An Exploration of Peer Recovery Support Services Across State Behavioral Health Systems
SUPPORTING STATEMENT

JUSTIFICATION

A1. *Circumstances Making the Collection of Information Necessary*

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is requesting approval from the Office of Management and Budget (OMB) to conduct a pilot study to obtain an overview of peer recovery services across state behavioral health systems. This data collection includes one data collection instrument – a semi-structured interview questionnaire **(Attachment A) -** that will be utilized with state and organizational representatives from mental health and substance abuse agencies.

Authorizing Legislation

This data collection is authorized by Section 505 of the Public Health Service Act (42 USC 290aa4 – Data Collection).

Background, Need, and Legal Basis

Peer recovery support services have emerged as a key method to assist individuals with mental health and/or substance abuse disorders to achieve and maintain recovery. Given that a key provision of the Affordable Care Act is integration of primary and behavioral healthcare, peer recovery services will continue to expand to meet the needs of individuals with chronic behavioral health conditions (Laudet & Humphrey, 2013). SAMHSA is a leading voice in the promotion of the Recovery Oriented Systems of Care (ROSC) model for recovery support services. The ROSC model emphasizes a multi system approach to address the chronic behavioral health needs of individuals along the continuum of care of prevention, treatment, and recovery.

In an effort to support behavioral health systems' adoption and management of recovery oriented services, SAMHSA created the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS is a mechanism for implementing SAMHSA's Recovery Support Strategic Initiative. A goal of this initiative is to understand the finance and quality assurance issues that impact peer recovery personnel in the workforce and the services they deliver. A grasp of these complex issues can enable BRSS TACS to advance its work of supporting states by creating policy guidance on best practices for peer recovery support services and/or resources about mechanisms of funding, monitoring, evaluation, and sustainment of peer recovery services.

The proposed pilot study can inform the work of BRSS TACS. The questions of interest include:

(1) How is reimbursement for peer recovery services linked to the role labels given to peer support personnel, credentialing, the types of services rendered, the supervisory structure, the particular settings in which services are delivered, and the funding streams utilized to finance services?

(2) What training and supervision policies and activities do state mental health & substance abuse agencies and organizations have in place for integrating peer support providers with more traditional providers in the behavioral health workplace?

(3) What procedures (formal and informal) are used by state mental health and substance abuse agencies and organizations to monitor and/or evaluate the impact of and need for peer recovery support services?

(4) How are peer recovery services sustained by agencies and organizations?

(5) Given the passage of the Affordable Care Act (ACA), what challenges, if any, do state mental health and substance abuse agencies and organizations anticipate for peer support services?

Data collection will be conducted via phone interview with 1 mental health and 1 substance abuse state agency director or designee that provides peer recovery support services, and 1 mental health and 1 substance abuse grassroots organization that provides peer support recovery services in 10 states, for a total of approximately 40 responses/respondents.

A2. ***Purpose and Use of Information***

In an effort to meet SAMHSA's mission of addressing the behavioral health needs of Americans, the agency has identified eight strategic initiatives to focus its limited resources on areas of urgency and opportunity: (1) Prevention of Substance Abuse and Mental Illness; (2) Trauma and Justice; (3) Military Families; (4) Recovery Support; (5) Health Reform; (6) Health Information Technology; (7) Data, Outcomes, and Quality; and (8) Public Awareness and Support. These initiatives enable SAMHSA to respond to national, state, territorial, tribal, and local trends as well as support the implementation of the Patient Protection and Affordable Care Act and the Mental Health Parity and Addictions Equity Act. The information collection proposed by the pilot study will support strategic initiative #4 (Recovery Support), the mission of BRSS TACS, and its deliverables.

As noted, state behavioral health systems and authorities are striving to become more recovery oriented in the delivery of behavioral health care. Integrating peer support personnel into the workforce is paramount to realize this effort. Peer recovery support services create a critical link between the two systems that provide treatment for mental health and/or substance

abuse conditions in a clinical setting and the larger communities where individuals are seeking to achieve and sustain their treatment goals in daily life.

State behavioral health systems face challenges in their efforts to incorporate peer support personnel in the workforce. A major challenge is building the infrastructure and skills needed to develop policies that highlight the utility of peer support personnel in the workforce. Other challenges include the financing, credentialing, monitoring, evaluation, and sustainment of peer recovery support services. Given that current health reform will result in a greater demand for peer recovery support services, state behavioral health systems will likely require more technical assistance regarding how to effectively manage peer recovery support services in the context of the Patient Protection and Affordable Care Act.

The information collection proposed by the pilot study is necessary to inform the technical assistance that SAMHSA's Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) provides to state behavioral health systems about how best to address these challenges. In this way, SAMHSA can continue its support of ensuring the development of a capable recovery oriented behavioral health workforce in collaboration with grantees, states, territories, tribes, and communities.

The information collection proposed by the pilot study will allow BRSS TACS to obtain an overview of the current practices of peer recovery services across state behavioral health systems. Specifically, the study findings can be utilized by BRSS TACS to identify a) the funding challenges faced by state mental health and substance abuse agencies and organizations for peer recovery support services; b) training opportunities about the financing and expansion of peer recovery support services in the context of the Affordable Care Act; c) training opportunities about quality assurance issues such as credentialing, core competencies, and supervision of peer personnel in the workforce; d) additional management challenges in peer support services that state mental health and substance abuse agencies and organizations will require guidance about.

BRSS TACS can use these findings to collaborate with the Centers for Medicare and Medicaid Services as well as the managed care and insurance industries to develop policy guidance and/or training about how state behavioral health authorities can include peer support services within Essential Health Benefit (EHB) plans and explore how to effectively integrate peer support services with Medicaid populations. These efforts by BRSS TACS are relevant for advancing SAMHSA's strategic initiative to develop and increase best practices for effectively deploying peer recovery support services in integrated healthcare delivery systems as mandated by the Affordable Care Act.

A3. ***Use of Information Technology***

The collection of information for the proposed pilot study will be gathered via phone interviews with representatives of state mental health and substance abuse agencies and

grassroots organizations within the states contacted. In the event that some respondents need additional time to respond or elaborate further to a particular question, they will be given an additional week to submit their responses electronically via email to the principal investigator. The questions flagged by representatives for a later response will be noted in the thank you email sent to representatives for their participation in the study.

A4. *Efforts to Identify Duplication and Use of Similar Information*

The data collection proposed for this pilot study of peer recovery support service providers is not available elsewhere, is not duplicative, and is seen as critically valuable for technical assistance and support of peer recovery services provided to behavioral health systems by BRSS TACS. Given the present health policy landscape- most notably, the passage of the Affordable Care Act - and the continued growth of peer support services, the findings from the proposed pilot can provide updated information about the current strategies and challenges of state and local behavioral health systems to implement, finance, and sustain peer recovery services.

Although two earlier snapshots of peer recovery support services were conducted on behalf of SAMHSA, they are limited to a siloed examination of the financing of peer recovery services for addiction (2010) and mental health (2012). The proposed pilot aims to provide a broader portrait of the state of peer recovery support services for both addiction and mental health within the context of the Affordable Care Act.

Additionally, efforts were made to utilize valid questions for ascertaining operations and funding structures of peer recovery support services. The questions in the interview guide for the proposed pilot were developed in collaboration with the committee members of SAMHSA's strategic initiative for recovery services.

A5. Impact on Small Businesses or Other Small Entities

The participating organizations vary from small entities to large provider organizations or State agencies. Every effort has been made to minimize the number of data items collected from programs to the least required to accomplish the objectives of the effort.

A6. Consequences of Collecting the Information Less Frequently

As this is a proposed pilot study, the scheduled data collection will occur only once. Each respondent is asked to respond to questions and follow-up probes during one interview. However, if the need arises where some respondents need additional time to respond or elaborate further on a particular question, they will be given an additional week to submit their responses electronically via email to the principal investigator. The questions flagged by representatives for a later response will be noted in the thank you email sent to representatives for their participation in the study

A7. Consistency with the Guidelines in 5 CFR 1320.5(d) (2)

This information collection fully complies with 5 CFR 1320.5(d) (2).

A8. Consultation Outside the Agency

The notice required by 5 CFR 1320.8(d) was published in the Federal Register on December 24, 2013 (78 FR 77693). No comments were received.

A9. Payments to Respondents

Respondents will not receive any payments.

A10. Assurance of Confidentiality

SAMHSA has concurred that this collection of data is subject IRB review, hence consent for participation in this study will be obtained. IRB approval for the proposed study is currently under review.

Participation in this data collection is voluntary. All data collection forms inform respondents that privacy is protected and that they are free to skip any question that they do not wish to answer. Personal identifiers will be removed from the data, and the data will be aggregated. Additionally, all data collection forms include the purpose of the information collection, intended use of the information, and that this activity is sponsored by the federal government. There will be no generalized national estimates.

A11. Questions of a Sensitive Nature

There are no questions of a sensitive nature included in this proposed data collection.

Respondents will participate and use standard informed consent processes that have been approved by an IRB for this project. All consent forms will inform respondents as to 1) The name of the agency that is involved in the information collection; 2) The purpose of the information collection and the uses which will be made of the results; and 3) Whether providing the information is voluntary, required to obtain or retain a benefit, or mandatory.

A12. Estimates of Annualized Hour Burden

It is estimated that the total number of respondents for the proposed pilot study will be forty. The total hour burden will be 20 hours. There will be no direct cost to representatives of the behavioral health systems interviewed. Total hour of burden was estimated using the average hourly wage ($ 18.37) for miscellaneous community and social service specialists from the publicly available data (May 2012) of the Occupational Employment Statistics Survey (OES), a mail survey that measures occupational employment for wage and salary workers in non-farm establishments in the US. The OES collects data from over 1.2 million business establishments through six semiannual panels over a three year period. It is sponsored by the Department of Labor, Bureau of Labor Statistics, and uses the OMB-required occupational classification system (the Standard Occupational System (SOC).

Form Name	# of Respondents	Responses per Respondent	Total Responses	Hours per Response	Total Hour Burden	Hourly Wage Cost	Total Hour Cost($)
Structured Interview Questionnaire	40	1	40	.50	20	$18.37	367.40

[1] Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics Survey (OES), May 2012.

A13. Estimates of Annualized Cost Burden to Respondents

There are no capital, startup, operational, or maintenance costs to respondents.

A14. Annualized Cost to the Federal Government

The GS-9 level Public Health Advisor principally involved in the program will spend on average approximately 3% of his/her time (1.5 hours weekly) conducting various research and support activities related to this project. On an annualized basis this would be the equivalent of $1,247 in federal employee personnel costs (based on an annualized GS-9 salary of $41,563). Transcribing an hour-long interview will cost approximately $3,576 (based on transcription at $1.49 per minute). The annualized cost to the government is $4,823. The GS-9 level staff will be supervised by a more senior staff member, Beda Jean-Francois.

A15. Change in Burden

This is a new project.

A16. Time Schedule, Publication, and Analysis Plans

The data collected from the structured interview will be analyzed and interpreted to produce preliminary briefing of results and a final study report to BRSS TACS. A timetable for data collection, analysis, and reporting is noted below.

Activity	Expected Date of Completion
In-house pre-testing of interview questionnaire	1 month following OMB approval
Pilot study invitation is sent to state mental health agencies & organizations in each public health region to create a sample pool of respondents.	1 month following OMB approval
Sample pool of respondents is finalized and appointments for interviews are set for collection of data.	2 months following OMB approval
Phone interviews and follow-up data collection activities, as needed	2-3 months following OMB approval
Data analysis	3-4 months following OMB approval
Preliminary briefing of results	5 months following OMB approval
Final Report	6 months following OMB approval

Analysis Plan

The research design for the proposed study is qualitative. Content analysis will be utilized to identify the themes generated for the five core questions outlined earlier in the background section of this document. Commonalities and disagreements among the themes across respondents of state and organizational agencies of mental health and substance abuse will be noted. To validate the content of themes identified, inter-rater agreement will be established with two raters –the GS-9 level public health advisor and senior staff supervisor (Beda Jean-Francois) identified under the section, Annualized Cost to the Federal Government. Descriptive data, where appropriate, will be reported. For example, frequency tables can be created for the listing of peer roles, service activities, and service settings across the agencies and organizations reporting within each state.

A17. Display of OMB Expiration Date

The expiration date for OMB approval will be displayed.

A18. Exceptions to Certification for Paperwork Reduction Act Submissions

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions.