

# A Policy Analysis of Peer Qualifications in Mental Health Treatment in Michigan

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## Abstract

The inclusion of peer specialists, who are individuals with their own mental health recovery experience, is a relatively new addition to the mental health system. The Michigan Department of Community Health (MDCH) Medicaid Provider Qualifications specifies the criteria for Certified Peer Support Specialists (CPSS) as Qualified Mental Health Professionals (QMHP), and narrowed those qualifications to only those who had been served in public mental health system in 2011. Analysis is reviewed the impact of this specific change on the peer and non-peer workforce, MDCH staff, policy-makers, and public at large. Recommendations for policy, future research, and applications for practice are made to enhance mental health service teams with robust peer workforce members.

**Keywords:** Public mental health; Peer support; Recovery

## Introduction

In 2003, the President's New Freedom Commission published a sentinel white paper, *Achieving the Promise: Transforming Mental Health Care in America*, challenging this history and advocating for significant changes to the system of care to emphasis mutuality, consumer voice, and recovery, stating "we envision a future when everyone with a mental illness can recover" [1]. The same report offered a working definition of recovery, "Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability [1].

The Substance Abuse and Mental Health Services Administration, SAMHSA, then convened consumers, providers, and policy-makers, and identified 10 components to recovery-oriented mental health. They were: self-direction, individualized and person-centered, empowerment, holistic, nonlinear, strengths-based, peer support, respect, responsibility, and hope (SAMHSA, 2006). In order to incorporate peer support into the service array, the Center for Medicare and Medicaid Services added peer support in 2007 as a Medicaid billable service as part of the 1915b3 waiver. In addition, SAMHSA published an Evidence-Based Practice (EBP) toolkit for Consumer-Operated Service Programs [2]. Neither the SAMHSA toolkit nor the Center for Medicare and Medicaid Services specify a preference of background for peers being served in the public or private system, but only that they have experience with mental illness and use that knowledge to provide peer services to others with mental illness.

The addition of a major class of professionals into the mental health workforce meant important changes to the organization of mental health teams, the manner in which mental health services are perceived by recipients, and the workforce pathways that peers have at their disposal. Like all mental health provider groups, it is crucial that peers be well-trained, that the certification process be clear and relevant to practice, and that the service delivery, reporting, and payment models be appropriate to match needed mental health resources. Also, research on the impact of peers on clinical outcomes for mental health recipients can provide

important clues related to how this group of professionals may impact recovery for service recipients.

Although peer services have been part of the informal system for substance use and mental health mutual aid/self-help groups for 90 years [3], peer support services have been studied only in the last 25 years [4]. Peer services have been part of a professionalized service array during this time, but have also been an advocacy and civil rights movement in mental health for far longer.

The evidence on the effectiveness of peer support services is uneven, in part because peer supports do not represent a single well-defined set of professionals or interventions. In two exploratory qualitative studies based upon interviews with recipients of peer services [5,6] participants reported that peers, those who shared the experience of having a mental illness, offered positive relationships, a sense of belongingness, and increased connection to the mental health system. The treatment background of peers was not discussed or noted as an issue in these qualitative studies.

There are two important studies which address the effect of peer services on the Peer Support Specialist (PSS) themselves. In a content analysis of semi-structured interviews with twelve peer specialists in Canada focused on the work experience of new peer specialists [7], themes emerged including tension between peer and non-peer staff and a learning curve to the peer role. In a qualitative meta-synthesis [8] of 27 articles focused on themes in studies on the impact of being a peer on the peers themselves, 44% of articles had themes of low pay and few hours, peer support workers being role models, and training and supervision are important to success as peer supports.

Quantitative reviews of the outcomes of peer services correlate peer services to decreased hospitalization, improved housing, and decreased substance use among recipients. Several recent systematic reviews, including a 2013 Cochrane review, have concluded that there is a moderate level of evidence to support the impact of peer services on outcomes [9,10] in both public and non-profit mental health systems and the Veteran's Administration [11,12]. In one particularly high

quality randomized controlled trial, Sledge et al. [13] related to peer services following psychiatric hospitalization. In this study, randomly assigned participants to peer services or services as usual following an inpatient psychiatric hospitalization, participants with peer services had significantly fewer admissions and days. In a retrospective claims record review of almost 500 files, [14] evaluated differential re-hospitalization rates over 3 years for participants in a peer support group and those that were not. Participants in peer support had significantly lower rates of re-hospitalization within three years. Most of the outcomes measurement on peer services relates to peers being added to the existing service array, or peer-delivered curricula [10,9] and examines not only quantitative clinical outcomes, but recovery measures including the Recovery Self-Assessment (RSA), and demonstrate the positive association of peers with improved sense of wellness and inclusion for service recipients. This provides important evidence that the inclusion of those with lived experience into the mental health service array is crucial for continued movement on quantitative and qualitative improvements to practice and outcomes.

An additional aspect of peer services relates to cost [15], found that peer services were associated with higher Medicaid costs, but that this could potentially be balanced by the improvements in recovery outcomes for individuals with mental illness.

### Peer Support Policies

The specific endorsement of peer support by lead federal policy and funding bodies pushed state mental health systems to codify peer support. In all but three states [16,17], a new classification of professionals, the peer support specialist, has either been developed or is in development. Peer support specialists are people with lived experience with mental illness who provide peer support as described by SAMHSA. States that incorporate peers have needed to identify qualification expectations, training or certification requirements, and professional practice standards [18].

In Michigan, all providers of mental health services to Medicaid recipients are classified under the Michigan Medicaid Provider Standards as Qualified Mental Health Professionals (QMHP) [19]. These standards include qualification, certification or licensing standards, and scope of practice limitations, set forth by MDCH. A Deputy Director of MDCH issued a 2007 policy statement announcing the “creation of the Michigan Recovery Council and the availability of Peer Support Specialists. The Michigan Recovery Council is charged with reviewing all MDCH policies that support or hinder recovery and proposing proactive changes.” [20].

The Michigan Recovery Council consisted of invited individual peers and representatives of peer agencies in Michigan, and staff from the Michigan Department of Community Health. At that time, the qualifications for peers were stated as follows: Peer Support Specialist—An individual in a journey of recovery who has a serious mental illness *who is now receiving or has received services from the public mental health system* [This is a requirement for any Peer Support Specialist certified after July 1, 2011.]. Because of their life experience, they provide expertise that professional disciplines cannot replicate. Individuals employed as Peer Support Specialists serving beneficiaries with mental illness must meet MDCH specialized training and certification requirements. Peer Support Specialists who assist in the provision of a covered service must be trained and supervised by the qualified provider of that service [19].

To situate peer specialists among other Qualified Mental Health Professionals (QMHP), it is helpful to identify the structural differences between the three groups of QMHP: licensed, certified, and paraprofessional. In the first group of QMHP, including physicians,

nurses, and social workers, are licensed practitioners. Licensing means that educational and other qualification standards are established by the Michigan Public Health Code 368 of 1978 [21] and the profession is monitored by a public licensing board, which can issue sanctions. The second group of QMHP includes Peer Support Specialists. Certification standards are established *via* administrative rules as opposed to statute. Certified QMHP have to meet qualification and/or certification exam standards, and in some cases a code of ethics. However, the certification body can be public or private, and it does not have the same enforcement and sanction ability as licensing boards. Peer Support Specialists are certified directly by the Michigan Department of Community Health within the Office of Recovery Oriented Systems of Care [22]. In the third group of QMHP are non-licensed and non-certified practitioners, or paraprofessionals. These positions, primarily aides, sometimes require educational or experiential background, but are not licensed or certified at the individual level. For a visual depiction of these three groups (Figure 1).

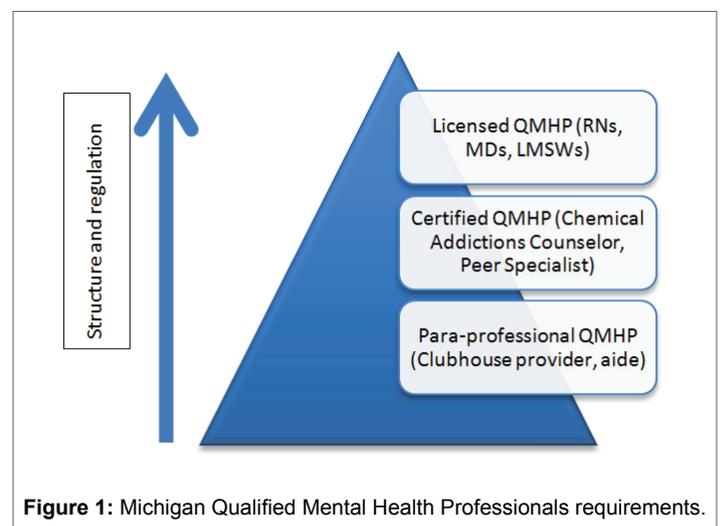


Figure 1: Michigan Qualified Mental Health Professionals requirements.

In Michigan, a certification process was established in 2007 for peers who wanted to become Peer Support Specialists [23] and provide services in the public mental health system as part of the newly available 1915b3 Medicaid waiver. Peers applied directly to MDCH, to the office now called the Office of Recovery Oriented Systems of Care [22]. In order to be eligible to apply, peers needed to already be working as a non-certified peer provider with mental health consumers for at least 10 hours/week in paid or unpaid employment. The application process asked peers to identify their experience with mental illness and recovery, and are evaluated by staff at MDCH for inclusion in the training step of certification. If accepted, peers attend a weeklong peer specialist training workshop offered several times a year by MDCH and a one-day Michigan specific module. Upon completion, peers may take a certification exam. If peers pass the certification exam, they become Certified Peer Support Specialists and as such are eligible to report peer services (H0038 CPT code under 1915b3 Medicaid services). Figure 2 depicts this process.

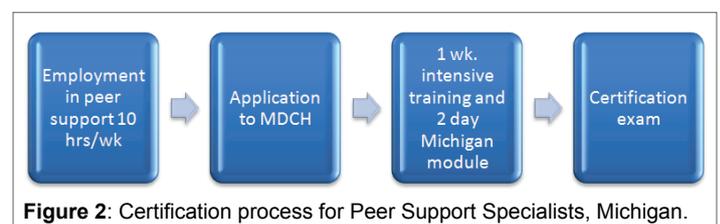


Figure 2: Certification process for Peer Support Specialists, Michigan.

Michigan had over 1200 Certified Peer Support Specialists working in the public mental health system as of October 2016. Although Michigan was one of the first to train and certify Peer Support Specialists, by 2016, 47 states had some process of training or certifying people with lived experience who are willing to assist others in recovery [16]. This makes Michigan's policies all the more important not just in the state, but nationally as other states utilize the standards of early adopter states in setting their own guidelines for peer support services.

In July 2011, a requirement was added to the policy that Peer Support Specialists (PSS) had to be "now receiving or has received services from the public mental health system" [19]. This analysis will specifically explore the rationale for this change, and effect of this narrowing of the practice guidelines for PSS in Michigan since 2011 on all relevant stakeholders.

### Evaluation

To analyze the effect of this 2011 change in qualifications for Peer Support Specialists in Michigan, a search for policy statements, memos, and minutes from the Michigan Recovery Council was completed, from the Council's inception in 2005 forward. In addition, stakeholders were queried directly about their perceptions of the impact of the change. Since there are complex issues at play related to employment, funding, and professional relationships, those stakeholders are referenced by role as opposed to name in the results [24]. Policy analysis framework was used and lends itself to a utilitarian ethical analysis frame to look at real world effects of this policy change and the alternatives. "To determine what is right we should simply aggregate the total pleasures and subtract the total pains reasonably foreseeable from any course of action. This is of course still the main criterion used in much public policy, including public health" [25], and the net benefit and detriment to the major categories of stakeholders of this specific 2011 change that PSS must be "now receiving or has received services from the public mental health system" [19].

A policy change which narrows the pool of PSS to those who have received services in the public mental health system effects several groups of people: consumers of peer services, existing and prospective Peer Support Specialists, employers of peers, the administrators of the peer support delivery system, and the advisory board responsible for recommending policy changes (Figure 3).



Figure 3: Major stakeholders in Peer Support Specialist policy.

Before reviewing the net effects of the policy change, it is important to identify the intended effect, or rationale for policy change. Here there is scant information. No administrative memos or announcements were located explaining the need for this narrowing of qualifications for PSS published by MDCH.

The Michigan Recovery Council is an advisory board charged with making policy recommendations to MDCH regarding peer services, composed of peers and MDCH staff. Minutes from the Michigan Recovery Council do not reference the policy change to restrict the background of Peer Support Specialists, either before or after the change in 2011. Even though no specific written rationale was discovered for the policy change, there are several possible reasons that might explain it. The narrowing of Peer Support Specialists to those served in the public system could address a logistical problem of the number of applicants. There could be specific skills gained by having been served in the public mental health system that a Peer Support Specialist can transfer to consumers to navigate that same public system. It is possible that those served in the public mental health system are closer, "more peer" than those served in the private mental health system. To evaluate whether the policy change demonstrated utility in any of these areas, net benefits and detriments to each major stakeholder group will be explored.

### Stakeholder Group Potential Impact

The potential impact on the most upstream stakeholder group and the policy advisory group, are unclear, since there is no mention in their meeting minutes acknowledging that the change occurred. The Michigan Recovery Council has two main groups in its membership: peers and peer-run organization representatives, and staff from MDCH (some of whom are also peers). The fact that there is no mention of this policy change could be reflective of the change not being a priority for the Council, or of reluctance on the part of Council members to criticize the policy change promulgated by MDCH, their fellow Council members [7]. Speak to this tension between peer and non-peer staff, and the learning curve of peers in determining their role. However, peer organizations around the state have been more vocal in their opposition to the policy change separate from the Council meetings, citing it as arbitrary and a way to address administrative issues rather than the quality of the peer workforce (peer organization director, personal communication, October 27, 2014).

The potential impact on MDCH itself relate to these logistic or administrative issues. The narrowing of the candidate pool could potentially lessen the number of applicants, although by how much is not clear. If each year MDCH were to review 150 applicants instead of 300 for 90 PSS training spots, time could be saved on the review of each applicant. However, since there are finite training spots for the initial and Michigan module portions, and a certification exam to be passed, the additional administrative burden is limited to the application phase. If we revisit Figure 4 with the effects of the policy change, it is hard to envision a substantive administrative burden would be lifted. The net workforce would be the same, presuming there are a finite number of PSS positions available at any time.

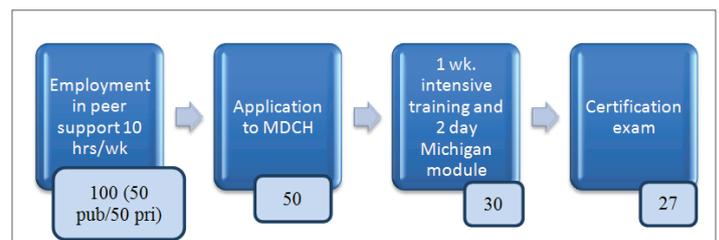


Figure 4: Hypothetical effect of policy change on numbers in Peer Support Specialist process.

The effect on employers of the policy change to narrow the background of Peer Support Specialists to only those served by the public mental health system, is clearer. If agencies hire or want to hire peers with a private background of care, they will not be eligible for certification, and employers will not be able to bill for Medicaid 1915b3 service. One hiring supervisor I interviewed spoke to this, stating “there is a big shift in our applications for peers. It seems like the state wants to use this policy to exclude people they find undesirable, meaning they weren’t served in their system, from becoming Peer Specialists.” (Agency supervisor, personal communication, August 7, 2014). Not only is the change perceived as a negative for the agency workforce, but there is the indication that the change is perceived by some as a way of getting at other aims, such as eliminating some applicants from the pool because they are “undesirable” rather than unqualified.

For Peer Support Specialists who applied after the policy change, those with a private treatment background would not be eligible to become Peer Support Specialists, a clear negative effect. Peers with a public treatment background might benefit from a smaller applicant pool, and thus a higher chance of their applications being accepted. The other possible effect on Peer Support Specialists approved before the change is less concrete, but important nonetheless, if they perceive their background as less valuable as a peer.

They now require that you have received services in the public mental health system (either in Michigan or outside). So if you are somebody whose parents or husband had a job and gave insurance and you got treatment that way, you couldn’t be a Peer Support Specialist (Peer Support Specialist, personal communication, November 13, 2013).

One possible rationale for limiting Peer Support Specialists to those served by the public system relates to the experience of being in the public system itself. Perhaps being served within the public system gives peers the skills needed to help their consumers navigate that same system. However, these precise system navigation knowledge and skill components are included in the peer training, as is information about statutes and the system of care in Michigan. If the application review is comprehensive, the training thorough, and the certification exam an appropriate test for knowledge and skills, then all peers completing that process to become certified have the skills of navigation in the public system.

Although there is evidence of the positive effect on hospitalization rates, and relationship for consumers of peer services, there is no research on differential outcomes for consumers stratified by peer background. The effect of the policy change to narrow the background of Peer Support Specialists is unknown.

## Key Findings

- Federal and state agencies have established peers with lived experience as mental health providers over the last 25 years.
- During the same time, research began to demonstrate the effect of peer services on hospitalization, employment, substance use, and recovery outcomes.
- Michigan has certified Peer Support Specialists since 2007, and changed the certification requirements to include only those served in the public mental health system in 2011.
- There is insufficient evidence of the need for this limitation, which should be eliminated.
- Peers provide a crucial addition to the mental health treatment system, and add important components to peer services and teams including peers.

## Conclusions

In summary, the net benefits of this policy change appear to be decreased administrative resources at the application point, and less competition for Peer Support Specialist training slots among peers with a public treatment background. Net detriments appear to include a decreased pool of applicants, especially impactful for peers with a private treatment background, and their employers. There is insufficient evidence to determine actual net benefit or detriment of this policy change on Peer Support Specialist personal wellness, consumers, or policy-making bodies. There also remains lack of clarity about the motivation for the change, perhaps due to the lack of evidence or explanation for the policy change. In conclusion, the policy change to limit the applicant pool of Peer Support Specialists after 2011 to only those serves in public mental health system is not referenced as a policy priority nationally or at a state level, is not noted as an issue in the research on peer support, and does not appear to fix a logistical or fiscal problem. There is insufficient evidence of the benefit of this policy change.

In its earlier incarnation of the provider qualification standards, peers who themselves were on “an individual in a journey of recovery who has a serious mental illness” [19] were eligible to apply to become CPSS. Those best qualified, most able to articulate their recovery process in the furtherance of the recovery of those they served, would be selected to complete training and test for certification, ultimately becoming CPSS. This original policy offers the greatest net benefit for the greatest number, both in Michigan and other states that may be considering a similarly restrictive policy.

Peers are fast becoming a codified part of the mental health treatment system. The relationship of peers serving on teams or in peer-delivered services to best practice fidelity is an area for further research. In addition, further research on the impact of peer policies on the PSS themselves needs continued research given the rapid expansion of peer services in all but a handful of states.

Peer practice implementation in mental health offers barriers and opportunities for systems of care. The cost and benefit of training, incentivizing, and supporting peers are significant considerations for systems of care. Continued analysis of data across the state and beyond over time on the association of peers and outcomes of hospitalization, housing status, employment, and criminal justice involvement could not only determine a correlation, but also have further policy and staffing implications.

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