

CLASP

The Center for Law and Social Policy

Giving the

(YOUNG)

People What They Want:

A Policy Framework for
Youth Peer Support

By: Kayla Tawa, Emily Kim, and Marissa Howdershelt

July 2023

Introduction

The existing mental health system is failing to meet the needs of young people, particularly Black, brown, and Indigenous young people, 2SLGBTQIA+ young people, and young people with disabilities.ⁱ Within the current mental health system, they often experience the effects of institutionalized racism such as harsher treatment, stigmatization, and professionals minimizing their mental health symptoms.ⁱⁱ The current mental health system is also experiencing a workforce shortage, with many young folks unable to access care, particularly in mental health deserts—geographic areas with no or limited access to mental health services like psychologists and counselors.

Youth peer support offers a solution to both these problems: peer support is a non-clinical practice rooted outside of Western medicine that taps into a new provider workforce – peers. Research shows peer support is an effective and equitable practice.ⁱⁱⁱ

these interviews, we identified the key barriers to expanded youth peer support and developed a set of best practices states can implement to expand youth peer support.

As one of our interviewees stated, peer support is like an onion: Once you confront one barrier, you will be presented with another layer of problems. In most states, the barriers to implementing a robust youth peer support program are multiple and interconnected. To achieve a robust and effective youth peer infrastructure, states will need to pursue multiple simultaneous policy changes, targeting Medicaid policy, the culture of clinicians in the state, accreditation boards, and more.

Further, states must prioritize operationalizing youth peer support with fidelity to the practice. One of the biggest concerns we heard from interviewees was the fear of peer support being coopted by medical

“Peer support occurs when people in a particular circumstance reach out to help others in the same or a very similar circumstance. It is the act of a person or persons reaching out to others to help them deal with life challenges.”^{iv}
– Steve Harrington, Founder of the National Association of Peer Supporters.

Despite the promise of youth peer support, it remains unavailable to most young people and is generally concentrated in grant-funded programs. In an ideal scenario, young people would be able to easily access youth peer support services in a variety of locations, including schools, community centers, and more.^v

To better understand the current policy landscape of youth peer support, we conducted 14 in-depth interviews with multiple stakeholders, including experts in peer support policy, peer supporters, and state officials who run peer support offices. Through

models, meaning peer support will exist in name but will not be practiced as it was intended. Because Medicaid is designed around clinical practices and thereby forces non-clinical practices to adopt certain procedures to get reimbursed, Medicaid currently facilitates the cooptation of peer support. This paper seeks to answer how a non-clinical practice like youth peer support can be reimbursed by Medicaid without it being incorporated into a medicalized model. Receiving Medicaid reimbursement for youth peer support without youth peer support being coopted requires states to explore creative payment options under Medicaid.

Peer Support Explained

Defining Peer Support

Peer support, most generally, is the “process of giving and receiving encouragement and assistance to achieve long-term recovery.”^{vi} In this paper, peer support is more specifically defined as people receiving and giving encouragement to others who have gone through similar mental health/behavioral health experiences. Youth MOVE National explains that “peer support is not based on psychiatric models and diagnostic criteria,” but “is [instead] about understanding another’s situation empathically through the shared experience of emotional and psychological pain.”^{vii} Done well, peer support is also based on shared identities and cultural backgrounds.

Peer support is founded on core values that emphasize recovery, mutuality, and equity. The National Practice Guidelines for Peer Supporters identified 12 core values of peer support through surveying and conducting focus groups with nearly 1,000 peer supporters.^{viii} These core values include peer support being strengths-focused, person-driven, and sharing equal power between peer supporters and peer support recipients.

Defining Youth Peer Support

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines youth peer support as connecting youth and young adults with mental health conditions, substance use conditions, and/or a history of systems involvement with “young adults who have experienced similar challenges and completed specialized training to learn how to use their experience to support others.”^{xiv} As a practice, it is sharing one’s lived and living experiences with mental health challenges or systems with other young people by folks who are ready to share and use their stories for the growth of others.^{xv} Like peer support, youth peer support is also grounded in equity and equitable principles.

The History of Peer Support

The peer movement grew out of the belief that people with mental conditions can change their lives and help others. Since its inception, peer work has been a radical vision of mental health and wellness that was established outside of traditional mental health practices and systems. Many peer workers were born out of the anti-psychiatry movements of the 1970s and 1980s.^{ix} Having people with mental health conditions working within the mental health system seemed impossible in the 1960s and 1970s; however, consumer-driven advocacy and activism that grew out of earlier civil rights movements led to an increased focus on recovery.^x Much of the recovery work being done was led by peers. By the 1990s, peer support began to be endorsed by clinicians, the federal government, and state Medicaid agencies.^{xi}

Today many peer supporters are embedded in clinical organizations, the same kinds of organizations the recovery movement organized against. However, peers are often devalued in these institutions. Peer specialists are treated as “second-class clinicians,” which directly contradicts their intended purpose.^{xii}

Peer supporters continue to organize to ensure fidelity to the practice, meaning peers have the “ability to be transformative, the ability to actually change the model from the inside.”^{xiii}

Core Values of Youth Peer Support^{xvi}



Mutuality through co-creation

Peer support recipients are equal leaders to peer support specialists in deciding how, where, and when they would like to receive peer support and what goals they'd like to set for themselves.



Equity focused^{xvii}

Equity is not limited to peer-to-peer interactions. Instead, youth peer support programs are founded on principles of equity, youth culture, and non-hierarchy which are incorporated into every part of youth peer support from youth peer support supervisors, hiring practices, and approaches to speaking with peer support recipients.



Disclosure with intent



Respect and shared mutuality



Community and belonging



Focus on prevention



Detach services from a diagnosis

Youth Peer Support is Unique

Because youth have their own culture, socialization, and way of understanding the world, working with them is different from working with adults. Youth peer support makes sure that the support provided to young adults and young people is “developmentally attuned, engaging, and culturally responsive”^{xxviii} to youth and young adults. Youth peer support seeks to “[break] barriers related to feelings of loneliness, shame, stigma, and low self-esteem.”^{xxix} Young people with lived experiences (youth peer support specialists) sharing their journey helps normalize and destigmatize mental health – it shows young people that they can also participate in changing their lives.

Adult peer support does not work for young people for many reasons.

First, adults are not peers to young people. Having the same experiences impacts mutual understanding, connectability, and relatability.^{xxi} Adult peer support specialists, such as someone who is 45 years old, have difficulty intimately understanding the life, world, and feelings of a 16-year-old. Mutual relatability is more than just the shared experiences of mental health. It “encompasses things like current life experiences, strengths, talents & challenges, identity (i.e., race, ethnicity, gender, sexuality, culture, religion), family & social network, interests & hobbies, goals, hopes & dreams, childhood experiences, neighborhood & community, and values”^{xxii} and shared historical and cultural events. Youth peer support understands the importance of being age

peers, while also recognizing that while both could benefit from youth peer services, a 16-year-old may not consider a 24-year-old to be a peer.

Second, young people often view recovery differently than adults. Young people are learning and discovering who they are and how their mental health contributes to or impacts their identity. Because young people are at a different stage of their identity creation than older adults, the language of recovery, which is commonly used in adult peer support programs, might not always resonate with young people. Instead, youth peers can help young people make sense of who they are as a person and how they can grow into the person they want to be. Within this broader framework, the language of recovery could feel minimizing rather than empowering to young people.

Finally, youth peer support centers youth voice and youth decision-making. Recipients of youth peer support are given the tools, knowledge, and space to set their own goals and take steps toward building fulfilling, self-determined lives for themselves.^{xxiii} Youth peer support is established on youth leadership, authentic youth engagement, and youth-driven practices.^{xxiv} Additionally, navigating the U.S. health care system, including behavioral and mental health systems, can be daunting. Youth peer support specialists can connect young adults with adult providers and/or other mental health services if they choose to seek those additional services.^{xxv}

“

Youth peer support is all about young people, for young people, and by young people.

”

The Work of Peer Support Specialists

Although youth peer support specialists provide peer support in many ways, the following summarizes what peer support specialists do:^{xxvi}



Provide one-on-one coaching



Advocate for themselves, for their peers, and for systems change



Encourage young people to actively participate in treatment



Help youth navigate services and support



Strategically share personal stories and/or lived/living experience to promote hope and recovery



Serve as a bridge between service providers and practitioners and the young person



Connect the young person to other community-based services and support

Not everyone with lived and/or living experience with mental health can or should be a peer support specialist. Peer support specialists should be folks who feel comfortable and ready to use their stories to help others.^{xxvii} Many programs require peer specialists to have been in recovery for at least a year. In other words, peer support is a way in which people can help create and participate in a sustainable and long-term way of living.^{xxviii}

Above all, a peer support specialist is someone people can talk to and who can provide hope and inspiration. Peer support specialists “encourage healthy perspectives” by using their stories and lived experiences to teach problem-solving techniques, listening empathically, encouraging self-reflection, and supporting their peers in taking better control of their mental health.^{xxix}



Peer Support, including Youth Peer Support, Is Effective

The positive effects of peer support include: xxx, xxxi, xxxii



Reduced ER admissions and increased tenure in the community



Lowered readmission rates



Increased community contact



Reduced inequities in service use



Improved physical health



Enhanced functioning, self-esteem, and awareness of diagnosis



Reduced costs



Improved self-esteem



Decreased substance misuse and depression



Increased sense of control over one's life



Promoted sense of hope



Decreased psychotic symptoms

Funding Youth Peer Support

Two major funding sources for youth peer support are grants and Medicaid.

Grants

Many strong youth peer support programs rely on grants, whether private, public, or a combination of both. Academic institutions also fund peer programs. One of the advantages of grant-funded programs is that they have a great deal of flexibility to determine the target population, the peer supporters, and the training curriculum. Within these programs, peers are trained according to a curriculum developed or adopted by the program. They may use or adapt an existing peer-led curriculum, but there are no set requirements for the training. The organization determines who it will support. These programs have strong outcomes,^{xxxiii} which further bolster the evidence base that youth peer support is an effective intervention and liked by young people. However, grant funds are limited, and grant funding can run out and not be renewed, meaning the programs could be forced to shut down.

Example of a Grant-Funded Youth Peer Program: YouthLine

YouthLine is a free 24-hour helpline that provides crisis support to young people via call, text, and chat. YouthLine is staffed by volunteers who are students in the Portland, Oregon Metro Area. Both callers and volunteers are anonymous. YouthLine is a 501(c)(3) non-profit supported primarily by private foundations, Multnomah County, and donations.

Medicaid

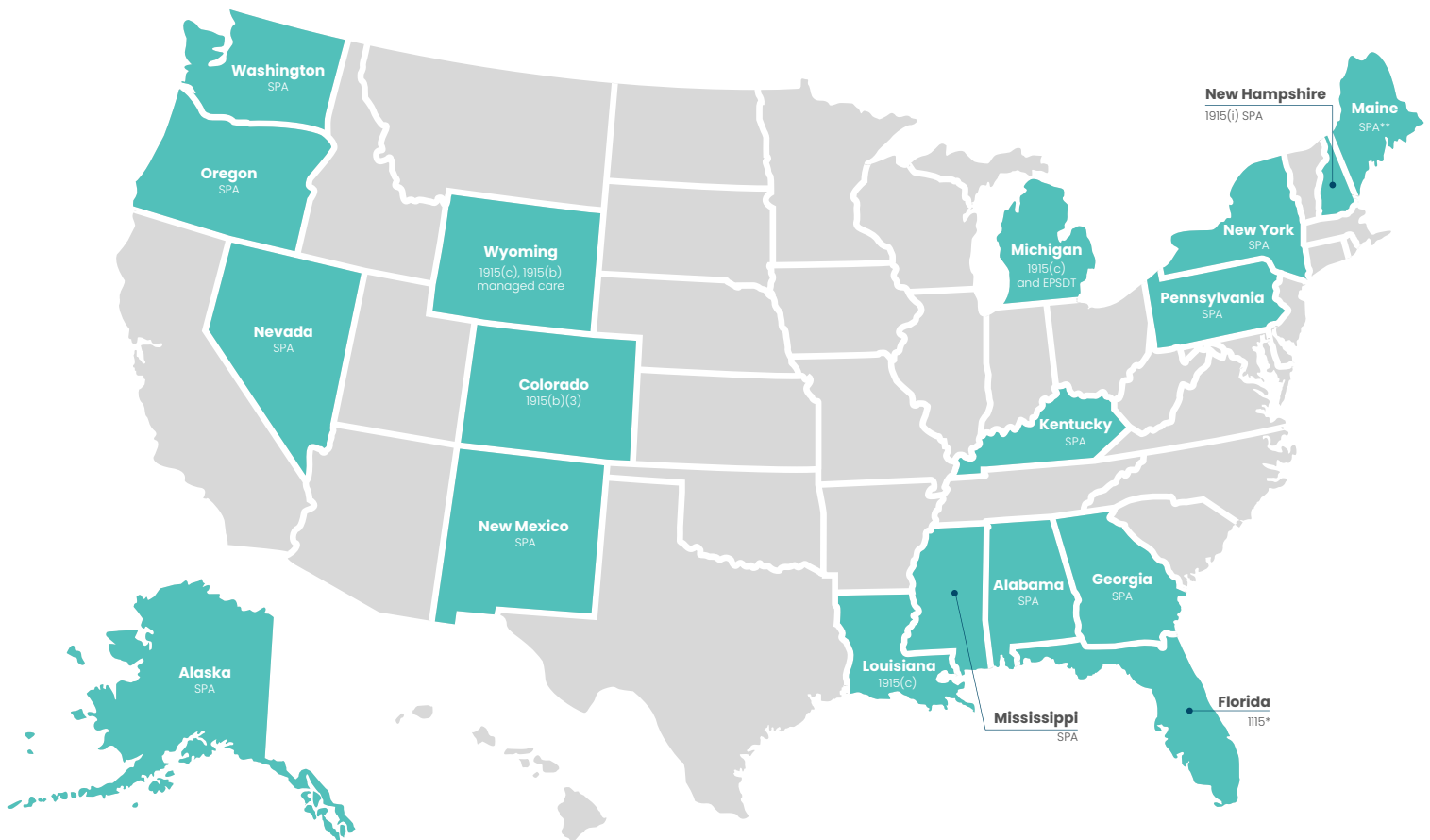
Another major funding source is Medicaid. Medicaid is a public health insurance program that covers millions of people with low incomes including children; parents and other adults; seniors; and people with disabilities. Medicaid, which is jointly funded by states and the federal government, is administered by states, within federal requirements. States have significant discretion in what services to cover, how much to reimburse providers for services, who to consider a provider (such as a youth peer worker), whether to use managed care or fee-for-service models, and, within limits, who to cover. Medicaid is an entitlement program, meaning that anyone who is eligible may apply for and receive health coverage through Medicaid.

Peer support has been a Medicaid-billable service since 1999, with Georgia being the first state to add peer support to its Medicaid program. Unlike grant funding, Medicaid is a sustainable funding source, as it is not time-limited or capped. Therefore, tapping into Medicaid funds is one critical way to expand access to youth peer services and maintain it long-term. However, Medicaid requires a high level of documentation, which creates barriers for both providers and recipients of services.

Because grant-funded programs, particularly those that rely on private funds, primarily operate independently, this paper will focus on Medicaid-reimbursed services and other public sources of funding.

Current Medicaid Framework

Eighteen states allow Medicaid billing for youth peer support.^{xxxiv} States define “youth” differently, with some states considering youth peer support to serve people ages 18–26 and other states allowing minors in their definition. For example, Pennsylvania allows people as young as 14 to receive youth peer support while Washington and Wyoming allow it for people as young as 13. Most states added youth peer support services through a State Plan Amendment (SPA), although using waivers is also possible.^{xxxv} SPAs, which include 1915(i) waivers, offer the most flexibility. Under a 1915(i) waiver states cannot limit how many people are served, can serve a broader range of diagnoses, and don’t have to prove cost neutrality. Reimbursement rates for individual youth peer support ranged from \$7.83 per 15 minutes to \$24.36 per 15 minutes.^{xxxvi}



States that allowed Medicaid billing for Youth Peer Support.^{xxxvii}

Additional states may offer Youth Peer Support through grant funds.

*Florida: Florida offers Youth Peer Support as an In Lieu of Service, which are typically authorized by an 1115 waiver ^{xxxviii}.

**Maine: Youth Peer Support is only available in Behavioral Health Homes

In many states, the majority of youth peer support occurs in programs designed for young people with high levels of need, such as in first-episode psychosis programs or high-fidelity wraparound programs.^{xxxix}

Both these programs serve young people with complex needs and involve intensive care coordination using a team-based approach. Peers are often included as part of a coordinated care team. Peers working in high-fidelity wraparound teams, or similar teams, might receive different training and reimbursement rates than peers working through general Medicaid funding. For example, in Pennsylvania, peers are part of high-fidelity wraparound care teams. The peer supporter is referred to as a youth support partner and is trained through high-fidelity wraparound, not through the state peer certification process.

The federal Centers for Medicare & Medicaid Services (CMS) has released minimal guidance on how states should administer their youth peer support programs. In 2007, CMS released guidance on peer support but did not call out youth peer support specifically. The 2007 guidance makes three key recommendations:^{xl}

- 1 **Supervision:** Peer supporters must be supervised by a “*competent mental health professional (as defined by the State).*”
- 2 **Care Coordination:** “*peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.*”
- 3 **Training and Credentialing:** “*Peer support providers must complete training and certification as defined by the State.*”

Given scant federal guidance on youth peer support, states have broad authority to make the necessary

changes to expand access in their states. Because every state runs its Medicaid program differently, there is no one-size-fits-all solution for Medicaid-funded youth peer support.



Best Practices for Medicaid-Funded Youth Peer Support Services

- 1 Limit the extent to which peers are forced to engage in clinical practices, such as clinical notetaking, as these practices are antithetical to the peer model.
- 2 Young people deserve true peers, which means allowing young people under 18 to be certified peer specialists and recruiting a diverse and holistically affirming workforce.
- 3 Create youth-specific training, certification, and supervision requirements, designed by young people for young people.
- 4 Young people should be able to move seamlessly from child- to adult-serving systems, without experiencing interruptions in peer support services.
- 5 Peer support should be a viable career option for young people, meaning both that the reimbursement rates reflect market rates and a living wage and that youth peer supporters have strong career ladders.
- 6 Clinical organizations must value and understand the work of peers as agents of change within the system.
- 7 Peer support should be available across the continuum of care and recognized and funded as a preventative service.
- 8 States should pursue a diverse array of funding sources for youth peer support, both within and outside of Medicaid.



1 Limit the extent to which peers are forced to engage in clinical practices, such as clinical notetaking, as these practices are antithetical to the peer model.

Medicaid has strict documentation requirements for reimbursement. CMS requires that “Medical necessity and medical rationale are documented and justified in the medical record,” but notes that each state adopts its own medical necessity criteria.^{xlii} This level of clinical notetaking creates a power dynamic between the peer supporter and the person receiving peer services, interrupting the mutuality inherent to peer support. Given this disruption, many peer supporters are uncomfortable taking notes as it goes against the values of intentional peer support and active listening. Multiple interviewees shared that doing fidelity peer work while billing Medicaid seems impossible, in part because once you start entering documentation it’s no longer peer support. As a result, many states and organizations forgo Medicaid reimbursement.



Strategies to Implement Best Practice:

Short-Term:

- CMS and state Medicaid agencies should provide guidance to peer supporters on what level of documentation is required for reimbursement, being mindful to maintain the mutual dynamic between a peer supporter and a person receiving services. Guidance should make clear that notes don’t need to focus on diagnoses and symptomology. Peers can instead focus on documenting the service they provided (i.e., what they did, not what the person receiving services did). The guidance could provide generic language that peers can adapt, so they have a clearer understanding of what does and doesn’t need to be documented for reimbursement. Finally, if peer providers are part of a care team, they could ask another member of the care team to be the primary notetaker.

Long-Term:

- CMS should explore ways to minimize documentation requirements for non-clinical providers. For example, peers who are reimbursed through a self-directed payment model would not have to provide the same level of documentation.

2 Young people deserve true peers, which means allowing young people under 18 to be certified peer specialists and recruiting a diverse and holistically affirming workforce.

Within peer support, peers are self-defined. People conceptualize who is a “peer” to them differently, and to truly access peer support, everyone should be able to work with someone they consider a peer. A peer could be defined by age, racial/ethnic identity, socioeconomic status, diagnosis, geography, ability and disability, gender identity and expression, sexual orientation, and more. Near-age peer support requires peers to be similarly aged.

Currently, no states allow young people under 18 to be qualified providers. Credentialing young people under 18 requires coordination among the state Medicaid agency, the state department of health, and state accrediting or licensing bodies. For example, in Mississippi, young people 16 and over can be Medicaid-reimbursed youth peer support providers but the state’s Department of Health doesn’t certify young people under 18.^{xlii} Many states also require a high school diploma or equivalent to be certified, although states can choose how they define “equivalent.”

Additionally, multiple states noted the challenge of recruiting and training diverse peer support specialists. Peers tend to be older, whiter, and represent cisgender, heterosexual, hegemonic views, meaning people of color and younger people are less likely to find a peer support specialist who is truly a peer, especially since recipients are not always able to choose their peer provider when the peer is part of a care team.

Strategies to Implement Best Practice:

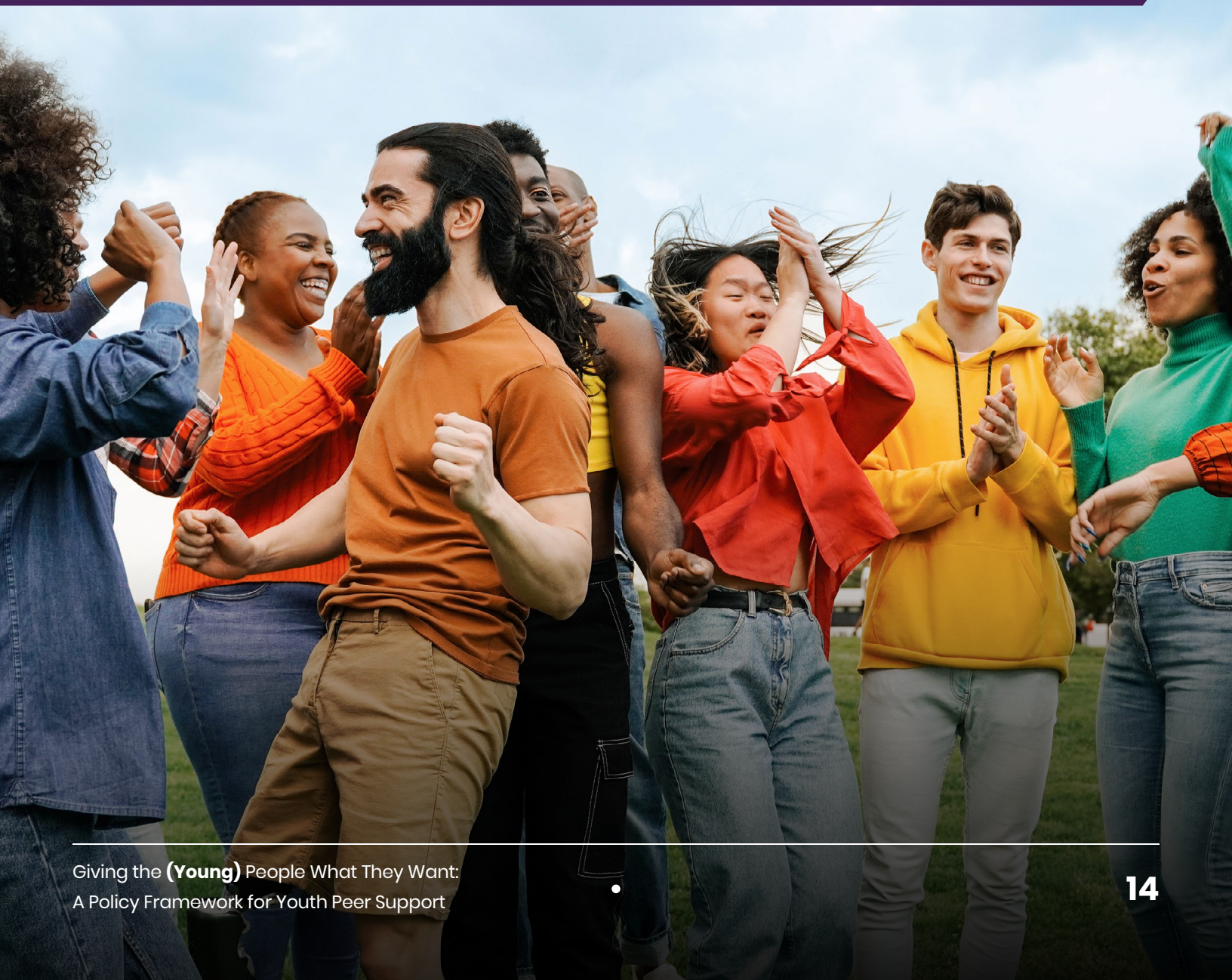
- CMS should release updated guidance recommending young people 16–26 be certified as youth peer support providers, clarifying if there is no federal barrier to credentialing youth peer supporters.
- State Medicaid agencies and state departments of health must similarly update their criteria for youth peer support providers.
- Accrediting and licensing bodies must also license young people under 18 to be accredited providers. Accrediting bodies should have an advisory structure with young people who review the regulations. Accrediting bodies should have separate requirements and criteria for youth peer support.
- The federal Department of Labor should create a standard occupational code for peer support professionals (including youth peer professionals), so peer support professionals are no longer included under community health workers. This would not only allow for an occupational code that responds to the unique needs of peer workers but would also result in a more accurate count of how many peer workers are in the field.

Young people deserve true peers, which means allowing young people under 18 to be certified peer specialists and recruiting a diverse and holistically affirming workforce.

Addressing Liability Concerns

We consistently heard during our interviews that states and policymakers distrust people younger than 16 to provide youth peer support. They often called it a “liability issue,” contending that Medicaid and other state agencies believe that young people don’t know what they’re doing or will make mistakes, despite the training that must be completed to become a youth peer support specialist.

Young people are already informally providing youth peer support with their peers, friends, and family. We urge policymakers, stakeholders, and states to acknowledge that young people are intelligent, professional, and ethical. No research suggests that youth peer support specialists are unable to follow the same code of ethics or professional standards as older peer supporters.



3 Create youth-specific training, certification, and supervision requirements, designed by young people for young people.

CMS guidance states that peer supporters must be trained and certified; however, states can determine what is included in the training curriculum and what is required to be credentialed. In some states, youth peer supporters are given the same training and have the same certification requirements as adult peer supporters. This is a problem because:

- The training and certification processes are not designed for young people, resulting in an older peer workforce because young people may struggle to meet the certification requirements. For example, young people may struggle with larger classes, stringent testing requirements, or teaching methods that are not youth friendly.
- The training and certification processes do not address the unique developmental needs of young people, meaning peer supporters are not equipped to work with younger populations.
- Some states have a separate training add-on for peer supporters who want to work with youth, meaning youth peer supporters must do additional training.
- In some states, in person training is required, limiting access for youth with mobility needs, who may be immune compromised, lack accommodations for travel, or any other barriers that hybrid and virtual components help to mitigate.

As one of our interviewees said, “let the young people drive it. Young people at the helm of

everything.” Provide the space and resources for young people to self-design programs that would be the most youth-friendly and meaningful to them.

CMS also requires that peers be supervised by a qualified mental health provider; however, states can determine who is considered a qualified mental health provider. States should ensure peer support specialists are considered as qualified mental health professionals and peer supporters should be supervised by fellow peers. Youth peer supervisors should receive their own training, specific to supervising peers and to supervising young people. Bridging the Gap, a youth peer support program in New York, has a sample curriculum for youth peer supervisors. In states that require clinical supervision, they should adopt a co-supervision model so peers can talk to someone who understands their work.

Strategies to Implement Best Practice:

- State agencies in charge of peer support should create a separate training curriculum that is designed for young people by young people. Youth MOVE National can support states in developing training curriculums.
- State agencies in charge of peer support should invest in multiple youth training programs, including virtual options, so young people can be credentialed in a program that works for them.
- Youth peer trainings may be smaller in size than adult trainings to ensure every peer receives adequate attention and support. Georgia noted

that its youth trainings are 1/2 to 1/3 the size of adult training programs, which helps retain peer workers.

- Youth peer support trainings should be free, as done in Pennsylvania.

- States should ensure peers are considered qualified mental health professionals and should ensure youth peers are supervised by fellow peers who have undergone youth-specific supervision training.

Create youth-specific training, certification, and supervision requirements, designed by young people for young people.

State Spotlight: Oregon

The Oregon Office of Recovery and Resilience provides grant funding to culturally specific youth-run organizations so they can create a new youth-led curriculum for youth peer support certification. These organizations can then use the curriculum to generate sustainable funding. This allows peer support to remain non-clinical while peer-run organizations can still generate sustainable funding without billing Medicaid for peer support services.



4

Young people should be able to move seamlessly from child- to adult-serving systems, without experiencing interruptions in peer support services.

Providing youth peer support services to young people ages 14-26 requires coordination across child-serving and adult-serving systems. Young people experience service gaps as they transition from one system to the next. While the age range for “youth” peer services varies from state to state, as does the age range for child-serving systems, states should ensure that youth peer services are not interrupted as young people move from one system to the next.

As an example, in a state where youth peer support is available to people as young as 16 and where the child-serving systems ends at 18, youth peer specialists who work with minors may be trained under a different system than peer specialists working with people over 18. Because no states are currently certifying minors to be peer specialists, young people ages 18-26 may be trained as “youth peer specialists” who work in the child-serving system, providing near-age peer support to minors. What this means for young people receiving services is that when they turn 18, they may lose access to their youth peer support specialist, despite now being an age peer to that specialist. Within the adult system, they may struggle to find another young peer support specialist, as the youth specialists are trained in the child-serving system, not the adult-serving ones. Youth peers who wish to work in both systems may need to receive two certifications, one to work with minors and another to work with adults.

Strategies to Implement Best Practice:

- Youth peer support specialists should be simultaneously certified to work in both the child-serving and the adult-serving system.
- CMS should create billing codes for transition-age youth (TAY) groups that are accepted in both the child and adult serving systems. The TAY age group should also have unique medical necessity criteria that allow TAY to access services with preventative benefits more easily.
- CMS should encourage states to have a separate code for youth peer support and family peer support. These are different services and should not be conflated.
- Within the state agency that oversees peer support, youth peer support should have its own office/team, administration, and guild. However, parent, adult, consumer, and youth peers should be housed in the same place to allow for warm hand-offs and movement-building.



5 Peer support should be a viable career option for young people, meaning that both the reimbursement rates reflect market rates and a living wage and that youth peer supporters have strong career ladders.

Many states have low reimbursement rates for peer support specialists, and peers are often the last to get a pay bump. This can be particularly true for young workers as their work is often further devalued due to their age. When reimbursement rates do not reflect the market wage and a living wage, peers do not have any incentive to become Medicaid providers. Similarly, an interviewee shared that by using Medicaid to fund their youth peer support, everything becomes about “units, units, units all the time.”

For youth peers, peer support may be one of their first jobs, so it’s important to provide professional development opportunities and career ladders. Many states noted high turnover among youth peer supporters and the difficulties recruiting a workforce. To retain a youth peer workforce, agencies must be intentional about creating a youth-friendly workplace for peers and investing in the career and personal development of the youth peer workforce. While some youth peers may opt to remain a long-term peer supporter, others may be interested in pursuing other career opportunities in the mental health field.

Strategies to Implement Best Practices:

- State Medicaid agencies should raise reimbursement rates for youth peer support specialists.
- State agencies in charge of peer training should follow up with their youth peers continually, particularly as youth peers age out of being a youth provider (usually age 26) and support them in seeking other employment.



Peer support should be a viable career option for young people, meaning that both the reimbursement rates reflect market rates and a living wage and that youth peer supporters have strong career ladders.

Examples of Career Ladders for Youth Peer Supporters:

- 1 Adult Peer Support:** Youth peers who are aging out of the youth system should be able to seamlessly transition their credentials to the adult workforce and become an adult or family peer support specialist. States could provide additional training to youth peers on the differences when working with an older population, but the state certification should transfer.
- 2 Youth Peer Support Supervision:** Youth Peers should be able to become youth peer supervisors as they age out of the system. They should receive their own training, specific to supervising peers and to supervising young people.
- 3 Peer Support Policy:** State agencies should hire peers to staff the offices tasked with implementing peer support. We interviewed multiple states with peers leading peer offices, including Oregon and Texas.
- 4 Mental Health Clinicians:** For peers interested in going into a clinical profession, such as becoming a therapist, social worker, or psychologist, states should create strong career ladders to do so. This should include creating tuition reimbursement programs for peers pursuing additional credentialing and consider hours worked as potential college credits or internship hours.



6

Clinical organizations must value and understand the work of peers as agents of change within the system.

The treatment of peers in clinical settings is one of the biggest barriers to expanded peer support. Many of our interviewees noted that embedding peers into clinical settings is where cooptation of peer support most often occurs.

However, given CMS guidance on peer support being operationalized in the context of coordinated care and Medicaid prioritizing funding to treat people with a diagnosed serious mental illness (SMI), many peers must be embedded in care teams to receive Medicaid reimbursement.

Peer supporters play a critical role in care teams. Peer support, when practiced to fidelity, helps people make meaning of their own experiences and determine what “care” and “treatment” look like for them, and peer supporters can help change the culture of the organizations they’re working in. Peer supporters should be recognized as “disruptive innovators,” who can help clinical organizations de-center Western colonial conceptions of health and wellbeing and disrupt the medical industrial complex. Peers should lead trainings for staff, talk about the language staff use when discussing “recovery,” “treatment,” and “diagnosis,” and break down power dynamics within clinics between patients and providers. This is often not the role clinicians want peers to play.^{xliv}

What is a Care Team?

Care teams provide wraparound support to individuals with complex needs, working together to develop and implement a treatment plan. Care teams often consist of a case manager and clinical providers. Care teams can also include a peer support specialist. Within this model, peer support specialists often work for a clinical organization where the care team is located.

Care teams frequently devalue the work of peers. This leads to what one interviewee described as the “dustbin” problem wherein clinicians don’t understand the purpose or value of peer support and use peers as a “dustbin,” meaning peers are asked to perform whatever tasks the organization needs, including case management,

administrative or janitorial tasks, and more. This is exacerbated with youth peer support specialists as clinicians might devalue the work of both peer supporters and the ability of young people to provide competent and high-quality care.

Further, many clinicians don’t understand the value of peer supporters as part of a care team and create a care team hierarchy in which the opinions and recommendations of the peer supporter are given less weight than those of others on the team. Clinicians also tend to rely on medical terminology when discussing mental health challenges, which may be contrary to the language preferred by both the recipient of services and the peer support providers.

OnTrackNY, a mental health treatment program for young people in New York State, developed a checklist for peer support specialists and supervisors working in the program. The checklist helps to define the peer role, ensure fidelity in peer support, and facilitate peers as agents of change.^{xlv}

Strategies to Implement Best Practices:

Not every peer feels comfortable working in a clinical setting, as discussed below. However, peers do play a critical role in clinical settings as agents of change. For peers who are willing to work in clinical settings, the following strategies can help support and empower them to be agents of change within the system:

- State agencies that oversee peer support should have peer supporters help to draft and review contracts that mandate peer specialists be incorporated into care teams or into clinical organizations like Federally Qualified Health Centers (FQHCs).
- State agencies should ensure clinicians and clinical organizations understand peer support before a peer supporter begins working.
- States should have clear scope of practice guidelines and service definitions for youth peer specialists to help ensure they are not asked to act as junior clinicians or perform tasks outside their scope of work. Peers should be actively involved in creating the scope of practice and service definitions.
- When peers are embedded into a clinical organization, peers should provide ongoing training to other members of the team. Setting up peers for success in a clinical environment requires clinicians being on board and knowing what the role of a peer is. This includes clinicians seeing their own work with a critical eye, challenging themselves to listen to the peer and their experiences, and ensuring that they're not just thinking about people as diagnoses but as valuable sources of wisdom and agents of change.
- States should avoid having clinical professionals supervise peers, as clinical providers often don't adequately understand the work of peers and may be unable to provide quality supervision.

Clinical providers who supervise peers may also intentionally or unintentionally ask peers to provide services that are antithetical to true peer models, such as by overmedicalizing their work.

- Peers working in clinical settings should regularly meet with other peers working in the system to check in and share what challenges they face working in clinical settings. Building community among peers could help with the retention of a peer workforce while also helping peers stay connected to grassroots movements. Peers' job descriptions—and compensation—should include meeting with other peers.
- States must recognize that many peer support specialists are not interested in clinical settings and would feel uncomfortable working in such settings. While the conditions in clinical settings can be improved, clinical settings cannot be the only option.

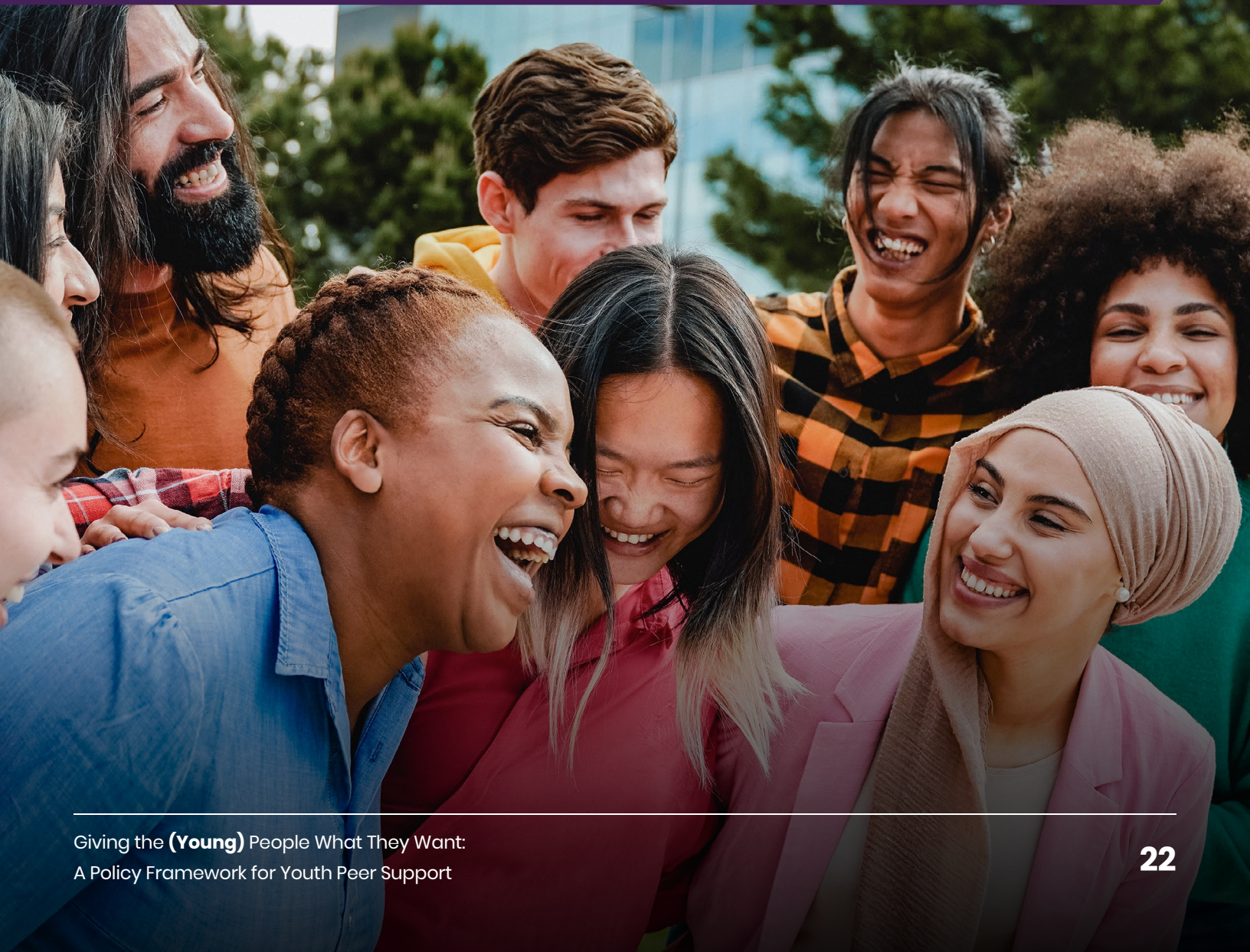
“

“At their best, peer workers create an opening in a formally closed system: a space which allows for new voices in an old model, especially if there is a vibrant peer movement outside the system offering alternative visions and creative practices. In this way, the peer role is a potential change agent in a system desperately needing change.”^{xlvi} – *Sascha Altman DuBrul, co-founder of the Icarus Project*

”

State Spotlight: Georgia: Embedding Peers into Care Teams

In Georgia, peer support is heavily embedded in a team-based clinical model. To get to where it is now, Georgia used both carrots and sticks to embed peer support into the system. The state had consumer and peer support specialists present on the benefits of peer support to clinicians, helping to build understanding and buy-in among both the provider workforce and state leadership. Georgia also mandated peer support specialists be included in care teams established by existing models, such as requiring community health clinics, Assertive Community Treatment (ACT) teams, and wraparound teams to include peer support specialists. To sustain this model, Georgia notes the importance of high reimbursement rates for peers and of organizational readiness of clinical organizations to understand and value peer workers.



7

Peer support should be available across the continuum of care and should be recognized and funded as a preventative service.

To have a truly robust peer support system, peer support needs to be funded and widely available both within and outside of clinical organizations. Another major barrier is the distrust many peer providers and peer-run organizations have toward clinical organizations and the systems that support the peer clinical model, including Medicaid. Because peer support can involve speaking against harmful clinical models, many peer supporters do not want to simultaneously work within those systems.

Unfortunately, Medicaid, as it exists now, is ill-equipped to fund peer support outside of clinical settings. Because peer support is often only billable when embedded into care teams, peer support is not a widely available service. Care teams are mainly only utilized to support people with complex diagnoses or high levels of need, often people with a diagnosed SMI. In some states, a person needs an SMI diagnosis to be eligible for peer support services under Medicaid, and states often require peer support specialists to prove they have an SMI diagnosis to be certified as a peer. In addition, in some states youth peer support is only available in high-fidelity wraparound or first-episode psychosis programs, which are both only for individuals with high levels of need.



State Spotlight: Pennsylvania

State agencies in charge of credentialing the peer workforce should not require peer support specialists to have an SMI to be a provider. For example, Pennsylvania submitted a State Plan Amendment (SPA) to change the requirement for lived experience of a behavioral health diagnosis. Now, peer supporters can respond on a short answer form to show their credentials rather than proving they had an SMI.

The focus on peer support within coordinated care makes clear that CMS views peer support as a supplement to clinical services, not as a service in and of itself. CMS reiterated their guidance on embedding peers into care teams in a 2013 joint bulletin with SAMHSA. The bulletin highlighted peer services as an integral part of programs designed for young people with significant mental health conditions, focusing both on peers working in residential facilities and on peers working in community-based settings. CMS noted that peer services can help youth move into the community from residential treatment.^{xlvii} Medicaid's focus on SMI and medical necessity criteria over prevention hinders payment for free-standing peer support and prevents youth peer support from being widely available.

Therefore, it's important to invest in existing peer-run programs that can and do serve a wider range of people, regardless of diagnosis. Because peer-run organizations are not limited by Medicaid payment models the same way as peer providers on care teams, they are more able to serve a broader range of individuals and have a stronger understanding of peer support as a preventative service. However, billing Medicaid is complicated, and many peer-run organizations do not have the capacity to do so, even if Medicaid does not explicitly limit reimbursement to them.

Strategies to Implement Best Practice:

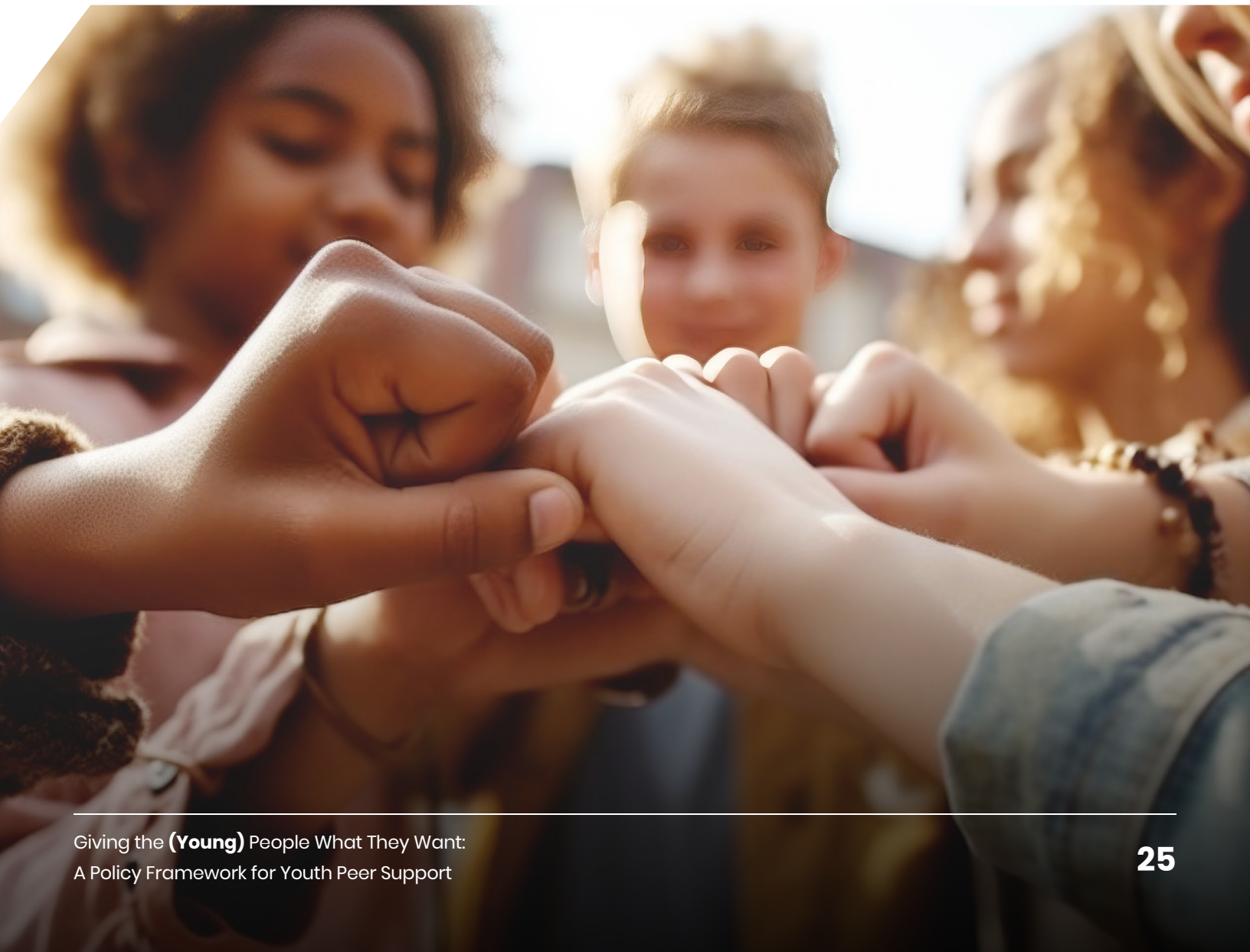
- **Strategies to bolster prevention funding:**

- State Medicaid agencies should include peer support in the list of services covered under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services by submitting a SPA.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) should have at least a 20 percent set aside for primary prevention strategies in the Community Mental Health Services Block Grant, with stricter state policies on how those block grants can be spent to avoid misappropriation of funds.^{xlviii}
- The U.S. Preventive Services Taskforce should evaluate the effectiveness of peer support as a preventative service. If it gives peer support a grade of A or B, it clears the path to getting Medicaid and Medicare coverage.
- State Medicaid agencies should not require a diagnosis of an SMI to qualify for peer services.

- **Strategies to support peer-run organizations:**

- Building a robust system is not just about embedding peers into clinical organizations, but also about embedding clinicians into peer-run organizations where peers can set the culture of the organization and clinicians must adapt to the peer culture.
 - To get Medicaid reimbursement, peer-run organizations need billing capacity. They could build relationships with medical billing training programs, outsource medical billing via contract, or hire a peer billing specialist. They could use grant funding to expand their billing capacity.
 - Peer-run organizations can consider partnering with a clinician, which might be necessary to receive Medicaid reimbursement in some states. Peer-run organizations could prioritize hiring clinicians with peer backgrounds, particularly former youth peer support specialists who pursued a clinical degree.

- Peer-run organizations can develop strong relationships with clinical providers who understand peer support and vice versa to create strong referral networks.
- State agencies in charge of peer support should focus on building trust and relationships with existing peer-run organizations in their state. For example, the Oregon Office of Recovery and Resilience noted the importance of showing up in communities and focusing on visiting community-based organizations with culturally specific programs. One way they build relationships is by hiring folks on their team who are from, or connected to, the communities they visit.
- Managed Care Organizations (MCOs) should contract with peer providers. The terms of the contract should be negotiated in such a way that peer-run organizations or peer providers are not required to work under the supervision of a clinical organization or a clinician.
- MCOs should contract with a youth-led peer-run organization to provide youth peer support to young people ages 16-25.



8

States should pursue a diverse array of funding sources for youth peer support, both within and outside of Medicaid.

While Medicaid offers the most sustainable source of funding for youth peer support and states have strategies for lessening the clinical practices required by Medicaid, Medicaid alone cannot adequately fund youth peer support infrastructure.

States should maximize Medicaid funding for youth peer support whenever possible but rely on other funding sources to further build out youth peer infrastructure. They can use grant funding to

- provide youth peer support to individuals not eligible for Medicaid services,
- support peer-run organizations,
- support training/credentialing or curriculum development,
- provide wellness support to people working as peers,
- offer trainings to clinicians and individuals on the value of youth peer support,
- underwrite youth peer support in non-clinical settings like schools and community centers, and more.

State Spotlight: Utah

Utah is in the early stages of bringing youth peer support to the state. Utah plans to braid funds for youth peer support, using funding from the state's System of Care, the Office of Substance Use and Mental Health, Division of Child and Family Services, and Division of Juvenile Justice and Youth Services. The state is developing memorandums of understandings (MOUs) between each agency/division. However, because developing MOUs takes time, Utah will use its System of Care grant to initially fund the full program. This will expedite bringing youth peer support to the state while giving the state time to develop sustainable funding. In addition to braiding agency funding, Utah is also exploring Medicaid reimbursement. Utah currently does not have a Medicaid billable code for youth peer support; however, they can add youth peer support (or near-age peer support) through a state plan amendment or waiver. Utah is working with Youth MOVE National on developing its youth peer training curriculum. Working with Youth MOVE National allows the state to train peers to fidelity while also meeting state accreditation requirements.

Strategies to Implement Best Practices:

- The following funding sources can help support peer support and/or the work of peer-run organizations:
 - SAMHSA Block Grant dollars including the Community Mental Health Block Grant.
 - State general operating funds. States should advocate for a percent set aside of general operating funds to support youth peer support.
 - Education funding for peer support in schools.
 - Child welfare, especially foster care funding, to support peer support for foster care and former foster care youth.
 - Public health and suicide prevention funding.
 - Foundation money, especially toward Diversity Equity and Inclusion (DEI)/diversity initiatives to ensure youth peer support is available to Black, brown, and Indigenous young people.
- Strategies Under Medicaid:
 - Change medical necessity criteria to be based on life experience rather than a diagnosis. California expanded the family therapy benefit under Medicaid to young people with certain life experiences, including experience of discrimination, food or housing insecurity, and exposure to domestic violence or other traumatic events. Other states are considering similar policies.^{xix} Youth peer support could similarly be a benefit based on life experiences, not diagnosis.
 - Explore different payment options under Medicaid including value-based payments and self-directed payment models.



Youth Peer Support Funded by SAMHSA: Bridging the Gap NYC

Based in New York City, Bridging the Gap is a youth peer support program. It is funded through a SAMSHA grant and focuses on expanding the range of service options for LGBTQIA+ young people. Bridging the Gap provides “confidential one-on-one support, job training, skills building, and social activities” and is “staffed by mentors who have been through, and overcame, experiences similar to yours.” Bridging the Gap is free. Because the program is grant funded, it doesn’t have to bill for services, meaning it can serve any young person without requiring that young person to have a diagnosis or meet medical necessity criteria. Bridging the Gap refers to its youth peer support specialists as youth development specialists. Youth development specialists are trained through the program and do not need to meet state certification requirements.

Summary of Policy Recommendations:

Centers for Medicare and Medicaid Services:

Create guidance specific to youth peer supporters that:

- Specifies the minimal level of documentation required for reimbursement.
- Clarifies that young people 16-26 can be certified as youth peer support providers.
- Removes guidance around coordinated care and instead recognizes peer support as a preventative service, a supplement to clinical care, and a service in and of itself.
- Encourages states to create separate billing codes for youth peer support and family peer support and encourages states to create TAY-specific codes that can be used in both the child- and adult-serving systems.
- Encourages peers to be supervised by fellow peers and recommends youth-specific supervision for youth peer workers.

Explore ways to minimize documentation requirements for non-clinical providers, increase access to preventative services for young people, and remove medical necessity criteria as a barrier to preventative services.

State Medicaid Agencies:

- Allow young people ages 16–26 to be certified youth peer support specialists and certify them to work in both the child-serving and the adult-serving systems.
- Raise reimbursement rates for peer support specialists
- Develop clear scope of practice guidelines and service definitions for youth peer specialists.
- Remove medical necessity criteria for youth peer support that mandates a diagnosed SMI.
- Change medical necessity criteria for youth peer support from specific diagnoses to life experiences.
- Include youth peer support as a benefit under EPSDT.
- Explore alternative payment models for non-clinical services, including value-based payments or self-directed payment models.

State Peer Support Offices:

- Create a separate training curriculum designed for young people by young people and invest in multiple youth training programs so young people can be credentialed in a program that works for them.
- Certify youth peers to work in both the child- and adult-serving systems.
- Create a separate office/team that oversees youth peer support. The office should be staffed by peers.
- Create strong career pathways for youth peer support specialists.
- Ensure peer supporters are considered “qualified mental health professionals” and mandate that peers be supervised by fellow peers. Supervisors of youth peer support specialists should be given specific training on how to effectively supervise young people.
- Peer supporters should help draft and review contracts that mandate peer specialists be incorporated into care teams or into clinical organizations like an FQHC.
- Build trust and relationships with peer-run organizations in the state, particularly culturally specific peer-run organizations.

- Help ensure clinicians and clinical organizations understand the value and ethos of peer support.

Other Stakeholders:

- State departments of health and accrediting and licensing bodies should allow young people ages 16–26 to be certified youth peer support specialists.
- The federal Department of Labor should create a standard occupational code for peer support professionals (including youth peer professionals), so peer support professionals are no longer included under community health workers.
- FQHCs and other clinical organizations with embedded peers should have peers provide ongoing training to other members of the team on the value of peer support.
- MCOs should contract a youth-led peer-run organization to provide peer support to transition-age youth.
- States should diversify funding sources to fund a full continuum of peer support services. This includes advocating for percent set-asides in general operating funds, using funds from SAMSHA block grants for youth peer support, braiding funding from across agencies, and maximizing prevention funding sources.
- The U.S. Preventive Services Taskforce should evaluate the effectiveness of peer support as a preventative service.
- Peer-run organizations interested in receiving Medicaid reimbursement can increase their billing capacity by developing relationships with medical billing training programs, outsourcing medical billing via contract, or hiring peer billing specialists. Peer-run organizations could also partner with clinicians who understand the value of peer support.



Conclusion:

Incorporating a non-clinical practice like youth peer support into Medicaid requires a shift in how Medicaid reimburses services. Medicaid was not designed to adequately cover non-clinical services, but these services are essential to promoting equity and prevention. Medicaid needs to invest in payment reform models to find new ways to fund these services, rather than forcing these services into a clinical payment model that they are misaligned with.

The lessons learned as states implement peer support services can offer a blueprint for how states can embed other non-clinical services into their Medicaid programs. State Medicaid Agencies must pursue creative strategies to fund non-clinical services, and CMS should release guidance on how states can utilize new payment models to fund a broader array of services. Key to this guidance should be how states can reduce documentation requirements for non-clinical providers, remove diagnosis and medical necessity criteria as a barrier to receiving care, and increase funding for prevention and universal services.

States must begin investing in the mental health supports young people are asking for, including non-clinical support like youth peer support. Young people are already seeking and providing peer support services informally, with many often noting they turn to friends when they need support. Bolstering youth peer services will help ensure young people can continue seeking care from peers, that peers are supported in the work, and that young people can be connected to additional youth-friendly services if they want them. Investing equitably in services like youth peer support can help transform the mental health system for young people.

Acknowledgments

The authors would like to thank Nia West-Bey, youth team director, and Isha Weerasinghe, senior policy analyst, for their constant encouragement and helpful feedback. We would also like to thank Suzanne Wikle, senior policy analyst; Elizabeth Lower-Basch, deputy executive director for policy; Barbara Semedo, deputy executive director, external affairs and strategic communications; Tom Salyers, communications director; Claudia Hernandez, communications manager; and Archana Pyati, senior media relations manager for their editorial review.



Appendix 1. Interview Participants

Stakeholders

- Amey Dettmer - Doors to Wellbeing NTAC Program Manager, Copeland Center for Wellness and Recovery
- Arc Telos Saint Amour (they/them) – Executive Director, Youth MOVE National
- Brie Masselli – Consumer Advocate and Youth Peer Support Subject Matter Expert
- Kelly Davis – Associate Vice President of Peer and Youth Advocacy, Mental Health America
- Keris Myrick – Vice President of Partnerships, Inseparable
- Kristin Thorp – Consumer Advocate and Youth Peer Support Subject Matter Expert
- Lydia Proulx (they/them) – Director of Youth Programs, Youth MOVE National
- Noah Gokul – Program Coordinator, Institute for the Development of Human Arts
- Sascha DuBrul – Mental Health Coach and Trainer, Transformative Mental Health Practices

States

Georgia

- Wendy Tiegreen – Director, Office of Medicaid Coordination & Health System Innovation at the Georgia Department of Behavioral Health & Developmental Disabilities

Oregon

- Brandy Hemsley – Director, Office of Recovery and Resilience, Oregon Health Authority

Pennsylvania

- Chris Lunford – Call for Change & Youth Care Coordinator, Pennsylvania Mental Health Consumers' Association
- Jenna Mehnert Baker – Director of Bureau of Policy, Planning and Program Development, Department of Human Services, Office of Mental Health & Substance Abuse Services, Department of Human Services

- Kevin Puskaric – Program Director, Youth MOVE PA
- Scott Talley – Director, Bureau of Children’s Behavioral Health Services, Office of Mental Health and Substance Abuse Services, Department of Human Services

Texas

- Elizabeth Castaneda – Peer and Recovery Services Manager, Texas Health and Human Services
- Felicia Mason-Edwards MA, Certified Family Partner – Manager, Peer Support and Recovery, Behavioral Health Services, Texas Health and Human Services
- Noah Abdenour – Certified Peer Specialist, Director of Peer Support and Recovery, Behavioral Health Services, Texas Health and Human Services

Utah

- Tyler Haven – Youth Coordinator, System of Care Utah

ⁱ Kelly Davis, Sriya Chilla, and Nghia Do, “Youth and Young Adult Peer Support: Expanding Community-Driven Mental Health Resources”, Mental Health America and Well Being Trust, 2022,

<https://mhanational.org/sites/default/files/reports/Youth-and-Young-Adult-Peer-Support.pdf>.

ⁱⁱ Maria Cohut, “Racism in mental healthcare: An invisible barrier,” MedicalNewsToday, 2020,

<https://www.medicalnewstoday.com/articles/racism-in-mental-healthcare-an-invisible-barrier>.

ⁱⁱⁱ “Peers Supporting Youth and Young Adult Recovery,” Substance Abuse and Mental Health Services Administration and Bringing Recovery Supports to Scale Technical Assistance Center Strategy,

https://c4innovates.com/brsstacs/Value-of-Peers_YYAPeerSupports.pdf.

^{iv} N.A.P.S. website, <https://www.peersupportworks.org/>.

^v Kelly Davis, et al., “Youth and Young Adult Peer Support.

^{vi} “What is a Peer?,” Mental Health America, <https://mhanational.org/what-peer>.

vii Dorothy I. Ansell and Sarah E. Insley, Youth Peer-to-Peer Support: A Review of the Literature, Youth Move National, 2013, <https://youthmovenational.org/wp-content/uploads/2019/09/YouthPeertoPeerLiteratureReviewFINAL.pdf>.

viii “National Practice Guidelines for Peer Specialists and Supervisors

National Association of Peer Supporters,” National Practice Guidelines for Peer Specialists and Supervisors, 2019, <https://www.peersupportworks.org/wp-content/uploads/2021/07/National-Practice-Guidelines-for-Peer-Specialists-and-Supervisors-1.pdf>.

ix Noah Phillips, “CityViews: Is New York’s Mental-Health System Listening to the Peers Who’ve Lived It?,” City Limits, 2019, <https://citylimits.org/2019/02/13/cityviews-is-new-yorks-mental-health-system-listening-to-people-whove-lived-it/>.

x Ibid.

xi Ibid.

xii Ibid.

xiii Ibid.

xiv “Peers Supporting Youth and Young Adult Recovery,” https://c4innovates.com/brsstacs/Value-of-Peers_YYAPeerSupports.pdf.

xv “Young Adult Peer Mentoring Organizational Self-Assessment & Capacity Building Toolkit,” Massachusetts Department of Mental Health and CBH Knowledge Center, 2021, <https://static1.squarespace.com/static/545cdfcce4b0a64725b9f65a/t/604f76bdda2fa72f9c06aa42/1615820477818/CBHKC+YAPM+Toolkit+%28002%29.pdf>.

xvi “National Practice Guidelines for Peer Specialists and Supervisors
National Association of Peer Supporters,” National Practice Guidelines for Peer Specialists and Supervisors, 2019, <https://www.peersupportworks.org/wp-content/uploads/2021/07/National-Practice-Guidelines-for-Peer-Specialists-and-Supervisors-1.pdf>.

xvii Antonia Barba et al., “Bridging the Gap Peer Kit for Agencies Employing Young Adults in Peer Roles,” Bridging the Gap, 2022, <https://socialwork.nyu.edu/content/dam/nyusilver/faculty-and-research/yyamh-g/btg-peer-kit-june-2022.pdf>

xviii Ibid.

xix “Youth Peer Support Supervisor/Administrator Manual,” Association for Children’s Mental Health, 2022, <https://www.acmh-mi.org/wp-content/uploads/2022/07/Youth-Peer-Support-Supervisors-and-Administration-Manual-Updated-6-15-22.pdf>.

xx Ibid.

xxi Antonia Barba, Vanessa Klodnick, and Michelle R. Munson, “Transforming Community Mental Healthcare: How to Grow the Youth & Young Adult Peer Support Workforce,” The Transitions to Adulthood Center for Research, University of Massachusetts Chan Medical School, 2022, <https://www.youtube.com/watch?v=pkbPxWqJv2E>.

xxii Ibid.

xxiii Miriam E. Delphin-Rittmon, Anita Everett, Johanna Bergan, et al., “Caring for Every Child’s Mental Health: Peer Support for Youth & Families,” Substance Abuse and Mental Health Services Administration, 2022, <https://www.samhsa.gov/sites/default/files/national-childrens-mental-health-awareness-day-presentation.pdf>.

xxiv Ibid.

xxv Janet Walker, Caitlin Baird, and Mary Beth Welch, “Peer Support for Youth and Young Adults who Experience Serious Mental Health Conditions: State of the Science,” State of the Science, 2018, <https://www.pathwaysrtc.pdx.edu/pdf/state-of-the-science-articles-2018-amp-plus.pdf>.

xxvi “Peers Supporting Youth and Young Adult Recovery.”

xxvii Ibid.

xxviii Ibid.

xxix Dawn Bunch, “Our Position Statements,” Adolescent Peer Support League, <https://www.adolescentpeersupport.org/the-solution>.

xxx “Peers Supporting Youth and Young Adult Recovery.”

xxxi “Peers Supporting Recovery From Mental Health Conditions.”

^{xxxii} C.R.M. de Beer, L.A. Nooteboom, L. van Domburgh, et al., “A systematic review exploring youth peer support for young people with mental health problems,” *European Child and Adolescent Psychiatry*, 2022, <https://link.springer.com/article/10.1007/s00787-022-02120-5>.

^{xxxiii} Antonia Barba et al., “Transforming Community Mental Healthcare: How to Grow the Youth & Young Adult Peer Support Workforce,” <https://www.youtube.com/watch?v=pkbPxWqJv2E>.

^{xxxiv} Melissa Schober and Kathryn Baxter, “Medicaid Funding for Family and Youth Peer Support Programs in the United States,” The Institute for Innovation and Implementation, University of Maryland School of Social Work, 2020, <https://youthmovenational.org/wp-content/uploads/2021/01/Medicaid-Funded-Youth-and-Family-Peer-Support-Guide-2020.pdf>.

^{xxxv} Ibid.

^{xxxvi} Ibid.

^{xxxvii} Ibid.

^{xxxviii} “What You Need to Know: Funding Youth Peer Services,” Florida Department of Children and Families, <https://www.myfamilies.com/sites/default/files/2022-11/Youth%20Peer%20Services%20-%20Fund%20InfoGraph.pdf>.

^{xxxix} “Intensive Care Coordination Using High Fidelity Wraparound/High Fidelity Wraparound,” Title IV-E Prevention Services Clearing House, <https://preventionservices.acf.hhs.gov/programs/330/show>.

^{xl} Centers for Medicare and Medicaid Services, Dennis G. Smith SMDL #07-011 (August 15, 2017) <https://www.medicare.gov/federal-policy-guidance/downloads/SMD081507A.pdf>.

^{xli} Centers for Medicare and Medicaid Services, “Medicaid Documentation for Medical Office Staff” (July 2014), <https://hhs.iowa.gov/sites/default/files/docmatters-officestaff-factsheet.pdf>.

^{xlii} Dayana Simons, Taylor Hendricks, Jessica Lipper, Johanna Bergan, and Brianne Masselli, “Providing Youth and Young Adults Peer Support through Medicaid,” Center for Health Care Strategies and Youth MOVE National, August 2016, <https://www.chcs.org/media/Providing-Youth-and-Young-Adult-Peer-Support-through-Medicaid.pdf>.

^{xliii} Antonia Barba et al., “Bridging the Gap Peer Kit for Agencies Employing Young Adults in Peer Roles,” *Bridging the Gap*, 2022, <https://socialwork.nyu.edu/content/dam/nyusilver/faculty-and-research/yyamh-g/btg-peer-kit-june-2022.pdf>

^{xliv} Noah Phillips, “CityViews: Is New York’s Mental-Health System Listening to the Peers Who’ve Lived It?,” <https://citylimits.org/2019/02/13/cityviews-is-new-yorks-mental-health-system-listening-to-people-who-ve-lived-it/>.

^{xlv} “OnTrack NY Peer Specialist Role Responsibilities and Supervision Checklist for Peer Specialist,” OnTrackNY, 2021, https://ontrackny.engagetest.com/Portals/1/Peer%20Specialist%20Role%20Responsibilities%20Tool%205_21.pdf.

^{xlvi} Sascha Altman DuBrul, “Collaborative Strategies for Re-Visioning the Public Mental HEALTH System,” Mad in America, 16 August 2019, <https://www.madinamerica.com/2019/08/re-visioning-public-mental-health-system/>.

^{xlvii} Pamela S. Hyde, “Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions,” The Substance Abuse and Mental Health Services Administration and The Centers for Medicare and Medicaid Services, 7 May 2013, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf>.

^{xlviii} Jace Peterkin and Isha Weerasinghe, “Congress must fund preventive approaches to mental health care,” The Center for Law and Social Policy, April 2023, <https://www.clasp.org/blog/congress-must-fund-preventive-approaches-to-mental-health-care/>.

^{xlix} Nia West-Bey, “California’s Medicaid Family Therapy Benefit Reimagines Medical Necessity,” The Center for Law and Social Policy, May 2022, <https://www.clasp.org/blog/californias-medicaid-family-therapy-benefit-reimagines-medical-necessity/>.