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Mental Health Peer Support Professionals in CCBHCs:

A Workforce Integration Needs Assessment

NATIONAL COUNCIL *for* Mental Wellbeing

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EXECUTIVE SUMMARY

Certified Community Behavioral Health Clinics (CCBHCs) represent one of the most significant public investments in behavioral health infrastructure in recent years, reflecting coordinated federal and state commitment to expanding access to integrated mental health and substance use disorder care. With required service categories that include crisis care, care coordination and access to health and social services — and supported in many states by a prospective payment system — the CCBHC model embeds high-quality, evidence-based, and person-centered care across varied populations and payer types. Peer support delivered by peer support professionals (PSPs) is designated as one of the nine required CCBHC service categories, reflecting federal acknowledgment of the value the model places on nonclinical supports based on lived experience (SAMHSA, 2023a). The long-term impact of this structural mandate, however, depends on the stability and sustainability of the peer workforce. The evidence base supporting peer support is well established, but its full realization within CCBHCs depends on intentional workforce development, supervision alignment, role clarity, fair compensation and organizational cultures that meaningfully integrate lived-experience expertise.

This paper examines the current landscape of mental health PSPs and their integration in CCBHCs across the United States. It draws on a targeted review of peer support and CCBHC literature, federal and state policy guidance, national workforce and implementation reports, and qualitative insights from key informant interviews with CCBHC leaders, PSPs and national stakeholders. Through this review, the analysis evaluates the structural, workforce and policy conditions shaping peer integration.

There are several areas of focus: training and certification requirements across states, recruitment and retention challenges, compensation and benefits, career pathways and advancement opportunities, workforce composition, and barriers to effective integration within CCBHC care structures. The paper further examines system-level and organizational conditions shaping workforce sustainability while identifying unmet needs and emerging strategies to address these gaps.

Although CCBHCs employ PSPs across mental health, substance use and family support roles, this paper centers on mental health PSPs, providing a focused examination of workforce integration and sustainability within the CCBHC framework.

METHODS

To inform this resource, National Council for Mental Wellbeing project consultants and staff employed a mixed-methods approach that included key informant interviews and a targeted literature review. Given the limited peer-reviewed literature from the U.S. that is specific to peer workforce integration within CCBHCs, relevant international peer-reviewed research was also examined to inform contextual understanding of workforce implementation. The review further incorporated peer-reviewed journal articles, national workforce and needs assessment reports, federal guidance and legislative materials, and publicly available Medicaid and Medicare policy documents.

Between January and February 2026, the project team conducted semi-structured key informant interviews with five PSPs from five separate CCBHCs, two CCBHC administrators and three representatives from national mental health advocacy organizations involved in the delivery, oversight or advancement of peer support services and the delivery of CCBHC services. Participating CCBHCs were located in five states: Connecticut, New Jersey, New York, Rhode Island and Texas.

An interview guide was developed to explore workforce recruitment, certification and training, supervision models, role integration, compensation structures and retention challenges. Interviews were conducted via telephone, Zoom videoconference and structured email correspondence. Findings from interviews were synthesized with literature and policy review findings to identify recurring themes, structural barriers and strategic considerations reflected throughout this report.

PEER SUPPORT PROFESSIONALS IN BEHAVIORAL HEALTH

Definition and core principles

Peer support in behavioral health is grounded in lived experience, mutuality, respect, empowerment and the cultivation of hope. Central to peer support practice is an emphasis on shared decision-making and client choice, reflecting the nonhierarchical, collaborative nature of peer relationships.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines peer support as "offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations" (SAMHSA, 2015). Peer support professionals[1] (PSPs) are individuals with lived or living experience of mental health and/or substance use conditions — either directly or through a dependent — who draw on that experience to support others in nonclinical, recovery-oriented ways (SAMHSA, 2023b).

Consistent with these principles, PSP activities include advocacy, mentorship, resource navigation and skill development, as outlined in SAMHSA's core peer support competencies (SAMHSA, 2015). PSPs also foster community connections and sustained involvement in care through the intentional use of lived or living experience (SAMHSA, 2015). These functions align closely with the Certified Community Behavioral Health Clinic (CCBHC) model's integrated, person-centered approach to care delivery. Within CCBHCs, peer support serves as a complementary modality to enhance continuity and coordination while remaining distinct from licensed clinical treatment.

Workforce context and demand

Increasing reliance on peer support is unfolding amid a substantial and persistent behavioral health workforce crisis in the U.S. While workforce shortages have accelerated hiring for peer roles, growing recognition of the unique contributions of lived experience — particularly in fostering engagement, trust and recovery-oriented care — has also contributed to increased demand for peer-delivered services. In 2024, an estimated 62 million adults experienced a mental health disorder, with nearly half receiving no treatment due to provider shortages, coverage gaps and structural barriers to care (Health Resources and Services Administration [HRSA], 2025; SAMHSA, 2025). Approximately 40% of the U.S. population lives in designated Mental Health Professional Shortage Areas (HRSA, 2025). These shortages disproportionately affect rural communities, which are significantly more likely than urban areas to lack behavioral health providers. Nearly 69% of rural counties lack psychiatric mental health nurse practitioners and 45% lack psychologists (HRSA, 2025). In many regions, these workforce gaps contribute to the emergence of "mental health deserts," where limited provider availability significantly restricts access to care. For example, in Texas, 97% of counties are designated as fully or partially Mental Health Professional Shortage Areas, illustrating the magnitude of geographic workforce imbalances affecting behavioral health service delivery (Espinosa, 2025). Taken together, these patterns suggest that projected deficits across licensed behavioral health occupations are likely to persist in the coming years (HRSA, 2025). In this context, nonclinical workforce roles — particularly PSPs — are increasingly recognized as essential to expanding service capacity, strengthening engagement and improving continuity of care within integrated behavioral health systems.

Within this constrained workforce landscape, demand for peer-delivered services has grown rapidly. Employer demand for PSPs increased by a factor of 17 from 2010-2020 (Ziemann et al., 2023), reflecting strategic adoption of peer roles to supplement licensed practitioner capacity and enhance engagement.

1 Across states and service systems, peer roles may be referred to by different titles — including peer support specialists, peer support workers or simply peers — but for consistency, this paper uses the term *peer support professionals*.

Workforce modeling suggests that more than one million PSPs may ultimately be needed to meet population-level behavioral health demand, compared to an estimated 74,000 currently active PSPs (Gingerelli et al., 2024).

Together, these trends underscore a widening supply-demand gap and highlight peer support not only as a required CCBHC service but also a strategic workforce investment within integrated mental health and substance use care delivery.

Evidence base supporting peer-delivered services

A substantial body of research demonstrates that peer support contributes to improved outcomes, including reduced self-stigma and increased hope, empowerment and engagement in care (Shalaby & Agyapong, 2020). Systematic reviews further identify associations with improved social functioning, treatment retention and quality of life among individuals receiving peer services (Gaiser et al., 2021). These individual-level outcomes translate into measurable system-level effects. Peer-delivered services reduce reliance on high-cost, acute care settings — including inpatient hospitalization and emergency departments — particularly when peer roles are structurally embedded within multidisciplinary care teams (Gaiser et al., 2021).

By facilitating early connection, supporting care transitions and addressing impediments to sustained engagement, peer-delivered services contribute to improved resource allocation and reduced system strain within publicly financed behavioral health systems. Although formal cost-effectiveness analyses remain limited, early CCBHC implementation research indicates that structured financing mechanisms and defined peer roles within team-based care models yield downstream economic benefits through improved continuity of care and reduced avoidable service usage (Matthews et al., 2025).

Beyond individual and system-level outcomes, peer support demonstrates broader stakeholder impact. For families and caregivers, peer engagement improves system navigation, supports shared decision-making and sustains involvement in recovery planning (Shalaby & Agyapong, 2020). For multidisciplinary teams, integration of peer roles is associated with stronger engagement and greater capacity to address relational, experiential and community-based dimensions of care (Gaiser et al., 2021; Matthews et al., 2023). These contributions enhance team-based care by extending dimensions of service delivery that licensed roles alone cannot fully provide.

Peer-delivered services also demonstrate relevance across varied service settings and populations. Peer support for people recently released from incarceration is associated with improved engagement during high-risk care transitions and reduced cycling between community and institutional settings (Lee, 2021). Consistent with earlier discussion of workforce shortages, national workforce assessments underscore the importance of peer roles in rural areas and for communities with unmet needs, where workforce maldistribution and persistent provider shortages constrain access to specialty behavioral health care (HRSA, 2025; Gazda et al., 2023). Collectively, these findings indicate that peer support generates

multidimensional value — not only for individuals receiving services, but also for families, providers, payers and publicly financed health systems seeking to improve access, continuity and resource efficiency.

Mutual benefits of peer support

In addition to benefits for service recipients, peer roles are associated with increased empowerment, strengthened recovery identity and professional development among PSPs themselves (Gaiser et al., 2021). Longitudinal research demonstrates sustained and comparatively high rates of employment following peer certification, exceeding historical workforce participation patterns among individuals with serious mental health conditions (Ostrow et al., 2022; Ostrow, Cook, Pelot, Robinett, et al., 2025). Attrition from peer-specific roles, when it occurs, is more often linked to organizational factors (e.g., supervision, compensation and advancement opportunities) than to lack of workforce viability. These findings underscore the importance of intentional workforce development strategies to sustain peer roles within high-demand systems, including CCBHCs.

Financing peer services

Medicaid reimbursement for peer support services has been widely adopted, but reimbursement policies, billing structures and payment rates vary substantially across states (Peer Recovery Center of Excellence, 2024). Of the 50 U.S. states, five U.S. territories and the District of Columbia, 48 currently offer some form of Medicaid reimbursement for peer services, while a small number have established peer certification without corresponding Medicaid coverage (Peer Recovery Center of Excellence, 2024). Service definitions, billing codes, supervision requirements and rate structures differ considerably across jurisdictions. Coverage of peer services has trended toward the components with direct service delivery (e.g., individual or group services) rather than other core peer services such as outreach, engagement and community-based activities (Peer Recovery Center of Excellence, 2024). Outside of Medicaid, coverage of peer services has largely been restricted to time-limited grants.

PEER SUPPORT PROFESSIONALS IN CCBHCS

Required services and staffing expectations: Peers as an essential service

Peer support is designated as a required service category under the CCBHC Certification Criteria (SAMHSA, 2023a). The criteria require CCBHCs to provide a range of peer-delivered services, including recovery coaching and family/caregiver support (SAMHSA, 2023a). Services may include crisis support, peer navigation across levels of care, youth and young adult peer services, community navigation support, mutual support and self-help groups.

Within CCBHCs, peer services may be delivered by certified peer specialists, recovery coaches or family peer specialists, depending on state certification standards and organizational structure (SAMHSA, 2023a). Services may be provided directly by the CCBHC or through Designated Collaborating Organizations (DCOs), a structural feature of the model that allows clinics to expand their capacity by developing formal relationships with another service entity to deliver one or more elements of the required CCBHC services. Partnerships with community-based or peer-led organizations can extend service reach and leverage established community networks. Referral pathways to peer services may also vary across CCBHCs depending on clinic structure, staffing models and the degree to which peers are integrated within multidisciplinary care teams.

Benefits of peer integration within CCBHCs

Peer integration within CCBHCs serves a dual function: expanding service capacity beyond licensed providers while reinforcing recovery-oriented, nonclinical approaches to behavioral health care.

Embedding PSPs within integrated mental health and substance use care delivery strengthens access to behavioral health services, meets growing service demand and preserves person-centered practice.

This approach aligns with SAMHSA's Core Competencies for peer workers, which emphasize recovery orientation, self-directed support, trauma-informed practice, ethical use of lived experience, and systems navigation as foundational elements of effective peer service delivery (SAMHSA, 2018). Integrating PSPs within CCBHC structures operationalizes these competencies within whole-person models of care (SAMHSA, 2023a).

Within CCBHCs, peer integration is particularly visible in crisis services. Analyses conducted by the National Council for Mental Wellbeing indicate that CCBHCs play a central role in delivering mobile crisis response, crisis stabilization and postcrisis follow-up, often in coordination with emergency departments, 988 call centers and first responders (National Council, 2024a, 2024b). PSPs frequently contribute to these functions, in which lived experience enhances trust, reduces perceived power differentials and supports engagement and de-escalation during periods of acute distress. Federal guidance recognizes peer support as a component of crisis systems across the continuum of response (SAMHSA, 2022).

The CCBHC PPS, which reimburses anticipated costs of care rather than discrete encounters, further supports peer involvement in outreach, follow-up and care coordination activities that are often not billable under traditional fee-for-service models. By supporting engagement, system navigation and continuity of care, PSPs help address service gaps that licensed providers alone are often unable to fill. Collectively, these elements position peer support as a core workforce strategy within the CCBHC model.

Structural features of CCBHCs supporting peer workforce integration

CCBHCs are structured to support peer workforce integration and sustainability through aligned financing, required service categories and flexible delivery. The funding model provides stable and predictable reimbursement, allowing clinics to sustain peer services as part of comprehensive care delivery rather than relying on time-limited grants or narrowly defined fee-for-service billing mechanisms.

Under the CCBHC model, Medicaid services are reimbursed through a clinic-specific PPS rate based on anticipated costs of care rather than discrete billing units. This approach enables clinics to allocate resources across workforce roles, including PSPs, based on clinical need and population demand. Because PPS payments are not constrained by individual Medicaid fee schedules, CCBHCs have greater flexibility to sustain services that are difficult to finance under traditional billing models, including outreach, engagement, care coordination and crisis-related support (Peer Recovery Center of Excellence, 2024). This financing model is particularly relevant for peer-delivered services, which frequently involve activities that are not encounter based and yet are central to recovery-oriented and community-based practice.

Within CCBHCs, early implementation findings indicate that structured financing and standardized service requirements are associated with expanded deployment of peer roles and measurable shifts in service utilization patterns (Matthews et al., 2025; National Council, 2024a). These findings indicate that the CCBHC PPS and required service framework better enable clinics to sustain peer roles across care settings compared to traditional fee-for-service models. Within the CCBHC care delivery model, peer support operates as a defined and reimbursable service embedded within integrated mental health and substance use disorder treatment — positioning peer roles as core service infrastructure rather than ancillary workforce support.

The option to deliver services through DCO partnerships further extends the CCBHC model's operational flexibility. National impact reporting indicates that expansion of substance use disorder services has coincided with strengthened partnerships with community-based organizations, supporting outreach to high-need populations and service delivery in nontraditional settings (National Council, 2024a).

At the same time, the use of DCO delivery structures introduces important considerations related to supervision alignment, reporting relationships, administrative accountability and organizational integration. Challenges with multidisciplinary integration are multiplied when several organizations are involved. While the PPS financing model may reduce historical reimbursement barriers to peer services, effective implementation across CCBHC and DCO entities depends on clear role delineation and intentional coordination. The degree to which these mechanisms translate into stable peer workforce integration will hinge on how clearly expectations and oversight structures are defined and implemented.

Integration implications within the CCBHC model

The evidence reviewed throughout this assessment indicates that successful integration of PSPs within CCBHCs depends less on demonstrating effectiveness and more on aligning the structural conditions that shape implementation. While CCBHC designation facilitates hiring through required service categories and PPS financing, sustained integration depends on clarity in supervision models, role duties, compensation structures and organizational culture. Without deliberate alignment of care delivery practices to incorporate peer-informed approaches, expansion of peer roles may not translate into meaningful workforce integration. As CCBHCs continue to scale nationally, attention to these structural conditions will be critical to stabilizing and advancing the professionalization of the mental health peer workforce.

TRAINING AND CERTIFICATION REQUIREMENTS ACROSS STATES

Overview of PSP certification, training and continuing education requirements

Across states, the criteria to become a certified PSP generally include lived or living experience related to mental health or substance use disorders, completion of a state-approved training program, and successful passage of a competency-based examination. However, eligibility requirements — including how lived experience is documented or attested — may vary by state and certification type. Most states require a defined number of training hours — often ranging from 40-80 — covering core competencies such as recovery principles, ethics and professional boundaries, trauma-informed practice, context awareness and system navigation. Additional requirements commonly include adherence to a professional code of ethics, background screening, supervised practice or mentorship components, and ongoing continuing education to maintain certification. In some jurisdictions, certification standards or examinations are aligned with credentialing frameworks developed by organizations such as the International Certification and Reciprocity Consortium, which establish competency-based standards used by member certification boards across the United States (SAMHSA, 2023b; National Governors Association, 2024).

While these foundational elements are broadly shared, certification structures vary considerably across jurisdictions. As of 2023, 49 states and the District of Columbia had established formal credentialing mechanisms for peer specialists, though certification categories, regulatory frameworks and scopes of practice differ substantially (National Governors Association, 2024). Some states maintain a single integrated peer certification encompassing both mental health and substance use disorders, while others administer separate credentials or recognize additional specialty peer roles. This variation reflects differing policy histories and workforce strategies but complicates reciprocity, workforce mobility and large-scale evaluation of peer-delivered services (Adjabeng & de Saxe Zerden, 2024; National Governors Association, 2024).

Credentialing is also closely tied to financing. State-approved certification programs are typically required for peer services to be reimbursable under Medicaid state plans or managed care arrangements, linking workforce eligibility directly to reimbursement structures (Gaiser et al., 2021; Adjabeng & de Saxe Zerden, 2024). As a result, variability in certification requirements can influence not only professional mobility but also access to reimbursable peer services across states.

National workforce analyses emphasize that clearer certification pathways, alignment with Medicaid reimbursement policies, and explicit integration of peer roles within state workforce development strategies are critical to expanding access and stabilizing the peer workforce (National Governors Association, 2024; Jones et al., 2020; Adjabeng & de Saxe Zerden, 2024). In response to fragmentation, SAMHSA released National Model Standards for Peer Support Certification, encompassing mental health, substance use and family peer roles (SAMHSA, 2023b). These standards aim to promote greater consistency across states while building upon SAMHSA's Core Competencies for Peer Workers.

However, national standards do not ensure uniform implementation. States continue to operationalize certification differently in terms of training hours, supervision expectations, continuing education mandates and scope-of-practice definitions. This variability may add to the administrative and financial burden on PSPs and employers. When combined with a lack of consistent alignment to standardized workforce infrastructure, this limits the workforce impact of certification reforms alone (Adjabeng & de Saxe Zerden, 2024). Strengthening portability and reciprocity mechanisms remains an ongoing policy priority for improving workforce mobility and supporting fair access to peer-delivered services across jurisdictions.

Labor market challenges and workforce development

National workforce research indicates that the peer support profession continues to operate within underdeveloped labor market structures characterized by inconsistent recruitment pathways, limited career ladders and variable compensation (Gingerelli et al., 2024). Rather than relying on standardized hiring pipelines, many organizations recruit PSPs through informal networks, reflecting the relatively recent formalization of peer roles within behavioral health systems. These structural conditions contribute to persistent challenges in recruitment, retention and long-term workforce development.

Employers and workforce stakeholders consistently identify low wages, limited advancement opportunities and the absence of clearly defined career pathways as significant barriers to sustaining the peer workforce (Gingerelli et al., 2024; Jones et al., 2020).

Peer roles are frequently classified within entry-level wage structures, with few formal mechanisms supporting progression into supervisory, training or leadership positions. Training and certification are often delivered through organization-specific or in-house programs rather than standardized statewide systems, limiting credential portability and constraining professional mobility across employers.

Research examining peer workforce mobility reinforces these findings. A national survey of 801 peer specialists found strong interest in pursuing higher education and continuing education. It also found substantial perceived barriers to professional growth, including financial constraints, administrative hurdles, stigma and devaluation of peer roles within organizations, lack of formal advancement mechanisms and limited access to academic pathways aligned with peer experience (Jones et al., 2020). Individual-level factors, such as internalized stigma, disrupted employment histories and collateral consequences associated with criminal legal system involvement (e.g., background checks and transportation barriers) further compound these structural challenges. further compound these structural challenges. further compound these structural challenges.

Consistent with national guidance, workforce strategies that reduce barriers to entry, support sustainable employment and expand participation among individuals with lived experience — particularly those who have long been excluded from traditional behavioral health career pathways — are essential to long-term stabilization of the peer workforce (SAMHSA, 2024).

Federal legislative recognition of peer support services

Recent bipartisan federal legislative activity reflects growing recognition of peer support as a distinct component of the behavioral health workforce. Collectively, these proposals advance federal investment in workforce development, infrastructure, training standardization and integration of peer-delivered services across behavioral health systems.

The Providing Empathetic and Effective Recovery (PEER) Support Act (2025) proposes targeted federal investment in peer support workforce development through grants to states and community-based organizations. The legislation emphasizes standardized training and certification alignment, peer-informed supervision models and integration of peer services within recovery-oriented systems of care. Importantly, the act affirms peer support as a complementary, nonclinical component of behavioral health service delivery while strengthening structural support for workforce sustainability.

Complementing this workforce-focused effort, the Promoting Effective and Empowering Recovery Services (PEERS) in Medicare Act (2025) proposes expanded Medicare reimbursement pathways for peer-delivered services furnished within team-based care models under appropriate supervision. Although PSPs would still not be enrolled as independent Medicare providers under the proposal, the legislation reflects a broader federal shift toward recognizing nonclinical, recovery-oriented roles within reimbursable behavioral health services.

Together, these bipartisan initiatives signal continued policy momentum: Peer support is increasingly recognized at the federal level as an evidence-informed workforce strategy within team-based behavioral health care. These legislative efforts align with recent Medicare Part B policy changes expanding billing for behavioral health integration and team-based services, reinforcing the relevance of peer roles within multidisciplinary care frameworks (Centers for Medicare and Medicaid Services, 2024; Cui et al., 2025).

For CCBHCs, these federal developments are particularly salient. Because CCBHCs rely primarily on

Medicaid reimbursement through the PPS, they are already positioned to integrate peer support services at scale. At the state level, Medicaid programs have been instrumental in supporting peer-delivered services through state plan amendments, managed care arrangements and other policy mechanisms that authorize reimbursement for certified peer providers (Earley et al., 2024). Expanded Medicare reimbursement pathways would not replace this financing structure but rather complement it, broadening cross-payer recognition and reinforcing peer roles within team-based behavioral health care. Federal legislative recognition therefore functions both as a financing expansion for Medicare beneficiaries and as a broader signal supporting workforce standardization, data infrastructure development and long-term sustainability of peer roles across care settings.

Standardized job classification and policy advocacy

Currently, the Bureau of Labor Statistics classifies behavioral health PSPs within the broader occupational category of community health workers rather than as a distinct workforce group. This classification limits the accuracy of workforce tracking, data collection and labor market projections, hampering informed policy development, funding allocation and workforce planning (Ziemann et al., 2023).

Policy analyses and workforce reports consistently identify the absence of a dedicated occupational classification for peer support specialists as a structural barrier to workforce development and sustainability. Recommended policy actions include establishing a distinct Standard Occupational Classification code for PSPs, clarifying recognition of peer support roles within team-based care models for reimbursement and supervision purposes, and providing technical assistance to states to leverage federal Medicaid matching funds for peer-delivered services (National Governors Association, 2024; Gazda et al., 2023).

Establishing a distinct occupational classification would improve workforce visibility, strengthen labor market data infrastructure and support more accurate long-term planning for peer-delivered services across behavioral health systems. Without formal recognition within federal workforce taxonomies, efforts to scale peer services lack reliable data to inform policy, financing and workforce strategy.

Portability of certification and licensing compacts

National peer certification initiatives present an important opportunity to strengthen professional recognition and expand access to peer-delivered services across care settings (Adjabeng & de Saxe Zerden, 2024). However, the absence of formal reciprocity between state certification programs limits workforce mobility and complicates service delivery in multistate regions. Interstate compacts — modeled after those adopted by counselors, social workers, psychologists and advanced practice nurses — could enhance portability, support coordinated care across state lines, and align with the CCBHC model's emphasis on integrated, team-based service delivery.

Variability in state certification standards, supervision requirements, scope of practice definitions and continuing education expectations creates challenges for consistent quality oversight, accountability

mechanisms, and role clarity across jurisdictions (Adjabeng & de Saxe Zerden, 2024; National Governors Association, 2024). In metropolitan areas that span multiple jurisdictions (e.g., the District of Columbia, Maryland, Virginia region), differences in credential recognition may restrict cross-border workforce deployment and complicate continuity of care. Divergent state regulations on data sharing, documentation standards and privacy compliance also create administrative barriers that may inhibit flexible integration of peer roles across systems.

Expanding reciprocity mechanisms or establishing structured interstate certification agreements could mitigate these barriers while promoting greater consistency in competency standards and workforce oversight. Such approaches would support more seamless integration of PSPs within regional behavioral health systems.

RECRUITMENT AND RETENTION CHALLENGES

Workforce demand and growth of the peer support profession

The peer support profession has expanded rapidly in response to national behavioral health workforce shortages, yet demand for peer-delivered services continues to outpace available workforce capacity. Within CCBHCs, PSPs have become integral to service delivery and workforce expansion; however, national impact reporting indicates that staffing growth has not kept pace with service demand, resulting in persistent vacancies across clinics (National Council, 2024).

Despite widespread integration of peer roles within CCBHCs, significant workforce shortages remain. A national CCBHC staffing analysis identified PSPs as the most frequently reported staff vacancies, indicating that recruitment and retention challenges have persisted even as the model has expanded (Matthews et al., 2023).

More recent workforce data underscores the depth of these constraints: In 2024, 41% of peer support positions created by CCBHCs remained unfilled, reflecting ongoing gaps between hiring efforts and available workforce supply (National Council, 2024).

Beyond CCBHCs, these challenges mirror broader system-level constraints, with 39 states reporting shortages of peer specialists in 2022 (Ostrow, Cook, Pelot, Robinett, et al., 2025).

These workforce gaps are particularly consequential given the expanding scope of peer roles within CCBHCs. With CCBHCs relying on PSPs across crisis response, outreach and care transition functions, persistent vacancies may limit the scalability and sustainability of these service lines amid rising demand. Workforce instability therefore presents not only a staffing challenge but a structural constraint on full implementation of the CCBHC model.

Recruitment challenges

Recruitment of PSPs is constrained primarily by structural features of the behavioral health labor market rather than by lack of interest in peer roles. As previously noted, workforce studies indicate that recruitment pipelines for peer positions remain underdeveloped, with many organizations relying on informal, word-of-mouth hiring practices instead of standardized recruitment strategies (Gingerelli et al., 2024). This reliance limits workforce growth and range, particularly within systems such as CCBHCs that require consistent staffing across multiple service settings.

Eligibility and hiring policies further restrict entry into peer roles. Background check requirements and exclusionary employment criteria frequently disqualify individuals with convictions, even though populations with criminal legal system involvement experience disproportionately high rates of mental health and substance use disorders. Additional organizational requirements — such as possession of a valid driver's license and minimum educational credentials (e.g., a high school diploma) — or conservative risk-management hiring practices may further exclude otherwise qualified and credentialed peers, even when such criteria are not directly related to job performance. National data indicates that approximately 30% of men and more than half of women who are incarcerated meet criteria for a substance use disorder, and that roughly 1 in 7 individuals in correctional settings has a serious mental health disorder such as psychosis or major depression (Gazda et al., 2023). These policies may unintentionally exclude individuals whose lived experience is highly relevant to engaging populations most in need of peer-delivered services.

Evidence suggests that peers with direct experience in criminal legal systems can be particularly effective in engaging individuals involved in jails, prisons, specialty courts and reentry programs. By drawing on shared lived experience, these PSPs can foster trust, increase engagement, instill hope and support continuity of care during high-risk transitions (Lee, 2021). Recruitment practices that rely on broad criminal background exclusions, rigid credentialing requirements or limited pathways for those involved with the criminal legal system often unnecessarily restrict the pool of qualified peer candidates and undermine workforce expansion.

Evidence from all-encompassing workforce models demonstrates that such exclusions are not necessary to ensure effective or ethical service delivery. Programs such as the California-based Transitions Clinic Network have successfully integrated people who were formally incarcerated into multidisciplinary care teams as community health workers, resulting in improved trust, communication and engagement among people impacted by the criminal legal system (Gazda et al., 2023). These findings suggest that restrictive recruitment policies may unnecessarily constrain the peer workforce pipeline and limit behavioral health systems' ability to leverage lived experience as a core engagement and recovery asset.

Retention and role sustainability

Retention remains a critical concern within the peer support workforce. Heavy caseloads, low compensation, limited benefits, unclear role expectations and insufficient organizational infrastructure consistently lead

to high rates of burnout, turnover and role instability among peers (Gaiser et al., 2021; Ziemann et al., 2023). National needs assessment data reinforces these findings. In the 2025 National Recovery Community Needs Assessment, stress, burnout and turnover were identified as the most common workplace challenges affecting PSPs, reported by **more than half** of respondents. Compensation and benefits concerns were reported by 41.6% of participants, and 38.3% cited unclear career advancement pathways as significant barriers to workforce sustainability (Center for Addiction Recovery Support [CARS], 2025).

Evidence from a national survey of the peer recovery workforce and related studies suggests that workforce instability is driven less by lack of motivation than by structural and organizational conditions (Foundation for Opioid Response Efforts, 2023; Siantz et al., 2023; Ostrow et al., 2022).

National survey findings show that PSPs report high levels of commitment to their roles, yet they express uncertainty about long-term retention due to burnout, compensation limitations, unclear role expectations and insufficient advancement opportunities (Foundation for Opioid Response Efforts, 2023).

Qualitative research with recently certified PSPs further demonstrates that workplace relationships, clarity of role expectations, and alignment between job duties and core peer values strongly influence job satisfaction and long-term retention (Siantz et al., 2023).

Consistent with these findings, PSPs report lower burnout and higher professional efficacy when workloads are manageable, supervision is peer-informed and organizational cultures affirm the value of lived experience (Ostrow et al., 2022). Collectively, this evidence suggests that retention challenges reflect broader system-level workforce conditions rather than lack of commitment to peer roles.

Retention pressures may be further intensified in small or rural communities, where PSPs are more likely to share social networks, service systems or community spaces with the individuals they serve. In these contexts, maintaining appropriate boundaries while preserving the relational authenticity central to peer support can introduce additional ethical complexity. Limited anonymity, overlapping community relationships and heightened visibility may increase role strain and emotional labor, particularly in regions with limited behavioral health workforce capacity. In the absence of clear organizational guidance and peer-informed supervision, these dynamics may contribute to burnout and workforce attrition (Gaiser et al., 2021).

Workforce instability may also be influenced by role expansion beyond the intended scope of peer practice. In workforce-constrained environments, PSPs may be asked to assume responsibilities that align more closely with case management, clinical documentation, crisis triage or administrative functions, particularly when licensed staff capacity is limited. While peer roles are adaptable and often embedded within interdisciplinary

teams, assignment of duties outside clearly defined peer competencies can blur role boundaries, create ethical tension and dilute the distinct value of lived experience. When organizational expectations and supervision structures do not reinforce defined peer roles, role creep — in which peers are asked to perform duties outside established competencies — may contribute to role strain, job dissatisfaction and attrition over time (Stefancic et al., 2021; Gaiser et al., 2021).

Within CCBHCs, role sustainability may also be complicated by the model's reliance on DCOs and cross-system partnerships. While DCO arrangements can expand access to peer-delivered services and allow CCBHCs to leverage established community-based expertise, they can introduce additional layers of organizational complexity. Peers embedded through external partnerships may have to navigate multiple supervision structures, documentation systems and team cultures across organizations. As a result, integration within CCBHCs may become operationally feasible while simultaneously presenting relational and administrative challenges, particularly when peers are not direct employees but are expected to function as core members of interdisciplinary teams.

Longitudinal evidence further clarifies structural drivers of attrition. A three-year multistate cohort study of newly certified peer specialists reported consistently high overall employment rates following certification, with approximately 73%-77% of respondents employed in any job across study years (Ostrow, Cook, Pelot, Robinett, et al., 2025). Employment specifically within peer support roles declined over time, however, decreasing from 73% in 2020-2021 to 63% in 2022 (Ostrow, Cook, Pelot, Robinett, et al., 2025). Notably, average job tenure was longer among those employed in peer roles than among those in non-peer positions, suggesting relative stability within peer support roles despite financial pressures and mobility incentives (Ostrow, Cook, Pelot, Robinett, et al., 2025).

These findings indicate that exits from peer positions are more likely to be associated with poor supervision quality, compensation alignment, role clarity and advancement opportunities than with lack of employability or workforce demand (Ostrow, Cook, Pelot, Robinett, et al., 2025; Ostrow et al., 2022).

Financial and administrative barriers further constrain retention across behavioral health systems. In the 2025 National Recovery Community Needs Assessment, nearly 52% of respondents reported that securing funding for peer services was very or extremely challenging, and more than 40% reported limited familiarity with Medicaid billing processes (CARS, 2025). Complexity in reimbursement infrastructure limits organizations' ability to fully leverage available funding, constraining wage growth and workforce stability (Gingerelli et al., 2024). These issues are particularly pronounced in fragmented funding environments. CCBHCs represent a relative stabilizing mechanism through the PPS model, which provides bundled, cost-based reimbursement for required services, including peer support, and offers greater financial predictability to support workforce integration.

Taken together, the evidence indicates that retention challenges within the peer workforce are structural and policy-driven rather than motivational. For CCBHCs, where peer support is a required service component, workforce sustainability depends not only on recruitment but on sustained investment in peer-informed supervision, organizational culture that affirms the value of lived experience, compensation alignment, defined advancement pathways, and reimbursement infrastructure that fully supports the scope of peer-delivered work. Without attention to these structural conditions, expansion of peer roles may outpace the system's capacity to retain and stabilize the workforce over time (Gaiser et al., 2021; Jones et al., 2020; Ziemann et al., 2023).

COMPENSATION AND BENEFITS

Compensation as a workforce sustainability issue

Compensation and benefits represent a central determinant of peer workforce sustainability.

Despite growing evidence supporting the effectiveness of peer-delivered services and increasing demand across behavioral health systems, PSPs are frequently compensated at lower wage levels and are less likely to receive comprehensive employment benefits than other members of multidisciplinary care teams (Ostrow et al., 2023; Ostrow, Cook, Pelot, Salzer & Burke-Miller, 2025; Gingerelli et al., 2024).

These imbalances persist even as peer roles carry substantial responsibility, emotional labor and expectations related to engagement, crisis response and continuity of care (Gaiser et al., 2021; Collier et al., 2024).

These compensation patterns reflect broader structural imbalances in how roles based in lived experience are valued within behavioral health hierarchies, where experiential expertise may be positioned at lower pay grades despite its central role in person-centered service delivery (Collier et al., 2024; Ostrow et al., 2023). Longitudinal evidence reinforces these concerns. Ostrow, Cook, Pelot, Salzer & Burke-Miller (2025) found that while wages for certified PSPs increased between 2020 and 2022, wage gains in peer roles remained smaller than those observed in non-peer positions; moreover, certified PSPs did not experience significant improvements in overall financial wellbeing over time, highlighting persistent economic vulnerability among practitioners.

These compensation imbalances have direct implications for recruitment, retention and long-term workforce stability across behavioral health systems, including within CCBHCs, where peer support is designated as a required service yet may remain undervalued within organizational compensation frameworks. Without careful attention to wage fairness and benefits, the sustainability of peer-delivered services within high-demand systems is likely to remain constrained even as reliance on peer support continues to expand.

Typical compensation levels and access to benefits

Compensation for PSPs remains low and highly variable across states and employers, though available national wage estimates are drawn largely from workforce surveys conducted over the past decade (Gingerelli et al., 2024; Ostrow et al., 2023).

Earlier labor market analyses estimated median hourly wages for PSPs at $14-$16 per hour, depending on state policy, certification status and service setting (Gingerelli et al., 2024). Gazda et al. (2023) summarize a 2016 national survey conducted by The College for Behavioral Health Leadership reporting an average peer specialist wage of $15.42 per hour — substantially lower than the mean hourly wage for community health workers ($22.97) and the national average wage across all occupations ($27.07). Although wages have increased modestly in recent years, imbalances between peer roles and comparable frontline health positions persist (Ostrow, Cook, Pelot, Salzer & Burke-Miller, 2025).

Peer Specialist Wage Comparisons

Gingerelli et al. 2024 | Gazda et al. 2023

PSP Wages:
Depending on State, Certification and setting

Community Health Workers

National Average
(All Occupations)

Compensation imbalances also reflect sex and geographic variation, with women earning slightly less than men and wages differing considerably across regions, payer mix and employer type, though these analyses generally reflect reported wages rather than adjustments for regional cost-of-living differences (Ostrow et al., 2023; Jones et al., 2020). In addition to lower wages, many peer support positions do not include full-time employment benefits such as health insurance, paid leave and retirement contributions, further contributing to financial insecurity and workforce attrition (Ostrow et al., 2023). These patterns underscore that compensation is not solely a wage issue but a broader employment stability concern affecting recruitment, retention and long-term workforce sustainability.

Documented Medicaid fee schedule rates for peer support services vary significantly, with reported 15-minute unit rates ranging from under $6 to more than $27 depending on state policy and service designation (Peer Recovery Center of Excellence, 2024). In many states, reimbursement remains limited to direct service delivery and excludes outreach, engagement and community-based activities unless separately authorized. In clinics that have not implemented the CCBHC model, high variability in Medicaid coverage and fee schedules for peer services, as well as reliance on time-limited grants, contributed to persistent variability in wages, benefits and job stability for PSPs (Peer Recovery Center of Excellence, 2024; Gazda et al., 2023).

Reimbursement mechanics further shape how peer roles are operationalized within CCBHCs. In demonstration states operating under federal Section 223 authority, CCBHCs receive cost-based reimbursement through PPS models, which provide bundled rates for required services — including peer support — and offer greater flexibility to support activities such as outreach, care coordination and engagement that are often not separately billable under traditional fee-for-service Medicaid structures (SAMHSA, 2023a). In contrast, behavioral health organizations operating outside of the CCBHC model under conventional Medicaid fee-for-service arrangements may face more restrictive billing parameters, requiring discrete service codes, time-based documentation and specific treatment plan alignment that can limit reimbursement for nonclinical peer activities (Peer Recovery Center of Excellence, 2024; Gazda et al., 2023). Variation in telehealth reimbursement policies, electronic health record documentation standards and supervision requirements further influence how peer services are structured, documented and compensated across states (Peer Recovery Center of Excellence, 2024). Emerging pilot efforts within Medicaid managed care and select Medicare and commercial plans have expanded reimbursement pathways for peer services; however, coverage remains inconsistent — particularly for engagement activities that are central to peer practice (Adjabeng & de Saxe Zerden, 2024).

While the CCBHC PPS methodology is designed to improve funding stability and predictability (SAMHSA, 2023a), legacy reimbursement structures continue to influence organizational compensation norms and wage baselines (Peer Recovery Center of Excellence, 2024). This policy inheritance is central to understanding persistent wage imbalances and long-term workforce sustainability within the CCBHC framework.

CAREER PATHWAYS AND ADVANCEMENT OPPORTUNITIES

Availability of defined career pathways for PSPs

Meaningful advancement and leadership opportunities for PSPs are essential not only for workforce retention, but also for the effectiveness of person-centered service delivery.

Without intentionally including peer perspectives in leadership and decision-making roles, behavioral health systems risk designing services that fail to engage individuals who already distrust traditional care settings.

Despite growing reliance on PSPs across behavioral health systems, career pathways and advancement opportunities for peers remain limited and inconsistently defined. Workforce analyses indicate that peer roles continue to operate within underdeveloped labor market structures, with recruitment, advancement and leadership opportunities often occurring through informal or organization-specific mechanisms rather than standardized professional pathways (Gingerelli et al., 2024). As a result, many peer positions remain concentrated in entry-level classifications with limited opportunities for progression, contributing to persistent challenges in retention and long-term workforce sustainability.

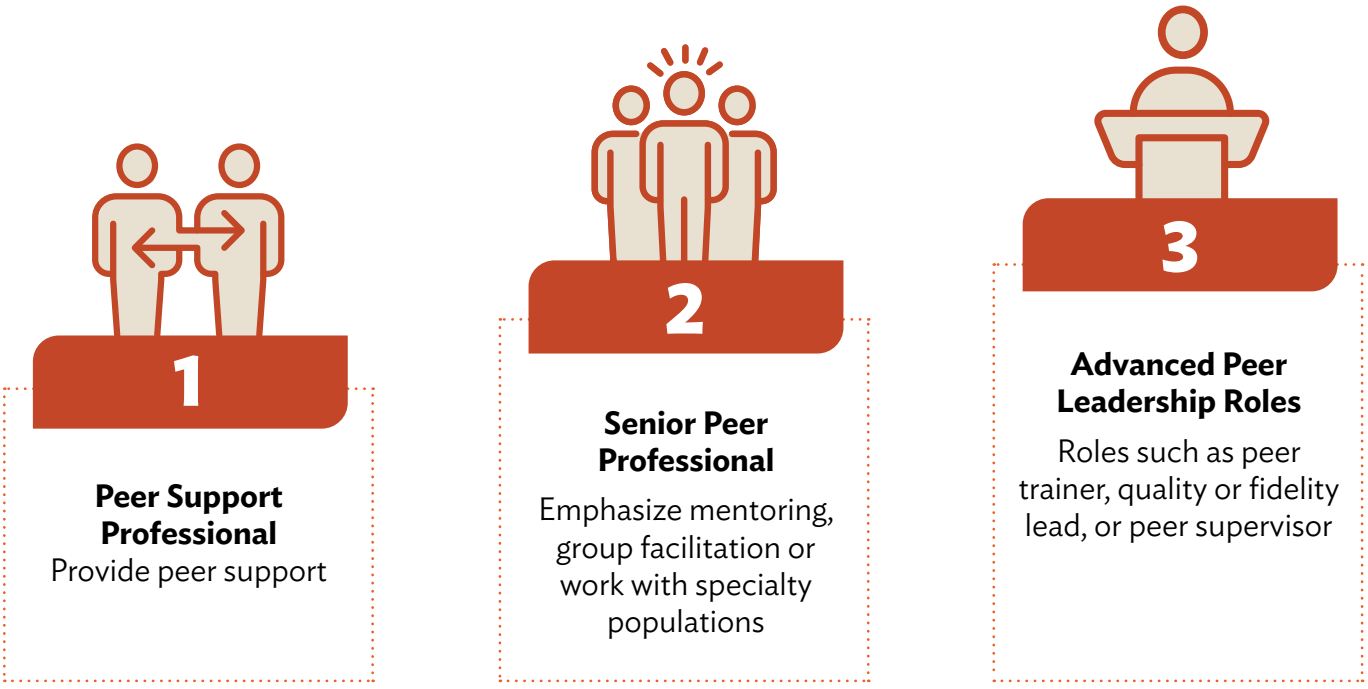
Consistent with earlier findings regarding peer motivation and interest in professional growth, research consistently demonstrates strong interest among PSPs in continuing education and professional advancement. National survey data indicates that many peers aspire to pursue additional training, leadership roles or related career pathways; however, multiple barriers — including financial constraints, administrative hurdles, disrupted educational trajectories, stigma and limited access to academic programs aligned with peer experience — continue to stifle professional mobility (Jones et al., 2020). These findings suggest that workforce development efforts must address not only the availability of training, but also the structural and organizational conditions that support peer roles at the lower end of behavioral health hierarchies.

Variability in career pathways and leadership opportunities

The availability of formal career pathways and leadership opportunities for PSPs varies substantially across states and organizations. While some systems have developed structured advancement models, many PSPs advance primarily through accumulated on-the-job experience rather than through clearly articulated career ladders tied to standardized competencies, role differentiation or leadership preparation (Gazda et al., 2023). As a result, advancement is often contingent on local leadership priorities rather than transparent, replicable expectations for progression.

Within CCBHCs, a practical peer career ladder could include progression from peer support professional to senior peer professional roles that emphasize mentoring, group facilitation or work with specialty populations, followed by roles such as peer trainer, quality or fidelity lead, or peer supervisor. These positions allow peers to expand leadership, training and workforce development responsibilities while preserving peer identity and fidelity to lived-experience-based practice.

Peer Career Ladder Within CCBHCs



Importantly, creating these pathways can be more than just an aspiration. Examples from state and local systems indicate that peer-led training, mentoring and supervisory roles can be implemented within behavioral health organizations to support workforce development while preserving peer identity. Such approaches illustrate how intentional advancement structures can promote leadership development, professional identity and workforce stability without requiring peers to exit peer-designated roles or pursue clinical licensure. These models align with national workforce guidance emphasizing structured supervision, defined role differentiation and clearer leadership pathways for PSPs (National Governors Association, 2024; Adjabeng & de Saxe Zerden, 2024).

WORKFORCE COMPOSITION

Overview of the PSP workforce within CCBHC settings

Within CCBHCs, PSPs are embedded across a wide range of service functions, including outpatient behavioral health care, crisis response, care transitions, and community-based outreach and engagement (National Council, 2024a). National impact reporting further indicates that peers are frequently deployed in roles extending beyond clinic-based encounters — such as community navigation, reentry support and outreach — consistent with the CCBHC model's emphasis on whole-person care and addressing social and structural barriers to engagement (National Council, 2024a; SAMHSA, 2023).

Survey data from Medicaid CCBHCs and established SAMHSA grantees shows that a majority of responding clinics report employing PSPs, and many indicate the creation of new peer-designated positions, reflecting continued workforce expansion within the model's structured service framework (National Council, 2024a).

At the same time, national CCBHC reporting consistently identifies peer support roles among the most difficult positions to recruit and retain, alongside other frontline behavioral health roles (National Council, 2024a). Workforce shortages affecting peer positions are frequently cited as barriers to service expansion and long-term sustainability, underscoring the importance of examining not only the presence of peer services within CCBHCs, but how peer roles are distributed, defined and supported across service settings (National Council, 2024a; Ziemann et al., 2023).

Distribution of peer roles across mental health and substance use services

Across CCBHCs, PSPs serve individuals with wide-ranging needs, including serious mental health conditions, substance use disorders, criminal legal system involvement, lack of housing and transitions from inpatient or crisis care (Matthews et al., 2023; SAMHSA, 2023). While CCBHC-specific reporting shows peer deployment within the model, broader national facility-level analyses provide context regarding how peer roles are distributed across the behavioral health system more generally.

National data indicates that peer services remain more consistently embedded within substance use disorder treatment settings than within mental health services overall. Facilities providing substance use treatment are more than twice as likely to offer peer support services (56.6%) as facilities focused on mental health care (24.7%) (Videka et al., 2023).

This discrepancy suggests that structural, financing and policy factors — rather than differences in the relevance or effectiveness of peer support — continue to shape where and how peer roles are integrated (Adjabeng & de Saxe Zerden, 2024; Ziemann et al., 2023). Within CCBHCs, this pattern has implications for access, particularly given the model's emphasis on person-centered mental health services and continuity of care. Uneven integration of mental health peer roles may limit the reach of peer-delivered support for

individuals navigating serious mental health disorders and complex service transitions.

Certification pathways and scope of practice for PSPs vary across states. In many jurisdictions, peers are credentialed to support individuals across both mental health and substance use recovery domains, while other states maintain separate certification tracks tied to Medicaid reimbursement structures and programmatic funding streams — a variation that, as noted earlier, has prompted increasing discussion of national workforce standardization.

Employment settings, role variability and scope of practice

Across behavioral health systems, the PSP scope of practice is highly dependent on context, with responsibilities shaped by service setting, population served and organizational model (Matthews et al., 2023). Within these contexts, peers may engage in advocacy, mentoring, recovery group facilitation, system navigation, crisis support and provider education (Matthews et al., 2023; SAMHSA, 2023). In some organizations, peers also supervise other peer workers, administer programs or provide specialized services for people impacted by the criminal legal system or people experiencing housing instability (Matthews et al., 2023; Ziemann et al., 2023).

Given evidence that nonmedical factors account for a substantial proportion of health outcomes, the expanded scope of peer-delivered support underscores the importance of care delivery and financing models — such as CCBHCs — that extend beyond traditional clinical intervention to address social and environmental factors that affect health and wellbeing (Cui et al., 2025). These cross-system functions introduce additional layers of coordination beyond the immediate clinical team. In many CCBHCs, this coordination is operationalized through partnerships with DCOs, which can expand the reach and capacity of peer services across community settings while also introducing governance and integration complexities examined previously in this paper.

National facility data further reflects substantial variations in the availability and implementation of peer services across settings, including higher prevalence in co-occurring treatment facilities (Videka et al., 2023). While this flexibility allows peer roles to be adapted to local needs and populations, it also contributes to fragmented role expectations, inconsistent supervision structures and uneven access to peer-delivered services across settings (Adjabeng & de Saxe Zerden, 2024; Ziemann et al., 2023).

Peer services are most frequently reported in public-sector behavioral health facilities, with lower levels of implementation in private settings (Ostrow et al., 2023; Adjabeng & de Saxe Zerden, 2024). Geographic imbalances also persist, with several Southern states reporting lower rates of peer service availability (Videka et al., 2023). Recent multistate survey data further illustrates the breadth of peer support activities across outpatient, crisis, inpatient and community-based contexts, confirming the variability of peer roles and implementation across behavioral health systems (Hagaman et al., 2025).

Available national workforce data indicates that PSPs are predominantly female and White (Collier et al., 2024). These demographic patterns highlight the need for intentional strategies to support variety, representation and fairness within peer roles as CCBHCs and other integrated care models expand (Collier et al., 2024; SAMHSA, 2024).

Implications of workforce composition for service delivery

Workforce composition has direct implications for access and service delivery within CCBHCs. Employment rates among certified peer specialists —approximately 73%-77% — suggest that many individuals who complete peer certification subsequently obtain employment (Ostrow, Cook, Pelot, Robinett, et al., 2025). This indicates that peer roles can contribute to workforce stability while expanding service capacity. At the same time, variability in peer roles, training requirements and scope of practice complicates evaluation, limits workforce mobility and contributes to inconsistent access to peer-delivered services across settings (Adjabeng & de Saxe Zerden, 2024; Ziemann et al., 2023).

Together, these patterns underscore the importance of clearer role definitions, improved workforce data collection and policy alignment to support sustainable implementation of peer support within integrated behavioral health systems. For CCBHCs, addressing these workforce composition challenges is essential to ensuring that peer-delivered services are not only widely adopted, but consistently integrated in ways that advance access, engagement and recovery-oriented outcomes.

ROLE AMBIGUITY, ORGANIZATIONAL CULTURE AND SUPERVISORY SUPPORT

Building on the workforce composition and integration patterns described above, research identifies role ambiguity as a persistent organizational barrier affecting the integration of peer support professionals within multidisciplinary teams.

Unclear responsibilities, overlapping duties with clinical staff, and uncertainty regarding authority and scope of practice can impede collaboration and limit the effective use of peer expertise (Stefancic et al., 2021; Heetderks-Fong & Bobb, 2024).

Interdisciplinary team dynamics may further complicate integration. In some settings, overlap between case management, care coordination and peer support responsibilities can lead to uncertainty regarding task ownership and decision-making authority. Without clearly delineated role definitions and team-based communication protocols, peers and case managers may experience role tension or perceived encroachment on professional domains. Such territorial dynamics can inadvertently undermine collaboration and limit the effective use of peer expertise within multidisciplinary care teams.

Variability in state certification requirements, organizational expectations and training standards further exacerbates role confusion, contributing to inconsistent implementation across settings (Adjabeng & de Saxe Zerden, 2024; Heetderks-Fong & Bobb, 2024). When role parameters are inconsistently defined across jurisdictions or organizations, integration efforts may depend heavily on local interpretation rather than standardized guidance, increasing the risk of uneven implementation.

Organizational culture also plays a critical role in shaping the acceptance and legitimacy of peer roles. Research indicates that PSPs may experience stigma, financial precarity and devaluation of lived experience, particularly when peer knowledge is framed as *supplementary* rather than integral to care delivery (Stefancic et al., 2021; Gaiser et al., 2021). Advancement pathways for peer roles remain limited in many systems, with constrained access to leadership, supervision or organizational decision-making positions (Ziemann et al., 2023; Stefancic et al., 2021). These structural dynamics may restrict PSPs' ability to influence program design, advocate for peer-informed practices or shape service delivery models within integrated care settings.

Supervision presents an additional and closely related barrier. Peer support is grounded in nonclinical, recovery-oriented principles that may not fully align with traditional clinical supervision models that emphasize diagnosis, treatment planning and risk management (SAMHSA, 2023). When PSPs are supervised exclusively within clinical frameworks, the distinct contributions of lived experience may be insufficiently recognized or supported (Stefancic et al., 2021). Insufficient access to peer-informed or hybrid supervision models has been associated with increased role strain, reduced professional efficacy and burnout, contributing to turnover and workforce instability (Gaiser et al., 2021; Stefancic et al., 2021).

For PSPs themselves, these structural barriers often involve navigating sustained emotional labor, boundary negotiation and engagement with individuals in crisis — without commensurate authority, compensation or organizational support (Gaiser et al., 2021; Ziemann et al., 2023). When clear role delineation is absent, collaborative team structures, supportive supervision models and integration challenges may persist even in systems formally committed to recovery-oriented care.

POLICY AND PRACTICE IMPLICATIONS FOR PEER WORKFORCE INTEGRATION

Federal, state and organizational alignment

Building on the policy considerations discussed earlier, strengthening the peer workforce within CCBHCs requires coordinated action across federal, state and organizational levels. **System-level reforms must align certification standards, financing mechanisms, workforce data infrastructure and career pathways as interconnected policy levers rather than isolated adjustments.** The scale of the CCBHC initiative further underscores the importance of this coordination. More than 500 CCBHCs now operate across 48 states and territories, representing a substantial federal investment in behavioral health infrastructure, crisis response and workforce development (National Council, 2024b). This national footprint positions CCBHCs as a key platform for embedding mental health peer support within integrated systems of care.

At the policy level, priority reforms include establishing a distinct occupational classification for PSPs, aligning certification requirements across states, stabilizing Medicaid reimbursement mechanisms, and strengthening

workforce data infrastructure to support long-term planning and evaluation (Adjabeng & de Saxe Zerden, 2024; Gazda et al., 2023; National Governors Association, 2024). These reforms are most effective when pursued as coordinated strategies rather than isolated policy adjustments.

At the organizational level, CCBHCs are positioned to implement workforce practices that support meaningful peer integration. These include clear role definitions, peer-informed supervision models, competitive compensation and benefits, and structured career advancement pathways that preserve peer identity while expanding leadership opportunities. Federal workforce guidance reinforces that sustained integration of peer roles requires alignment between reimbursement policy, supervision structures and organizational culture to ensure fair compensation, career mobility and long-term workforce stability (SAMHSA, 2024).

Recommendations for strengthening peer workforce integration within CCBHCs

The following strategies are recommended to enhance the impact and sustainability of PSPs within CCBHCs and the broader behavioral health system.

- **Standardize training and certification:** Advance national standards with portability across states to promote consistency in competencies, role expectations and workforce mobility (SAMHSA, 2023b).

- **Establish a distinct occupational classification:** Advance federal action to create a formal occupational designation for PSPs within national workforce classification systems. This will strengthen data infrastructure, reimbursement alignment, interstate mobility and long-term workforce sustainability (National Governors Association, 2024; Gazda et al., 2023).

- **Enhance compensation and benefits:** Align wages and employment benefits with the scope, complexity and preventive value of peer work, to reduce turnover and improve workforce stability (Ostrow et al., 2023; Heetderks-Fong & Bobb, 2024).

- **Support career pathways and leadership development:** Establish structured advancement opportunities — including senior peer, trainer, supervisor and leadership roles — to foster retention and professional growth (Gazda et al., 2023; Collier et al., 2024).

- **Clarify roles and supervision models:** Implement organizational policies that clearly define peer scope of practice and supervision structures while preserving the nonclinical peer paradigm (Stefancic et al., 2021; Matthews et al., 2023).

- **Strengthen workforce wellbeing and burnout prevention:** Implement organizational strategies shown to reduce burnout among behavioral health workers, including manageable caseloads, supportive and peer-informed supervision, reduced administrative burden, flexible scheduling and access to professional development and mentorship opportunities (Espinosa, 2025; Gaiser et al., 2021).

- **Reform reimbursement structures:** Align payment models with the full scope of peer activities — including outreach, engagement, care coordination and community-based services — and support bundled or value-based approaches where feasible (SAMHSA, 2024; Adjabeng & de Saxe Zerden, 2024).

- **Strengthen recruitment pipelines:** Develop targeted outreach strategies and partnerships with recovery community organizations, reentry programs, educational institutions and community-based providers to expand awareness of peer career pathways and reduce structural barriers to entry, particularly in rural areas and for communities with unmet needs.

- **Promote access across settings:** Expand peer services across public, private and nonprofit behavioral health providers to address documented imbalances in service availability and reduce structural unfairness in access to peer-delivered support (Videka et al., 2023).

- **Advance national awareness and professional recognition:** Elevate PSPs as a distinct profession by including them in academic curricula, interdisciplinary training initiatives and coordinated workforce development strategies across behavioral health, social work and allied health education.

- **Promote the development of national reciprocity agreements for PSP certification:** Allow peer workers to transfer credentials seamlessly across states and organizations.

Strategic investment in peer workforce infrastructure will enable CCBHCs to fully realize the value of PSPs — enhancing engagement, improving continuity across care settings and strengthening behavioral health outcomes for the populations they serve.

Future research directions

As the CCBHC model continues to scale nationally, research must move beyond establishing the effectiveness of peer-delivered services to examine how implementation context shapes workforce sustainability and integration outcomes. Qualitative and mixed-methods studies are particularly well suited to examining organizational culture, supervision models, career pathways and the lived experience of PSPs within CCBHCs and other integrated behavioral health settings. Additional research is needed to assess peer contributions to crisis response, care transitions, reentry supports, community engagement and workforce stability — areas that remain underrepresented in empirical literature.

Strengthening federal and state workforce data systems would further support consistent tracking of peer roles, compensation and career progression over time. Persistent gaps in national workforce data limit the field's ability to assess representation, career trajectories and fairness within peer support roles, reinforcing the need for improved workforce data infrastructure and standardized reporting mechanisms (SAMHSA, 2024). As CCBHCs operate within defined reporting and quality measurement frameworks, integrating peer workforce metrics into existing data infrastructure may strengthen accountability and inform long-term workforce planning.

CONCLUSION

PSPs play a critical role within CCBHCs by expanding access to integrated behavioral health services, strengthening engagement and supporting recovery for individuals navigating complex mental health and substance use conditions. A substantial and growing body of evidence demonstrates that peer-delivered services improve engagement, enhance continuity of care and contribute to positive clinical and functional outcomes (Gaiser et al., 2021; Matthews et al., 2025). Workforce research further indicates that peer roles provide meaningful employment pathways and support professional identity, economic stability and sustained recovery among peers themselves (Ostrow et al., 2022, 2023; Ostrow, Cook, Pelot, Robinett, et al., 2025; Ostrow, Cook, Pelot, Salzer & Burke-Miller, 2025).

The long-term sustainability and impact of the peer workforce depend not on further validation of effectiveness, but on intentional workforce infrastructure. Standardizing training and certification, establishing defined career pathways, ensuring fair compensation, aligning reimbursement structures and implementing peer-informed supervision are essential to durable integration of peer roles within behavioral health systems (SAMHSA, 2023; Adjabeng & de Saxe Zerden, 2024; Heetderks-Fong & Bobb, 2024). CCBHCs are uniquely positioned to advance these reforms through integrated service delivery and PPS financing, offering a scalable national framework for embedding peer support as core workforce infrastructure (National Council, 2024a).

Despite persistent challenges related to stigma, inconsistent training and organizational barriers, the evidence reviewed throughout this paper indicates that the primary obstacles to effective peer integration are structural rather than evidentiary. PSPs function as critical connectors — bridging engagement gaps, strengthening continuity across care settings and extending the reach of integrated mental health and substance use services beyond traditional clinical encounters.

Realizing the full promise of the CCBHC model therefore requires sustained investment in workforce data systems, financing alignment and organizational practices that recognize peer support as an integral — not supplemental — component of integrated mental health and substance use services (Frank & Paris, 2024). With coordinated federal and state policy action, CCBHCs can stabilize and professionalize the peer workforce, strengthen access and engagement and more fully leverage lived experience as a strategic asset in meeting the evolving needs of communities nationwide.

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