and others' recovery. Peers report a desire to learn about recovery and express enjoying professional development and how access to formal training motivated many individuals seeking professional development opportunities in behavioral health. They shared how they viewed the first step in their own process of professionalism was to become a Peer Support Specialist.

Peers report a preference for hands-on, interactive trainings that enable them to practice 'real life' interactions and mock scenarios that Peers encounter daily on the job. One peer supporter describes the intensity of the course, "We did the suicide intervention, we talked about different scenarios. We did some role playing. We did some observational movies or real-life situations." Peers who pass

PS101 often leave the class with a sense of motivation, determination, and route for completing the Peer Support certification process that will enable them to perform their dream job.

For other peers, PS101 served as a job deterrent. When peers recount PS101, they describe a course with intense case studies that can trigger a peer's own trauma and serve as a mechanism to cull peers who might not be suited for a job with daily triggers. One Peer states, "You may be completely blown away by the intensity of the training. I've seen this in several of the PS101 trainings I've facilitated. The participants come in and they're like, "Oh my God, I can't do this. I'm not ready for this. And they realize the need for growth in their own lives." Many peer supporters recall peers dropping out throughout the week of PS101 training and having conversations with other peers who were considering leaving the course. This experience led several Peers to recommend a prerequisite to PS101 for individuals interested in the Peer Support Specialist training. This course would be shorter and operate as a screening tool for the more intense 40-hour training. A peer supporter reflects on her experience:

> *There are people that are being deceptive going into PS101, they're not ready. Then those are the ones that aren't in true recovery, they're basically holding up those spaces for other people, they don't completely understand what it is, and those are the individuals that for one, aren't getting licensed or they could be potentially dangerous if they were to be licensed.*

This earlier training would serve a twofold purpose. First, it would motivate peers to consider peer support as a professional development opportunity earlier in their recovery and prepare them for the more intense PS 101 course before enrolling; second, it would serve as a screening tool for those not suited or ready for the intensity of a peer support role. During the interim between these interviews, and the completion of this report, the MPN added a decision tree to their online application to link applicants with either PS101 or to a Peer Coaching Series. Initial impression from MPN staff are that the addition of Peer Coaching has helped to prevent some of the concerns identified by participants in this study.

BARRIERS TO CERTIFICATIONS

PS101 can motivate and dissuade potential Peer Supporters from a professional peer support role, but there are more prominent barriers facing potential peer supporters. First, bureaucracy associated with the certification process prevented many potential peers from certification. As a peer supporter reflects:

> *"I've seen people go through and get their peer support license within a couple months. Myself, it took about six months because of the felony background and what I've done. I had to supply a lot more documentation, a lot more things than somebody else that maybe just had something small. [My felonies] were drug-related charges so…"*

Applicants with criminal backgrounds, particularly a felony record, reported the most difficulty with completing the certification process. Another peer supporter describes the onerous certification process for peers with criminal backgrounds:

> *I had six DUIs from 1980 to 2000 stretched out. And they wanted me to describe each one of them. And I was like, 'are you kidding me?' And they already knew. They had my background; they do a background investigation. They know what you've done, but they want you to explain to them what happened.*

Another peer supporter states:

> *I never got my certification. I'm one of those people that took the class and then got detoured at applying with the Montana Board of Behavioral Health. I paid the fee, but I couldn't come up with my entire criminal*

> *history because it was 30 years long. Some of the places that they wanted me to come up with documentation from no longer exist—I couldn't come up with all the required information.*

Peer supporters describe certification requirements as onerous, contributing to long wait times, and even as impossible barriers to transcend. These requirements are passed by the Montana State Legislature and evaluated by the board. Concerns about this process were not unique to peers, as an administrator commented:

> *The behavioral health licenses [require an FBI background check]. [. . .] It is the legislature who makes that determination [. . .]. It's how the statute was passed. [. . .] The background checks are done through the Department of Justice when a person applies for any type of license. But the board exists to protect the public health and safety, not get people hired as fast as humanly possible.*

The administrator makes an important point when trying to understand where delays in the approval process exist: the board's role is to ensure those approved to be a CBHPSS contribute to the public good rather than pose a threat to people in recovery. When applying to the Board of Behavioral Health for certification, applicants must compile all the require documents; they must file requests for their conviction records within individual courts (district, circuit, federal), submit their fingerprints, and initiate a background check through the Department of Justice.

Members of the Board of Behavioral Health report that the board only considers an applicant's candidacy once they submit all the required documents; however, peers report submitting completed applications only to have the board misplace or lose documents. One peer described a lengthy six-month certification process in which he provided the same documents multiple times because the board reported each time that he had never submitted them. The peer described to JG researchers how he had submitted his application after he and his clinical supervisor reviewed the requirements and confirmed the application was complete, including all documents and all the explanations for the "Yes" answers pertaining to his criminal history. The peer reported to the interviewer that the board stated he was missing documents, so he submitted identical information a second time, in person, and the board, again, stated that they never received the documents. After hearing this lengthy story, the interviewer then asked, "It seems the board needs to tighten some screws in their review process, huh?" To which the participant responded, "I'm not sure I'd put it that nicely. This is my life—I'm on hold for six months while they lose documents? How is that professional?"

Another participant describes the challenge of hiring someone for a Peer Support Specialist position, only to have them wait for certification: "[. . .] You have to anticipate things that are impossible to anticipate, because you can't determine if it's going to take someone a month or six months to get their certification. [. . .] And then, what do you do with this person in the meantime, because they can't do any actual services?" The wait for certification puts employees and employers in a predicament: what role, if any, the peer will play while waiting for certification.

When asked to reflect on the, sometimes, lengthy review process peers endure, an administrator asked a key question:

> *Why does [PSS] need to exist as a license and certification? Does it? I think that is a very important question because people can fall into the trap of creating licenses and certifications for a lot of reasons, starting with other states do it, so we should do it too. Or just a political whim, or like I said, with healthcare, because it comes down to billing. I think that's an important question because is it necessary to have a license and certify this through a professional licensing board to protect public health and safety? Because if it's not, then a lot of these delays you talk about, they wouldn't exist because it would just be a job like my job. I just apply and they hire me, I don't need to have a license to do it. That's perhaps beyond the scope of your study, but I think it is an important question. [. . .] Peer support existed for a long time before the license was created for it.*

This participant's question about whether the certification process protects the public's wellbeing is an important one because the peer role existed before certification but was required for Medicaid reimbursement. Especially considering this administrator's statement: "Since the peer support certification has existed, the board has not denied any certification for peer support. And only the board has the authority to deny a certification, department staff do not have that delegated authority." If every CBHPSS eventually gets approved and Peer Support Specialists indicate that bureaucracy exists as a major barrier to their certification, the question posed by these participants remains: is this the most effective process for ensuring public wellbeing and retaining peers who complete PS101, particularly because peers existed in Montana before the certification law?

If Montana determines that the state certification process is the best approach to ensure public wellbeing, offering Peers assistance with the certification process may increase retention from training through certification. This PSS states: "[The certification process] is very comprehensive, and it's very overwhelming, and most people need help with it." Peers describe tackling the certification process independently, and state that reassurance, guidance, and encouragement would go a long way. This PSS captures this popular sentiment:

> *I think there needs to be a little more hand holding, or mentorship I guess, too. In getting certified, going to get your fingerprints taken, sending them to the state and stuff, I think there needs to be a little more mentorship from the people who have gone through it, saying, "Hey, wait a minute. This is 'easy peasy.' We'll help you. Just relax, you're going to be okay. We're going to get through this." And I think there needs to be a little more of that.*

Peer supporters advocate for a 'PSS-to-PSS support system' whereby experienced peers offer guidance to peers pursuing certification through the board of behavioral health.

UNDERSTAND THE EXPERIENCES OF PSS AND HOW THIS IMPACTS RETENTION

JOB RESPONSIBILITES

The roles and responsibilities for PSS differ based on their care setting and their clients' needs within each setting. Many times, their roles are defined on the job as this PSS states "a lot of [PSS] are brand new to the field, and it's not the kind of position that most people are just going to be able to jump into feet first." PSS often need guidance starting out on what their job responsibilities are and how to complete them. Some PSSs enter employment opportunities where clinics are unclear how to utilize peer support. For example, a rural Peer Supporter reflects:

> *That's kind of where I got hung up, because we had two weeks of training and I went in there expecting guidance in this field. And when I got there, I was told, 'we don't know what peer support really is, other than we're there to help people.' But they were looking to me for the answers and I didn't feel like I had them, I was still a trainee.*

Defining the scope of practice for Peer Support Specialists within health care settings can create inconsistencies between what Peer Supporters are trained to do and the roles clinics need them to perform. For example, several Peer Support specialists described the conflicts they encountered when healthcare providers asked or required them to transport or administer medications, something they are not trained to do and could jeopardize their own recovery. Peer Supporters also described other, more demeaning, tasks such as being required to mop floors, clean common areas, and take out the trash:

> *There's so little funding that I was mopping floors. Now other peers were going and advancing their career and one guy who was a peer went through and took some more college credits and became a licensed addiction*

counselor, but because of the dire need for workers, peer support specialists were often relegated to the work positions like mopping floors and cleaning tables…

This PSS describes how the size of one's employer can affect the tasks PSSs are assigned to perform throughout the course of a day. While mopping floors is an extreme example, administrators also discussed location as a factor affecting PSSs' obligations. As this administrator states: "It does seem like peer support to some degree if you work for certain organizations or even certain clients, it needs to be malleable. It needs to be regionally based versus just, this is what it is across the state." Standardizing the position might negatively affect healthcare settings that require flexibility among all staff to meet the needs of their clientele. Further, the differences in how community-based, residential, homeless outreach, PACT, MACT, and mobile crisis response PSS operate demands flexibility in the position's job requirements.

BENEFITS & PAY

Every respondent described CBHPSS as a low paying job across all care settings. When asked, "Do we need to increase the pay across the state of Montana for Peer Support Specialists or is it sufficient where it is? Peer Support Specialists succinctly captured the overwhelming sentiment:

I would highly suggest it, otherwise if businesses [. . .] continue to migrate towards that $15 average, I expect it to be extremely difficult, if not impossible to maintain any type of active workforce for peer support."

At the start, you're probably looking at like $13 to $15 an hour. You can go to work at Walmart, and you can get that or Sam's Club, any retail outlet and you're not counting on your personal experience to get you through it or anything.

*Some, I think one or two, are still getting $13/ hour, so that's ***.*

I don't feel that it's reimbursed fairly, but our counselors [at agency] are only making $22 an hour. And that doesn't seem fair either because they've got all kinds of college debt they're paying off. So, I feel like anyone working in this field, I don't feel like they're paid fairly.

I'm still under the federal government's poverty threshold. Still in the poverty level, which is sad. [Interviewer: At $13 an hour?] Yeah. All I can do is part-time—I cannot work 40 hours a week. I can barely handle 20, and if I lost my SSDI? Forget it. I wouldn't be able to live. It's only because I'm still collecting my SSDI [that I can do this job].

Many respondents referenced the pay at popular retailers and fast-food restaurants as higher than their current position, the work as less demanding, and the potential for benefits much higher. For example, one administrator explained: "And, like I said, when you're losing people to McDonald's and Wendy's, that's because they can offer benefits, [. . .] because we're a small clinic we can't offer benefits." Peer support specialists described larger healthcare settings able to pay higher wages and offer healthcare and retirement benefits as the most desirable. For example, a clinical supervisor describes what her clinic offers Peer Support Specialists,

Our peer support specialists are offered full benefits, vacation time, medical coverage, paid sick leave, and because we are a federally qualified health center, they get their medical care for free. I mean, I feel like if it can be done, we're doing it. I don't know. And the only way to raise the wage is for the reimbursement rate to be higher because, we can't lose money on our providers.

Many study participants described the current Medicaid reimbursement rate as the antecedent for low pay and limited benefits among Montana's Peers. For example, when asked, "Does the Medicaid billing rate affect the pay for a peer support specialist?" One participant suggested: "Yeah, so, that's why clinics don't want to pay you because they get that $54.87, they pay their biller, but the Peer Supporter is only getting like $15 an hour." Many administrators described operating within tight margins and prohibitive overhead costs, contributed to low pay among Peer Support Specialists.

CLINICAL SUPERVISION

All participants considered clinical supervision as one of, if not, the most important resources for Peer Support Specialists' work and their own recovery management. As one clinical supervisor states, it is ". . . their release from the week" and allows them to discuss professional challenges, client concerns, and future actions. Participants often conveyed confusion about the amount of clinical supervision Peer Support Specialists are required to receive. The perspective of the licensing board, as expressed in an interview for this study, is that there is a requirement for Certified Behavioral Health Peer Support Specialists to receive ". . . a minimum of one hour of face-to-face supervision and consultation for every 20 hours of work experience"; and "no more than 40 hours of work experience should transpire without receiving the required hours of supervision and/or consultation" (Personal Communication). However, the Montana Rule that originally put this requirement into place (Administrative Rules of Montana: 24.219.916) was repealed in 2019. Some administrators and clinical supervisors were under the impression that billable hours set the standard for supervision requirements, but the board specifies 20 hours of all "work experience" qualifies for the required hour of supervision. Based upon the range of perspectives presented by participants about supervision requirements, there is a need for further clarification and communication about the specific nature of supervision requirements for CBHPSS in Montana.

Clinical supervision differs by care setting, with some sites using individual, one-on-one clinical support, while other organizations using group supervision. For example, one PSS employed by a site that uses group supervision states, "Well, when we do clinical supervision, it's all of us in the room with her so there's 12, 13, 14 of us… It's more of a presentation than anything. [Interviewer: So how could it be improved?] Make it more one-on-one, more individualized." Another PSS reflected:

> *I'm a person-to-person [type of a] person. I have to tell you the whole video technology and all that crap, I just don't like it. I would prefer to have [a clinical supervisor] that I could meet with in person. Currently, it's me and two other people that are trying to vie for time during my supervision because it's me and two other [PSSs] that are working here.*

All Peer Support Specialists interviewed for this project preferred individual supervision, but many were never presented with opportunities for individual supervision. Group supervision was especially disliked by those forced to participate in virtual group supervision. Care settings with larger PSS rosters utilized group supervision to ensure clinical supervisors were not overwhelmed meeting Peer Support Specialists' weekly clinical supervision requirements in addition to their other job requirements. One peer reflects on the tension care settings face and the negative consequences that result from overworked clinical supervisors for peers:

> *You have 20 peer supporters underneath you and a whole other job on the side of that. That's not, that's not going to be effective for them or you, there were many times that I went to my clinical supervisor for guidance, and she just referred me back to my administration. My administration told me I needed to talk to my clinical supervisor, so it was loop.*

Healthcare settings faced difficulties ensuring peers received the required amount of clinical supervision while also balancing clinical supervisors' time. And the requirement that peers receive clinical supervision for their entire careers, also placed strain on health care settings. Unlike LACs or

other types of clinicians who "time out" of clinical supervision, this clinical supervisor states, "And then with the peer support specialist program as you know, it's forever. Forever and always, amen. It's a lifetime relationship." Administrators recognized the importance that clinical supervision played in peers' personal and professional development, however faced with staffing shortages and the day-to-day realities of providing healthcare in Montana, health care settings relied upon group supervision to afford clinical supervisors more time to perform other necessary job duties while still offering peers guidance.

In addition to the strain clinical supervisors feel and the group dynamics that exist in larger organizations, independent PSS grapple with a different challenge: affording their own clinical supervision. As one independent PSS states, "And that may mean $100 to $130 an hour to pay this individual to supervise you for that hour so you can maintain those qualifications." Peer Support Specialists describe affording their independent supervision on $15 per hour as unsustainable. An independent clinical supervisor states, "That's the business side of it. I'm upfront with people: my going rate is $110 an hour. I do cut a lot of my folks a better deal than that, just because they're not making enough money to do that." Affording this job requirement is often a daunting task for PSS, as peer rely on this resource as a release, but often dread the high cost of this job requirement. Peer Support Specialists describe clinical supervision as a necessity to their professional and personal goals, and one of the key combatants against their job's grueling demands, including burnout.

BURNOUT

Peer Support Specialists describe arduous cases that often test their emotional faculties and even strain their recovery management plans. Peers identify burnout as a major barrier to recertification among their fellow PSSs. One PSS remarks: "You get burnt out really quickly. [. . .] If you don't have the best coping skills or the best recovery [. . .] some peer supports relapse, most peer supports that I know that are no longer peer supports, they just got burnt out." Most peers take proactive measures to balance their personal and work lives and warn that "[violating your] own personal time to jump in and help a peer, which is really hard not to do, especially if it's somebody that you've been working with for a while and they're [struggling and calling you, but you've] got a family thing and end up picking up and violating your personal time to help. That also leads to burnout." Some peers describe implementing privacy controls that help draw boundaries between their professional and personal time. For example, one peer describes "I have a Google phone number, Google voice phone number that I link to my phone and give to clients. I don't give them my personal cell phone number. On the weekends, I put it on do not disturb." Actions that separate PSSs' personal and professional lives mitigate burnout creating healthy boundaries.

ADDITIONAL SUPPORT & RESOURCES

In addition to clinical supervision and boundary management, Peer Support Specialists sometimes require additional support and resources to adhere to their recovery management plan. To accomplish this, PSS rely on ". . . therapists, we have AA meetings, we have friends, we've got family, we also have [other] staff." Another PSS states, "Right now, they're supposed to be a peer-to-peer group, for peer supporters to peer supporters. That's over the phone, but I haven't kept up with it. I think it's on third Wednesday of the month, I think. And that's when you can troubleshoot and do things like that on a peer level." PSSs report low attendance in MPN's virtual peer-to-peer CPAAC group and a desire for additional resources. Many participants were unable to name additional support resources outside their clinical supervisor. The need for outlets beyond one's professional role is not unique to the PSS position, but it is particularly important for coping with the unique demands of the job.

Peer Support Specialists report differing amounts of knowledge about, access to and need for support. As one PSS states, "I'm not sure if there's any real support. It's up to the individual to find their own supports." A clinical supervisor explained "[SUD agency] is not a supportive working

environment. And the Peer Supporters, they need more support. Their jobs are very hard. They're doing some of the most important work out there and they don't get a lot of support from the workplace." When peers rely on themselves to find their own support for their recovery management plans, they sometimes prioritize their clients' personal growth and sacrifice their own recovery management plan. One PSS states, "Some people end up using their work as a peer support specialist as their own recovery work, instead of attending AA or NA or SMART meetings on their own, for their own benefit, they only attend meetings when they're taking a peer to a meeting." Prioritizing clients over themselves puts PSS in a difficult position to provide clients with the best support while also ensuring their own personal wellbeing. Some peers were unaware of any formal offerings by MPN and relied on ". . . all of us that took the class together have a Facebook group, we're all friends on Facebook and still talk." Social media serves as a tool to connect peers from across the state and cope with the challenges inherent in their jobs.

RECOMMENDATIONS

BUREAUCRACY

Peer Support Specialists recommend streamlining the certification process to eliminate bureaucratic bottlenecks. If, as the Montana State Legislature concluded, certification is necessary for the position, introducing greater efficiency into the process would increase retention. For instance, the standard 45 day wait time means over a month without pay for potential PSSs waiting for their license. Several Peer Support Specialists commented "You're going to have to go through this training, and you're probably going to go without pay for some time. And then, you're going to have to sit on your hands while you're waiting for the certification to go through the Board of Behavioral Health." Waiting for a certification without pay for a job that pays less than retail and fast-food establishments was noted as an essential fix that would increase retention after training ends. Streamlining the certification process would also eliminate the needs for mentorship and guidance through a process many peers felt was extremely onerous.

Participants also identified the requirement to show proof of clinical supervision at the time of applying for certification as another obstacle that complicates the certification process. Participants noted that Montana suffers from a shortage of behavioral health workers, and finding a qualified and willing clinical supervisor (one who is likely already overworked and under paid) proves impossible for many peers. A Peer Support Specialist reports,

> *I looked for people in the telephone book and I went to [BH agency], which I still had connections with, and they said, 'Oh, well, there's a whole bunch of LACs in these different organizations that you could contact.' And I found out from other clinics and other doctor's offices where I could find an LAC that would be willing to be a supervisor. I had to hit the ground running. I had to invent the stuff on my own. [Finding a clinical supervisor] that had enough experience to do the job and whose schedule was open enough to be able to work around my hours and my job at whatever agency [was very difficult].*

PSSs described challenges identifying licensed professionals willing to sign-on as their clinical supervisor to fulfill the certification process's clinical supervision requirement, and clinical supervisors report a reluctance to sign their name on certification forms, especially when they are unexpectedly contacted by peers with whom they have no personal or professional relationship, or when they are not well versed in Peer Support. A clinical supervisor states:

I have had people ask me to do clinical supervision. My name comes up quite a bit in [PS 101] and I get contacted and I have decided that unless someone is job attached, I will not sign off on their clinical supervision form. And the reason for that is just for my own protection. I don't know the person.

If peer supporters are trying to apply for certification before they have obtained a job (i.e., there are no jobs currently available, they have a different job to sustain them during the lengthy wait period, etc.) they are at a disadvantage to find and secure a clinical supervisor willing to sign off on their application. Further, PSS rarely described themselves as well connected within the behavioral health field and offering a list of qualified clinical supervisors willing to sign off on a PSS's certification application would help mitigate this obstacle.

The types of providers Montana allows to provide Peer Support services emerged as another bureaucratic barrier that Peers, Clinical Supervisors and Administrators recommended expanding. As these administrators state:

> *Peers can provide peer support under a home and community-based waiver provider, mental health center, or a federally qualified health center, rural health clinic, I.H.S./tribal 638 facilities. There's discussion on*

expanding who can do peer support, mainly open it up to allow hospitals or possibly some other providers, but the discussion has not ... I have not heard the discussion extend to allowing peers to enroll independently as a Medicaid provider. -Administrator

I've never seen a PPS clinic or a critical access hospital employ a peer and be able to bill. Typically, in my world, we don't have an all-inclusive rate like FQHCs, and so the peer support could be included as part of a care coordination team under an advanced practice model, like CPC+ or Primary Care First. That level of billing is not necessarily available to most non-large clinics. -Administrator

These participants support expanding the number and types of health care settings that can offer peer support services which would increase access in areas with limited healthcare options. Other participants supported the number of clinics able to bill Medicaid but felt peer support was better provided by independent peer support organizations contracted to serve peers across multiple healthcare settings. As this administrator states,

We have no interest, and we have no qualifications to run an SUD treatment facility. That's not who we are. Let's go to whomever it may be, the FQHC, an SUD state licensed provider, or even an independent, LAC that can bill Medicaid. And let's have them do our clinical supervision for us and bill Medicaid. [We are truly independent.] We know that we can have a very frank conversation, which we need to be able to have with our clinical supervisor, because we're not dealing with their business. All they are, is our advocate, the clinical supervisor. […] There's a lot of benefits to having an independent peer recovery support organization. One, now you don't have to have every single provider with peer support. Especially in a smaller community, let's say they have two providers, [it would] be better to have the one peer supporter over here than to have everybody trying to hire and compete.

This participant describes the independent PSS model as complementary to the other contract employees and subcontract employees that healthcare centers employ. This participant describes the independent PSS model as a way to expand peer support as a service and increase quality healthcare to Montanans. She goes on the state,

Under the current system, there's absolutely no incentive, if I'm a provider, to refer someone to another provider that has peer support. And there's actually a huge built-in disincentive that they can poach my client. If I have [access to] an independent peer support place that I know can't offer [SUD services], because they're not a licensed SUD provider, I'm going to send my patient there.

This participant raises a valid point: expanding the number of licensed SUD providers able to the offer peer support may not increase access to and availability of peer support, it may create competition between health care settings, conflicts within communities, and reduce the expansion of peer support.

Another recommendation among participants was to allow PSSs to operate as independent providers able to bill Medicaid themselves. Certified Behavioral Health Peer Support Specialists and Licensed Addiction Counselors are among a few other positions unable to bill Medicaid directly. While every participant expressed support for expanding the number and types of providers able to offer Peer Support, this administrator's sentiment encapsulates the views of several administrators, clinical supervisors and peer supporters' perspectives when asked whether they supported PSS billing Medicaid directly, "No, not with the horror stories that I have and the horror stories I've heard from others with ethical violations and boundary issues and all these things. No, I think it would be a terrible idea." Boundary issues and ethical violations were the two most common criticisms for why participants did not support PSSs billing Medicaid. Otherwise, there was widespread support for expanding the number and type of providers able to offer peer support.

BILLING GAPS, PAY & BENEFITS

Participants recommended increasing the starting pay for Peer Support Specialists. One peer succinctly states, "I would increase the starting pay for peer support specialists to between $18 and $20 an hour." Low pay was regarded as one of the primary reasons for low recruitment and retention rates among PSSs, and the Medicaid billable rate was deemed responsible for this shortcoming. As this participant states:

> *I think there definitely needs to be an increase. And I think it should be mandated that organizations pay a minimum amount because if the organization's getting paid say $55, I think it's $53 and change right now, but they're getting paid that amount that they're only paying our peer specialists 12 to $17 an hour. And 17 is if you've been there for a few years, I mean that doesn't help the employee feel like they're valued at all. And so expanding that and setting some of those foundational requirements, if you're going to bill for peer support, you have to pay the peer specialists a minimum amount. Otherwise, it's going, it's all going back to the organization and the administration. And I understand there's overhead costs, but the overhead costs and all of that are not more than $40 an hour.*

Peer supporters felt healthcare providers were taking an outsized cut of the Medicaid billable rate and expressed overwhelming support for paying PSSs more and increasing the rate itself. Other participants highlighted additional reasons for why the Medicaid billable rate should increase: "Well, I'm thinking if Medicaid was paying more, [providers] would probably trickle it down a little bit more for us [. . . and the Medicaid billable rate's] been the same. I don't believe it's changed since it started in 2017." Several participants echo this recommendation as they experienced no significant increase to Medicaid's billable rate. Montana's Medicaid billable rate for Certified Behavioral Health Peer Support Specialists in recent years are: July 1, 2019 - $13.48 per 15 minutes; July 1, 2020 - $13.73 per 15 minutes; July 1, 2021 - $13.87 per 15 minutes.

A participant states, "Medicaid is the only option right now [. . .], there haven't been any private insurances in the state of Montana that have stepped forward and said, yes, we will cover [Peer Support]." Peer support is only billable through Medicaid and grants that providers receive to be able to provide this service, therefore participants suggest rectifying this billing gap to promote expansion of Peer Support services.

Participants also suggested rectifying two other prominent billing gaps. First, as this participant states, "You can't do a [group] peer support note. If [clients meet in a] group, you can't do group notes." Participants recommended allowing Peer Support Specialists to bill Medicaid for group events and support. Second, participants recommended that transportation time be considered as a billable service. One administrator expressed their frustration with transportation billing gap: "So our peer supporters take a client to Missoula to a child custody hearing because the client is terrified, nervous, has a history of using after those when they don't go well, and the state won't let you bill for the time you're in the car to get them there." Participants highly recommended that transportation be a billable service, especially considering the population served, and Montana's geography. Many clients have lost a license due to their substance use or jail time and require transportation and support for distant appointments. Peers report 'donating' a lot of time to provide these necessary services without receiving compensation for them.

INCREASE RESOURCES & SUPPORT

Peer Support Specialists describe clinical supervision as their primary resource for alleviating job stressors, promoting retention, and reducing burnout. Participants recommend PSSs receive the required amount of individual, clinical supervision because group settings do not enable them to address their problems, and even describe supervision itself as "a hit or miss thing because LACs performing that job description were also very busy doing their regular work outside of being a clinical

supervisor for the peer support specialist position." Peers also recommend making clinical supervision more affordable for those without a designated clinical supervisor at their employer; affording the $100/hour supervisor cost on less than $20/hour salary is unsustainable. Clinical supervisors suggest offering trainings specifically intended for supervising peer support specialists. This would better prepare clinical supervisors to help PSSs with the antecedents to burnout like their own self-care, recovery plan, and compassion fatigue. Clinical supervisors report,

> *I really don't know any other clinical supervisors. [. . .] As a supervisor I would like a little more guidance. I think it would be nice to have a little more guidance on what the state requires or wants in their notes specifically. Am I supposed to be providing some of their continuing education or is that outside of supervision? Can I provide some of their continuing education? That kind of thing.*

Clinical supervisors recommend a training specifically focused on PSS clinical supervision that would enable them to connect and network on matters that promote the recruitment and retention of additional Peer Support Specialists. Further, clinical supervisors report wanting more information about how and what exactly the state requires.

Professional Network & Continuing Education Units (CEUs)

Peers report that PS101 serves as an opportunity to learn about peer support and galvanizes a social network that many describe as integral to perform the position well. One peer states,

> *I get a lot out of being around a bunch of other like-minded people who all have the passion. [. . .] Montana Peer Network does little webinars and stuff, which is not my preferred learning style. They do Zoom meetings, so that training is out there, I guess. But like I said, in-person trainings. I feel like PS101 [works] because [you're] sending a bunch of people out on their own [after an in-person training] ...*

This participant captured a popular sentiment among peers: a higher satisfaction level for in-person trainings and a recommendation to increase the number of trainings offered in-person. Another reason peers do not participant in MPN's webinar series is their commitment to peer groups in their local communities. For example, one peer states, "I don't really interact with MPN, no. I've been part of a peer-to-peer group at [community group]. It was originally a peer-to-peer work group out at the [community organization]." Many peers stated that membership in peer-to-peer groups in their communities suited them because they empower them to share resources among one another and better serve local clients. Another recommendation to expand peer support and community among peer supporters included this administrator's suggestion, "I would make seed money [available] for peer-based independent organizations. That's what I'd do. And I would do it vetted through [organizations like] MPN or MHCF. That's the number one thing I would do. I would give a pool of money that is dedicated to building independent peer support, peer led organizations." This participant suggests centralizing peer support in peer-led organizations and using these organizations to serve peers and connect peer supporters invested in their communities. A hub and spoke model, of sorts, for peer support.

Other respondents expressed a desire to connect across the state but were unaware of intra-state networking opportunities. JG researchers discovered and connected comparable peer-led groups located approximately 200 miles from one another that were unaware of one another's existence. Peers' formal and informal network enables them to better serve their clients and bolster their professional skills. One peer says, "My [family member] is also a peer supporter, so sometimes he'll [. . .] tell me, 'Oh, here's a training that you should watch.' Sometimes I'll let my clinical supervisor know about it. Me and the [other] peer supporter that I work with, he and I will set a time when we can watch that." Peers' professional networks are a conduit for information, including continuing education units (CEUs).

Peers are adamant that to do their job properly they need the proper training and CEUs. Most peers requested more training and CEUs, however this came with an important caveat: CEUs must cover new, innovative, and meaningful topics. Several peers regarded CEU offerings as redundant and a waste of time, "I'm required to get 20 CEUs per year. But those 20 CEUs, a lot of them are all the same things that are being covered. [. . .] I feel like we need to be trained more in all kinds of different things." Another peer echoes the previous participant:

> *Some of the stuff that we [did for CEUs was] just going over stuff we already knew and to me, that's not training. My idea of training is learning something that I don't know. I love learning things that I don't know. I know sometimes I need to be reminded of what I forgot, but I also like learning new things and that's what training is to me, is learning new things.*

An administrator states:

> *What I would like to see them improve upon is the trainings [offered]. Every year, they're supposed to have 20 credits of training every year. And I haven't seen those trainings really change over time and I'd like to see them have more of an offering, they're pretty standard. It's the same handful of credits.*

Peers report that when they take CEUs outside the standard offerings they fear they will not count for continuing education credit, and suggest, "I'd like to see Montana Peer Network lobby more for some standardized classes that can change year to year so that people have a selection to maintain that more effectively." Other participants suggested, "I definitely think that the youth and family education piece is something that is missing that I'd like to see more of." The interviewer met this participant while observing a Peer Support Specialist Doula Training that the participant rated as an exceptional continuing education course. While observing the doula training, a JG researcher reported that all attendees were engaged: "Judging by the high level of participation and engagement in group activities and class-wide discussions, peers appear excited about the topic and satisfied with the course's content and delivery." The researcher in attendance later contacted two peers with whom he had previously interviewed and they reported that they "loved" the doula training. Another highly rated CEU was the "Emotional CPR" (eCPR) course offered by the Montana Peer Network.

Peers, clinical supervisors, and administrators agreed: peers need more support. Participants often called for more workplace support,

> *And the peer supporters they need more support. Their jobs are very hard. They're doing some of the most important work out there and they don't get a lot of support from the workplace. And so there's not opportunities, I just think it would really improve the quality of their workplace environment and reduce their burnout. They're so burned out. If they had more tools, more enrichment activities, doing a course on spirituality…*

As this participant notes, teaching administrators, clinical supervisors, and workplace staff how to better support peers may lead to higher retention rates. Participants also recommended offering peer supporters a peer mentor to assist them with the certification process. This peer-to-peer mentorship was suggested as a CEU credit that would provide the new peer with a veteran peer mentor capable of helping them with the certification requirements, and the veteran peer with an opportunity to stay abreast of current certification requirements enabling them to recruit the next generation of peer support specialists.

CONCLUSION

Peer Support Specialists promote individuals' recovery process (Masih et al. 2021; Wayne et al. 2019), serve the public good (Magidson et al. 2021; Reif et al. 2014; Staton et al. 2021), and diversify recovery options outside the clinical setting (Kleinman et al. 2020). This study is the first of its kind to capture the voices of Peer Support Specialists to: (1) document the experiences of and the motivations to become a Certified Behavioral Health Peer Support Specialist; (2) understand the factors that affect recruitment and retention; (3) offer recommendations for strengthening this resource in Montana from the perspective of Certified Behavioral Health Peer Support Specialists.

Peer support specialists in Montana play various roles depending upon their care setting, and overwhelmingly pursued their professional role out of altruism and a desire to assist others in their recovery. Peers state that PS101 serves as a professional development opportunity that encourages recruitment and enrollment as CBHPSS, but one of the major deterrents to certification is the onerous and inefficient certification process. One of the most frequently mentioned methods to assist peers during the certification process was a peer-to-peer CEU that offers credit to CBHPSS's who assist those pursuing certification. Peers also recommended standardizing the peer role across services and agencies; however, this is challenging in Montana where geographic and access to social services differ drastically across the state, thereby potentially constraining the utility and effectiveness of peers in some care settings.

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