Integrating Peer Support in Crisis Care Settings Toolkit

UW Medicine
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BEHAVIORAL HEALTH INSTITUTE

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The project team is deeply grateful to the many people who contributed their time, wisdom, knowledge, and lived and professional experience to this toolkit. Their insights shaped this work and reflect the many people who have a shared commitment to strengthening peer support in Washington.

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How to Use This Toolkit

Each section can be read as a standalone resource or as part of the full toolkit. After the Introduction, readers are encouraged to begin with Section 2: Background and Foundational Context, which provides the foundation, evidence base, and system context for the rest of the toolkit.

Look for these callout boxes throughout:

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Practical implementation advice

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SECTION ONE

About This Toolkit

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IN THIS SECTION

Introduction

This toolkit is a practical resource for building and sustaining peer programs in crisis and emergency settings. It was developed by a team of peers and clinicians, whose perspectives are woven throughout.

Washington State has made significant investments in peer support as a core component of its behavioral health system. The Washington Health Care Authority (HCA) has developed peer certification, training, and workforce development resources that are available to organizations across the state. This toolkit builds on that foundation.

Additionally, comprehensive resources for integrating peers in behavioral health settings already exist and are valuable tools for program leaders. Rather than recreating that work, this toolkit builds on it and applies it to the specific context of crisis and emergency settings in Washington.

This toolkit is focused on Washington and is intended to be relevant and transferable to other states, with the understanding that local context matters. The Washington Tribal context is specifically addressed in Section 9.

FREQUENTLY CITED RESOURCES

Several resources were especially useful in grounding this toolkit. They are cited frequently across multiple sections for their depth, relevance, and applicability to crisis and emergency settings:

- Crisis Awareness and Communication in Peer Support (CACPS) Student Manual (WA HCA, 2023)
- Behavioral Health and Crisis Response Systems in Washington (Prevention Alliance, 2022)
- SAMHSA Peer Support Services Across the Crisis Continuum (2024)
- SAMHSA National Guidelines for a Behavioral Health Coordinated System of Crisis Care (2025)
- SAMHSA Advisory: Peer Support Services in Crisis Care (2022)
- DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)
- Peer Support Workers in the ED (University of New Mexico, 2019)

The Harborview Medical Center Psychiatric Emergency Services Peer Bridger Pilot

The guidance in this toolkit also draws on lessons learned from the Harborview Medical Center Psychiatric Emergency Services (PES) Peer Bridger program, a Washington psychiatric emergency services peer integration pilot. Located at a Level 1 trauma center and regional psychiatric emergency hub in Seattle, the program hired three peer support specialists to work alongside clinical staff to support people in behavioral health crises. The program represents an innovative and forward-thinking approach to crisis care.

Embedding peers directly within a high-acuity psychiatric emergency setting is an emerging practice nationally; health systems across the country are increasingly exploring this model as a way to support clinical teams and address behavioral health workforce shortages. In its first years of operation, the program identified meaningful lessons and opportunities around peer role integration. This toolkit was developed in part to capture those lessons and make it easier for other crisis and emergency programs to integrate peers more effectively.

Scope and Settings

This toolkit uses the term “crisis and emergency settings” to describe the main settings where peers may work as part of these care systems. Washington’s crisis and emergency systems are complex and vary by region. They include many access points and services, including 988, 911 response, mobile crisis, co-response, crisis stabilization, in-home stabilization, emergency departments, and post-crisis support. This toolkit does not cover every part of the system. The examples and recommendations are best aligned with settings such as emergency departments, psychiatric emergency services, and crisis stabilization services, but the guidance is intended to be useful across the broader crisis and emergency care continuum.

Intended Audience

This toolkit is designed primarily for frontline managers and leaders working to integrate peer roles into crisis and emergency care settings. It assumes some familiarity with peer support and focuses on the practical work of building and sustaining peer programs.

It was not developed with peers as the primary audience, though peers and advocates may also find sections relevant to their work. Policymakers, system leaders, and funders may also find it helpful for understanding what organizations need to support meaningful peer integration.

Language

Throughout this toolkit, "you" refers to the program leader, manager, or administrator reading it. We use "person" or "people receiving services" as our default when referring to the people peers support, reflecting person-first and recovery-oriented values. Where we reference clinical settings specifically, we may use "patient" to reflect the language or evidence base of that context. We also use "peer" consistently to refer to a peer support worker. We recognize that terminology varies across crisis and emergency settings, and organizations may use different terms for the people they serve (patients, clients, participants, members, and consumers). We acknowledge that language continues to evolve and encourage organizations to adapt terminology to fit their own culture and community.

Toolkit Development Process

This toolkit was developed in partnership with Washington crisis and emergency setting practitioners and leaders. This included peer specialists, peer leaders, peer educators, clinical staff, and agency partners. It draws on key informant interviews with 20+ practitioners and peers in Washington. It also incorporates a review of research and guidance focused on peer support in crisis and emergency settings, supplementing with broader peer support literature where crisis-specific research was limited. Several themes emerged consistently across interviews and are woven throughout the toolkit: the importance of supervision, the risk of peer drift, the need for clear roles, the risk of burnout, and the critical role of leadership buy-in.

The writing and compilation was led by three people: two individuals with lived experience, Topher Jerome and Amanda Kay Lipp, and a licensed clinical social worker, Elizabeth Perry. Our aim is to model what recovery-oriented practice and collaboration can look like when both clinical and lived experience expertise work together.

Values and Approach

This toolkit is grounded in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Guiding Principles of Recovery, which Washington has adopted as the foundation for recovery-oriented practice. We have made every effort to use recovery-oriented language and principles throughout, while also using language that is accessible and familiar to program leaders and administrators working in crisis and emergency settings. We also recognize that terminology varies across settings, cultures, and communities and continues to evolve.

WHAT IS RECOVERY?

SAMHSA defines recovery as "*a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential*."[1]

Guiding Principles of Recovery:

Hope

Person-Centered

Pathways

Holistic

Allies

Social Networks

Culture

Trauma

Strengths

Respect

Limitations

Much of the research on peer support outcomes in crisis and emergency settings comes from programs focused on opioid use. There is less research specifically on psychiatric emergency, crisis stabilization, and other crisis and emergency settings. This reflects the newness of formal peer integration in those environments, not a lack of effectiveness. The evidence base is expanding, including into psychiatric inpatient and non-opioid crisis settings. This toolkit sought to incorporate the best available information while acknowledging gaps in the evidence base.

This toolkit was developed primarily based on Washington's general crisis and emergency system. It was not developed specifically for or based on Tribal crisis systems. Guidance specific to Tribal communities and the Tribal crisis system in Washington is addressed in Section 9, developed by the HCA's Office of Tribal Affairs.

The information in this toolkit was accurate to the best of the project team's knowledge at the time it was developed. If you notice information that may be incorrect or outdated, please contact us at **bhinstitute@uw.edu**.

SECTION TWO

Background and Foundational Context

Introduction to the peer role and systems context

IN THIS SECTION

The Peer Role

A peer is defined as an individual who uses their lived experience of recovery from mental health challenges, substance use disorders, or both to support others on their recovery journey. This also includes parents and caregivers of someone with a mental health condition or substance use disorder. In Washington, qualified peers are credentialed through the Washington State Department of Health (DOH) as Certified Peer Support Specialists (CPSS) and Certified Peer Support Specialist Trainees (CPSST).

Peers bring a distinct kind of knowledge to crisis and emergency settings: what it feels like to be in crisis, what it feels like to be in a hospital or emergency setting, and what it takes to move toward recovery. That knowledge and lived experience complements clinical expertise and is the basis of peer credibility and effectiveness.

As SAMHSA describes it, peer support workers can relate without judgment, communicate hope in a time of great distress, and model the fact that recovery is possible.[2]

LEARN MORE: THE HISTORY OF PEER SUPPORT

SAMHSA: Peer Support Services Across the Crisis Continuum (2024)

Peers complement clinical and emergency response functions. They do not replace them. The peer role is distinct from clinical assessment, treatment planning, medication management, and emergency intervention. What peers do is work alongside clinical staff to engage people, support navigation of a complex system, and build the trust that makes ongoing care and hope possible. For a detailed breakdown of peer role structure, scope, and how to prevent role drift, see Section 5.

In crisis and emergency settings, that means a peer who can sit with someone in acute distress, help them understand what is happening in the crisis process, and connect them to what comes next while the clinical team manages assessment and treatment.[3]

In practice, that might look like:

- Greeting someone when they arrive and helping them feel less alone and less afraid
- Explaining what is happening in plain language during a confusing and stressful process
- Offering emotional support, coping strategies, and grounding techniques
- Connecting people to community resources, housing support, and follow-up services
- Facilitating a warm handoff at discharge so the person leaves with a plan, not just paperwork

The Unique Value of Peers in Crisis and Emergency Settings

Crisis and emergency settings are among the most demanding environments in behavioral health. They are also among the places where peer support can make the most difference.

Peer support is an evidence-based practice with a growing research base demonstrating impact across behavioral health settings. SAMHSA's 2025 National Guidelines explicitly name peer support as a core component of crisis care across call centers, mobile crisis, and crisis receiving and stabilization services.[4] Washington State has recognized peer support as a Medicaid-reimbursable service and invested in peer workforce development through legislation and certification infrastructure.[5]

Peers can meet people in acute distress with credibility rooted in shared experience. They can explain what is happening in a system that is often frightening and confusing. Some services extend support beyond the acute episode, helping individuals transition from crisis to ongoing recovery.

LEARN MORE: NATIONAL FRAMEWORKS

- SAMHSA National Guidelines for a Behavioral Health Coordinated System of Crisis Care (2025)
- SAMHSA Advisory: Peer Support Services in Crisis Care (2022)
- SAMHSA Peer Support Services Across the Crisis Continuum, TACC (2024)
- Bazelon Center, When There's a Crisis, Call a Peer (2024)

System Outcomes & Return on Investment

Available research suggests that peer support improves crisis care outcomes. There is strong national and federal support for using peers across the crisis continuum. Research consistently shows that peer support reduces emergency department (ED) admissions, decreases psychiatric hospitalization, increases engagement in community-based services, reduces criminal system involvement, and reduces burden on clinical staff.

Although most research comes from opioid-focused ED programs, findings are widely considered applicable to crisis care more broadly. Recent research on peer support in acute psychiatric inpatient settings also points to the importance of organizational culture, role clarity, and structured integration in shaping outcomes.[6] Notably, as of the time this toolkit was written, an ongoing randomized controlled trial is now specifically testing peer integration into ED behavioral crisis response teams focused on psychiatric crisis presentations (not opioid overdose) signaling that the research base is expanding beyond opioid-focused ED programs.[7] For detailed cost savings, return on investment (ROI) data, specific program outcomes, and further evidence- base, see Section 4.

Behavioral Health and System Demand in Washington State

Washington ranks sixth in the country for percentage of adults with a diagnosable mental, behavioral, or emotional disorder with 22.2% of adults experiencing such issues. According to a 2022 survey, almost 1.3 million adults in the state have a diagnosable mental health condition, and an estimated 410,000 adults did not receive the mental health care they needed in a recent year.[8] Crisis contacts in Washington increased 200% between March 2020 and July 2021 – a period that coincided with the COVID-19 pandemic and its significant impact on behavioral health across the state – while treatment demand increased 34% during the same period.[8]

Nationally, nearly 1 in 10 adults reported experiencing a mental health crisis in 2024-2025. Among those who sought help, relatively few turned to formal crisis services such as the 988 hotline, mobile crisis teams, or the police. Most relied on primary health care providers or informal supports such as family or friends.[9]

Recovery-oriented care and equity priorities are also reshaping crisis systems. A workforce that reflects the communities it serves and includes people with lived experience as part of the care team can be both a cost-savings and human-centered approach. It is also a practical strategy for reaching people who have historically disengaged from services.

6th
WA ranks 6th in the U.S. for adult mental illness prevalence

1.3M
WA adults with a diagnosable condition (2022)

410K
WA adults who did not receive needed care

+200%
Rise in crisis contacts, Mar 2020–Jul 2021

Peer Workforce Demand and Shortage

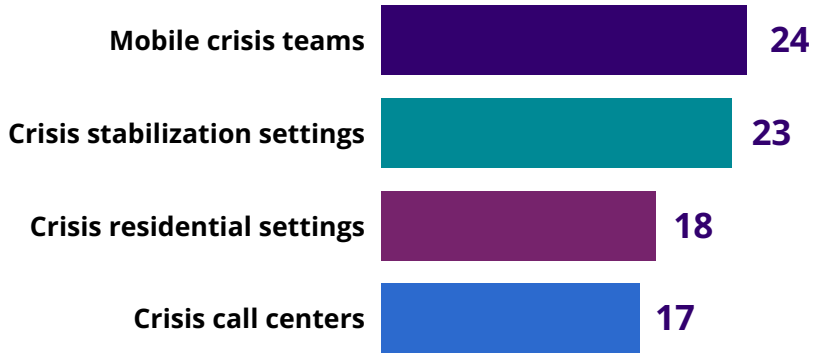
Understanding the peer workforce landscape matters when building a peer program. The pool of credentialed peers with crisis-specific experience is small and the demand is growing. You are not just designing a role; you are competing for a limited workforce in a field that has historically undervalued and undercompensated peer staff. Washington's behavioral health workforce is under strain. A survey by the Washington Council for Behavioral Health found a statewide average vacancy rate of 26% for master's level clinical staff, with the all-staff vacancy rate increasing 38% between May and October 2021.[10] The peer workforce faces similar pressures across the country.

MISCONCEPTION

"Peers are just volunteers." Peer support workers are trained, certified professionals with specific training hours, supervised experience, and a DOH credential in Washington.

Peers are often described as a cost-effective workforce strategy. That is true at the system level. But cost-effectiveness does not mean low cost to the peer. Programs that underpay or under-support peers lose them quickly. Washington ranks among the states with the highest unmet behavioral health need, with an estimated 410,000 adults unable to access the mental health care they need in a given year.[11] The cost of turnover, both financial and relational, is high. Building a sustainable peer program means investing in equitable compensation, structured supervision, and the organizational supports that keep peers in their roles.

Of 44 states surveyed in 2022, the number reporting a peer workforce shortage – by setting:



- **24 states** reported a shortage within mobile crisis teams
- **23 states** reported a shortage within crisis stabilization settings
- **18 states** reported a shortage within crisis residential settings
- **17 states** reported a shortage of peer support workers within crisis call centers

NASMHPD Research Institute: State Mental Health Agency Peer Specialist Workforce (2022)

LEARN MORE:

- **Peer Support Workers in the ED (University of New Mexico, 2019)**
  - Compensation as barrier to recruitment, p.9
- **NASMHPD Research Institute: State Mental Health Agency Peer Specialist Workforce (2022)**
- **SAMHSA Peer Support Services Across the Crisis Continuum (2024)**

Crisis System Context in Washington State

Washington is actively transforming its crisis care system through the 988 Suicide and Crisis Lifeline, Regional Crisis Lines, King County Crisis Care Centers, new Behavioral Health Administrative Services Organization (BHASO) contracts, and peer workforce development. Together, these efforts are expanding mobile crisis response, building facility-based crisis stabilization services, and supporting a shift toward community-based alternatives to emergency department care.

The Washington Health Care Authority (HCA) plays a central role in this transformation, including peer certification, training infrastructure, and workforce development programs available across the state.

Washington's crisis system is organized through ten regional BHASOs that manage crisis services, contracts, and funding. Peer roles are being integrated across BHASO regions, but implementation varies significantly by region, setting, and available funding. A note on national vs. Washington frameworks: National guidance from SAMHSA uses the term Behavioral Health Coordinated System of Crisis Care (BHCSCC) to describe the full crisis continuum. Washington uses its own terminology and structures that align with but are distinct from the national framework. The definitions below clarify key Washington-specific terms used throughout this toolkit.

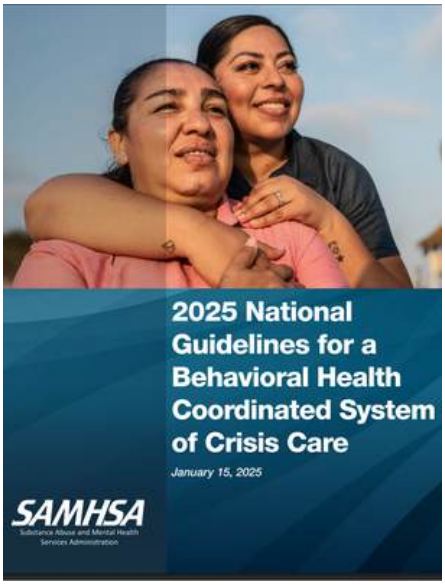
Washington's Crisis Care Continuum & National Model

The table below maps peer roles across each stage of Washington's crisis continuum, drawing on both the national BHCSCC framework and Washington's own crisis system structure. Implementation varies significantly by region and available funding. For Tribal settings, see Section 9.

THE CRISIS CARE CONTINUUM

Prevention & Early Intervention	Someone to Call	Someone to Respond	Safe Place for Help	Post-Crisis Recovery
Warmlines, outreach	988, regional crisis lines, DCR line	Mobile crisis teams, MRSS, MRRCT, DCR response	Crisis stabilization units, E&T facilities, PES, EDs, CRS facilities	Follow-up care, peer respite, LEAD, Peer Pathfinders
Warmline Peer Specialists, community outreach peers	Crisis Line Peer Specialists	Mobile Crisis Peer Specialists	Crisis Stabilization Peers, ED & Inpatient Peer Advocates, Peer Bridgers	Peer Pathfinders, Peer-Run Respite Staff, Peer Navigators

Sources: SAMHSA National Guidelines for Behavioral Health Crisis Care (2025), BHASO County Map



SAMHSA: NATIONAL GUIDELINES FOR A BEHAVIORAL HEALTH COORDINATED SYSTEM OF CRISIS CARE (2025)

The 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care establishes a framework to transform behavioral health crisis care systems and reduce the impact of substance use and mental illness on communities throughout the United States. Spearheaded by SAMHSA, these guidelines aim to provide accessible and effective responses to behavioral health crises in addition to supporting program design, development, implementation, and continuous quality improvement for behavioral health crisis care throughout the nation.

Learn more

Geographic & System Variation in Washington

Washington's crisis system varies significantly by region. Urban areas like Seattle and King County have dedicated crisis care centers, mobile rapid response teams, and established peer programs in EDs and Psychiatric Emergency Services (PES) settings.

Rural, frontier, and Tribal counties often have fewer crisis service options, limited local funding mechanisms, smaller behavioral health workforces, and greater distances between people in crisis and available care. EDs in these areas frequently serve as the primary entry point for behavioral health crises.[12]

LEARN MORE

Seattle Crisis Continuum Map

VOICES FROM WASHINGTON

Some regions can't staff teams, and it is more challenging for rural communities to recruit peers into crisis roles.

– Administrator / Leader

Tribal communities in Washington are developing their own crisis infrastructure under sovereign frameworks, on their own timelines and terms. What works in an urban hospital setting may not be appropriate or transferable to a Tribal context without meaningful adaptation and Tribal leadership. This toolkit applies broadly across Washington and is intended to be relevant and transferable to other states. Tribal context is addressed primarily in Section 9, which was developed by the HCA's Office of Tribal Affairs.

Key Definitions & Terms

TERM	DEFINITION
BHASO Behavioral Health Administrative Service Organization	Washington has ten regional organizations across the state that manage behavioral health crisis services, contracts, and funding. They govern regional crisis lines, mobile crisis teams, crisis stabilization access, DCR processes, ITA pathways, and 24/7 triage and dispatch.
BHA Behavioral Health Agency	A licensed provider organization that delivers behavioral health services in Washington
CRS Crisis Receiving & Stabilization services	A facility designed as an alternative to the ED for people in behavioral health crisis
DCR Designated Crisis Responder	A Washington-licensed mental health professional authorized under the ITA to conduct involuntary treatment evaluations
ED Emergency Department	A hospital-based setting providing emergency medical care. In this toolkit, EDs can be an entry point for people in behavioral health crises
E&T Evaluation and Treatment facility	A licensed inpatient psychiatric facility that accepts involuntary admissions under the ITA
ITA Involuntary Treatment Act	Washington law governing involuntary psychiatric holds and treatment
LEAD Let Everyone Lead With Dignity	A pre-booking diversion program redirecting people from the criminal justice system toward community-based services – formerly known as Law Enforcement Assisted Diversion. **Learn:** LEAD
MRRCT Mobile Rapid Response Crisis Team	A mobile crisis response team dispatched through the regional crisis line
MRSS Mobile Response and Stabilization Services	Washington's mobile crisis model for youth and families, emphasizing rapid response and stabilization outside hospital settings **Learn:** MRSS Reference Guide , Regional Crisis Lines & Youth Teams
ORCA Opioid Recovery and Care Access Center	A low-barrier walk-in stabilization and treatment access center focused on opioid use disorder
Peer Crisis Responder	A formal designation under Washington law (SSB 5555) for a Certified Peer Support Specialist employed by an entity to provide peer support services to individuals who may be experiencing a behavioral health crisis. Not all peers are peer crisis responders; the designation applies specifically to peers deployed in crisis response contexts.
Peer Pathfinders	A Washington HCA program deploying peers to connect people with housing, financial, transportation, and vocational services following a crisis episode. **Learn:** Peer Pathfinders Projects
PES Psychiatric Emergency Services	A specialized psychiatric emergency unit, typically located within or adjacent to a hospital emergency department

Note: Click here for a PDF version of the Key Definitions & Terms. These definitions reflect both national and WA-State-specific terminology. Different states and regions may use different terms for similar roles or settings.

KEY TAKEAWAYS

- Peer support is evidence-based and uniquely valuable in crisis settings.
- Lived experience complements clinical expertise and cannot be replaced by it.
- Washington is investing in peer certification and credentialing, training, and Medicaid reimbursement pathways.
- Peers play an important role in expanding access to behavioral health care and support.
- The Washington crisis system is complex and varies across regions.

SECTION THREE

Preparing Your Organization: Readiness and Culture Change

How to begin organizational readiness, leadership buy-in, and culture change

IN THIS SECTION

Readiness & Risk

Crisis and emergency settings are high-pressure, clinically-oriented environments. Employing a peer without preparation is a setup for failure for the peer, the care team, and the people they serve.

KEY QUESTIONS

Before a peer walks in the door, it's worth asking honestly: *are we ready for this? Is our clinical culture ready to make room for a different kind of expertise? What would it take for our organization to formally recognize peer support as a core component of our crisis care model?*

Preparation before hiring is key. There are two types of risk worth naming:

FOR THE PEER

Being placed in a clinical environment without adequate preparation, role clarity, or team support can lead to burnout, scope drift, moral distress, and turnover. Peers in unsupportive environments are more likely to leave.

FOR THE PROGRAM

A failed first attempt at peer integration can be hard to recover from. If it goes poorly, staff resistance grows, leadership loses confidence, and *the peer role gets blamed rather than the conditions.*

A practical first step is conducting a **readiness assessment** before moving into hiring. A readiness assessment doesn't have to be formal. It's simply a set of questions:

- ☐ Is leadership aligned and resourced to support this, and what culture shifts may be needed to support the peer role?
- ☐ Have we introduced the peer role to the people we serve, so they understand who peers are and what they offer?
- ☐ What will the peer be responsible for, and have we communicated clear role expectations to both the peer and their future coworkers?
- ☐ Do we have workflows in place?
- ☐ Do we have a designated supervisor for the peer who understands the peer role?

CASE STUDY · NEW MEXICO EMERGENCY DEPARTMENTS

A qualitative assessment of peer support programs across New Mexico emergency departments found that when organizations were ready to move forward, one of the first structural decisions was how to employ the peer. Two models emerged consistently: (1) hospitals develop a formal agreement with a recovery community organization to provide peer services, or (2) hospitals hire peers directly as employees. Each approach has tradeoffs around supervision access, role clarity, and organizational fit. The right choice depends on your setting, resources, and existing community partnerships.

Source: Peer Support Workers in the ED (University of New Mexico, 2019)

LEARN MORE · READINESS ASSESSMENT TOOLS:

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Preparing the organizational culture, p.17
  - Anticipating staff concerns and recovery-oriented assessment tools, p.26
  - Agency self-assessment and culture change tools, p.29
  - Sample questions for staff about integrating peer support, p.134
  - Prepare for the integration of peer support staff, p.44
- **SAMHSA Peer Integration and Stages of Change Toolkit (NY, 2018)**
  - Organizational readiness assessment, p.25
- **Peer Support Toolkit, Southern Plains Tribal Health Board**
  - Organizational self-assessment questions, p.17
- **Peer Support Workers in the ED (University of New Mexico, 2019)**
  - Overview of barriers and facilitators, p.23
- **National Council for Behavioral Health**

Leadership Buy-In

Peer integration works when the conditions are right. In crisis and emergency settings, creating those conditions starts with leadership. Adding a new role to an already stretched team requires a champion: someone who believes in the role, advocates for it, and wants to keep improving when things get hard.

KEY QUESTION

Who will champion this peer program when things get hard and help it succeed over time? A champion advocates for the role when others do not yet understand it. They secure resources and organizational support, helps remove barriers, reinforces the value of the role over time, and celebrates successes to keep momentum going.

Leadership buy-in is a critical first step. When executives, clinical leads, and administrators visibly champion and model respect for peer integration, it sets the tone for everyone else. Leadership buy-in opens the door; supervisors then translate that commitment into day-to-day expectations for the team and peer. The literature is consistent here: research from Emergency Department (ED) peer integration programs points to a collaborative planning phase involving leadership, ED staff, and peers as a key predictor of success.[13] Organizations that skip this step often find themselves troubleshooting or reacting to problems later that could have been prevented.

Once your readiness assessment is done, the next step is identifying who will lead this effort. This might look like naming **two people:** a clinical champion and an administrative champion.

VOICES FROM WASHINGTON

It can't be just a peer – it needs to be a peer program, leadership support, and peer supervisory structure.

– Clinician Administrator / Leader

What is your next step?

- [ ] Who in clinical leadership understands or is open to peer roles?
- [ ] Who in administration can help with HR, budget, and policy hurdles?
- [ ] Who on the front line will influence how peers are received by the team?

TIP

In crisis settings, this might be a charge nurse or medical director who already understands peer roles. Who in your organization *gets it* – or is willing to learn?

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Identify an executive champion, p.60
  - Senior leadership's commitment to recovery-oriented service, p.19
  - Peer staff integration leadership commitment checklist, p.132
- **Peer Support Workers in the ED (University of New Mexico, 2019)**
  - Hospital provider and leadership buy-in, p.12

Culture Change, Stigma, and Misconceptions

Culture change is often the hardest part of this work. Clinical environments, especially crisis and emergency settings, have deeply embedded norms (hierarchies, language, ways of doing things). Peers bring a different orientation. It's a complementary role, not a competing one.

KEY QUESTIONS

Is your clinical culture ready to make room for a different kind of expertise? What does your team actually believe about peer support, and where did those beliefs come from?

Research from ED peer integration programs points to one consistent finding: staff resistance most often comes not from bad intent, but from simply not knowing who peers are, what they do, or why they're there. One study calls this **"Peer Support Worker (PSW) Literacy."**[14] That's an information gap, and information gaps can breed misconceptions. When left unaddressed, misconceptions can turn into stigma.

DEFINITION:

Peer Support Worker Literacy:

The degree to which clinical staff understand the peer role, its value, and how it differs from their own

Stigma shows up in small ways that have a real ripple effect, including whether peers get introduced as part of the team and whether their input is taken seriously. For example, including peers in daily shift huddles has been found to help ED staff accept peers as part of the team.[15] Learn more about team integration in Section 5.

MISCONCEPTION	REALITY
"Peers are just volunteers"	Peer support specialists are trained, certified, and paid professionals.
"Anyone with lived experience can do this job"	The role requires specific training, certification, and skills.
"Peers can handle whatever the team needs"	Role clarity and scope boundaries protect everyone, including the peer.

Source: Peer Support Services Across Crisis Continuum, SAMHSA 2024

VOICES FROM WASHINGTON

Successfully integrating peers requires work around changing the culture, language and atmosphere.

– Peer Administrator & Educator

What is your next step?

- [ ] Identify where cultural friction is most likely to manifest within your team
- [ ] Engage in conversations with peers who are currently employed in your organization or a comparable environment

LANGUAGE

Small shifts signal value: say "lived experience" rather than "history of mental illness." Different people and cultures say things differently – it's OK not to know; just ask.

TIP

Culture starts at the top. Leadership sets the tone, but everyone has a role. Where can your leaders visibly model respect for the peer role and who can follow their lead?

LEARN MORE

DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)

- Myth or Fact activity facilitator's guide, p. 140
- Diversity and inclusivity organizational assessment tool, p. 147

Preparing Your Team: Role Education & Outreach

Role education can be simple and integrated into existing team huddles or connection points. Where do your staff already get information? Build from there. The goal is that everyone on the team across shifts and departments has a shared understanding of what the peer does and doesn't do before day one. This should be more than a passing reference; it should be an intentional conversation. Research from ED peer integration programs found that information should be disseminated on a continual basis, particularly in the early stages to ensure staff across all shifts and disciplines have access.[16]

Here are some simple ideas for how to educate the team on the peer role:

One-page peer role description

How to use: A quick reference on what peers do and don't do

Talking points for supervisors

How to use: Equips champions to answer questions consistently

FAQ document

How to use: Addresses common misconceptions up front

Bulletin board post or web page

How to use: Passive but persistent visibility across shifts

Short explainer video

How to use: Accessible for new or rotating staff, anytime

Lunch & learn

How to use: Deeper engagement with interested staff

30-minute team orientation

How to use: Interactive – invites questions before day one. Add one and three month follow-ups to re-educate, address confusion, and open a forum for concerns

Orientation packet for new staff

How to use: Ensures all incoming staff are informed from day one

TIP

In-person formats like team huddles, group discussions, and workflow walkthroughs have been found to be particularly effective for helping ED staff understand the peer role and the value peers bring to patient care. Don't rely solely on passive tools such as flyers, emails, or posted announcements.[17]

LEARN MORE

- **Peer Support Workers in Emergency Departments (National Council for Mental Wellbeing, 2022)**
  - ED staff understanding of the value and scope of peer support services, p.5
  - Shift huddles and team integration, p.7
- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Non-peer staff engagement and outreach strategies, p.49

KEY TAKEAWAYS

- Do a readiness assessment before hiring. An unprepared environment puts the peer, the team, and the program at risk.
- Leadership buy-in is an important factor in successful peer integration. Identify champions early.
- Clarify the role, scope, workflows, and supervision structure in writing before the peer starts.
- Prepare the team before the peer arrives. Stigma and role confusion are preventable with intentional preparation.
- Culture change takes time. Start early, address misconceptions directly, and build peer expertise into how your team talks about care.

SECTION FOUR

Sustaining the Peer Role: Program Planning, Funding, and System Value

The billing and policy side of integrating the peer role

IN THIS SECTION

The Business Case for Integrating Peers

Integrating peer support into a crisis or emergency setting requires organizational investment. Your leadership or clinical directors will likely ask for evidence of program impact, cost reduction, and outcomes. Thinking ahead about funding, reimbursement, and regulatory considerations is critical for starting and sustaining the peer role.

KEY QUESTION

Does your organization have a peer in your crisis or emergency setting? Can your organization make the case for peer support to leadership, finance, and clinical directors? If not, what would it take?

An important note on the evidence base: The evidence base for peer support in crisis and emergency settings is growing. Most of the research on peer support outcomes in Emergency Department (ED) and crisis settings comes from programs focused on opioid use. There is less research specifically on psychiatric emergency and crisis stabilization settings. This reflects the newness of formal peer integration in those environments and the lag between practice, adoption, and research evaluation – rather than a lack of effectiveness. The findings from opioid-focused ED programs point consistently toward value and are widely considered applicable to crisis care more broadly. The evidence base is expanding, including into psychiatric inpatient and non-opioid crisis settings, and increasingly beyond the United States. A 2025 qualitative study of peer support integration in a Canadian pediatric psychiatric emergency department identified clear role definition, staff preparation, and structured supervision as key implementation factors (Hews-Girard et al., 2025). Notably, an ongoing randomized controlled trial is now specifically testing peer integration into ED behavioral crisis response teams focused on psychiatric crisis and physical restraints (not opioid overdose), signaling that the research base is expanding beyond opioid-focused ED programs.[18]

Peer support is associated with:

- A 33-58% decrease in inpatient medical admissions and 13-38% decrease in ED visits after peer-supported discharge, with cost decreases of $37,760 to $88,886 per cohort (small pilot program, opioid-focused)[19]
- Reduced psychiatric hospitalization and increased use of crisis stabilization as a less restrictive alternative[20]
- Significantly higher rates of substance use treatment initiation within 60 days of discharge in peer-supported EDs[21]
- Increased social supports, patient engagement, and wellbeing across behavioral health and substance use disorder settings[22]
- Improved engagement, empowerment, and recovery outcomes for individuals with serious mental illness[23]

33-58%
decrease in inpatient medical admissions

$37K-$89K
Cost decreases per cohort

13-38%
decrease in ED visits after peer-supported discharge

NEW TO THE FIELD:

Maruta, M., et al. (2025). Peer Support in Acute Psychiatric Inpatient Settings: A Scoping Review. *Psychiatry and Clinical Neurosciences Reports.*

This 2025 paper synthesizes evidence on peer support in acute psychiatric inpatient settings – a context with significant overlap with crisis and emergency care. Findings suggest that peer support is shaped by organizational culture, staff attitudes, and role clarity; that non-judgmental presence and shared experience create opportunities for connection that conventional clinical care may not; and that structured peer integration with clearly defined goals tends to show stronger outcomes than informal peer presence.

KEY QUESTION

Does your organization have a system in place to track outcomes associated with peer support – such as reduced ED utilization or increased engagement in community services? If a funder or clinical director asked you to demonstrate the value of your peer program, what data would you have to show them?

VOICES FROM WASHINGTON

Peers have the time to sit and talk. ER staff are required to do many other tasks other than talking to patients. That's the sell.

– Clinician Administrator / Leader

VOICES FROM WASHINGTON

When there is a true non-clinical peer support, the engagement level goes up and the costs will go down as the person will engage in other supporting services rather than just cycling back to crisis.

– Peer Educator & Leader

TIP

Build in data tracking from the start. Programs that track outcomes like reduced ED utilization and increased engagement in community services are better positioned to sustain funding over time.

The Human Impact of Peer Support

The return on investment for peer support goes beyond cost savings.

These outcomes are harder to quantify but consistently reported by programs that have integrated peers successfully.

For leadership and clinical directors, the case for peers includes:

- People in crisis receiving care that meets them where they are rather than where the system thinks they should be
- Reduced pressure on clinical staff who are freed from engagement work that peer support workers can do instead
- A care team that reflects the communities it serves
- A signal to staff and people receiving services that recovery is possible – especially powerful when the peer has their own history with the organization or system and is now thriving in a professional role

Funding Peer Role: Opportunities and Limitations

As peer roles grow in crisis and emergency settings in the State, organizations need a clear plan for how to fund and sustain them over time. However, many peer roles in these settings are not supported through direct billing. Programs interviewed for this toolkit described a common challenge: peer roles in these settings are often funded through short-term grants, pilot funding, philanthropy, or special projects. These funds can help start a program, but they may not support the role long-term. This can leave programs searching for new funding and can create uncertainty for peers, supervisors, and care teams. Billing may be part of a sustainability plan, but billing alone doesn't currently sustain peer roles in crisis and emergency settings.

The current limits on peer billing are recognized at the state level. House Bill 1427, passed in 2025, directs the Washington State Health Care Authority (HCA) to examine barriers to billing for peer support services and to explore additional mechanisms for payment, including Medicaid, commercial insurance, and alternative funding models. This is relevant for many of the peer roles described in this toolkit because emergency departments, psychiatric emergency services, crisis stabilization services, and other crisis settings generally do not have a clear billing pathway for peer services.

Legislation to Watch: Policy Changes That May Affect Peer Funding

Washington is actively working on changes that may affect peer billing and financial sustainability. Programs should watch for policy and billing updates from the HCA and stay connected to the Behavioral Health Administrative Services Organization (BHASO), managed care organizations, and other funders to understand what is allowed in their specific setting.

- **SB 5555**, passed in 2023 – created Certified Peer Specialists and Certified Peer Support Specialist Trainees (CPSST) as new health professions in Washington. This change was intended, in part, to create a clearer credentialing structure for peer services, support future billing pathways, and strengthen recognition of the peer workforce.

- **HB 1427**, passed in 2025 – focused on expanding access to certified peer support specialist services and addressing limits in current billing structures. This is especially relevant for settings where peers work but cannot currently bill, such as emergency departments and behavioral health urgent care.

Why Billing Is Limited in Crisis and Emergency Settings

In many crisis and emergency settings, payment is structured at the program or facility level. This means the setting is paid for the overall service, stay, or episode of care. The payment is not usually tied to each staff role. For example, emergency departments and psychiatric emergency services are generally paid through hospital facility and clinician billing structures. These systems do not include a standard way to bill separately for peer support. Crisis stabilization programs may be funded through per diem, bundled, facility, contract, government, or grant funding. In these models, peers may be part of the staffing model, but their services are not usually billed separately.

Braided Funding is Often Needed

Because billing reimbursement is currently limited, most peer programs in crisis and emergency settings need more than one funding source. This is often called a braided funding model.

Braided funding means a program combines different funding sources to support the full operating costs over time. The amount and type of funding needed to support a peer role will vary by setting and will depend on many factors, including whether any part of the role can be reimbursed through billing. For example, a program may use Medicaid billing for some post-crisis follow-up services, hospital funding for ED-based peer support, and grant funding for start-up costs.

Common funding sources may include Medicaid billing, Behavioral Health Administrative Service Organization (BHASO) or regional crisis contracts, hospital or facility funding, county or local funding, grants, philanthropy, and value-based or alternative payment arrangements. Value-based payment is an agreement between a payer and an organization. The organization may be paid based on results, quality of care, or cost savings as opposed to how many services it provides.

The Essentials of Peer Billing in Washington State

In Washington, peer support is an approved Medicaid service and is included in the Medicaid State Plan as part of rehabilitative behavioral health services. At the time this Toolkit was developed, the most common billing code for peer support services was H0038, a Healthcare Common Procedure Coding System (HCPCS) code. Additional peer billing codes include S9484 (crisis intervention) and H2019 (therapeutic behavioral health services for crisis stabilization).

For crisis and emergency settings, the key point is that peer services are most often billable when they are delivered through a Medicaid-enrolled provider such as a licensed Behavioral Health Agency (BHA) or a BHASO crisis team and when all applicable Medicaid and service requirements are met. This is most relevant for outpatient behavioral health services and some post-crisis follow-up services. Peer services delivered outside an approved provider structure are not billable, even when the peer is providing similar support.

For example, a peer helping someone connect to care after a crisis may be billable if the service is provided through a BHA and meets Medicaid requirements. A similar service may not be billable if it is provided through a hospital program, peer-run program, or grant-funded service that is not set up as a Medicaid-billable provider.

Crisis-Setting Peer Billing Snapshot

SETTING	PEER BILLING STATUS	WHAT THIS USUALLY MEANS
Post-Crisis Follow-Up / Crisis Transition Support	Potentially billable in limited circumstances	May be billable through a Medicaid-enrolled provider (commonly a licensed BHA) when tied to a covered service, treatment plan, documentation, and supervision requirements – otherwise, usually contract, grant, hospital, or local-funded
Emergency Departments / Psychiatric Emergency Services	No standard pathway to directly bill for peer services	Typically funded through hospital facility and clinician billing structures – peer roles are usually supported through hospital budgets, grants, or state or local government funding
Crisis Stabilization Services	Not typically separately billable for peer services	Usually included in per diem, bundled, facility, or contract payment structures
Inpatient Psychiatric Units	Not separately billable for peer services	Paid through facility or per diem structures – peer roles may be embedded in the care model or supported through grants, contracts, or hospital funding
Mobile Crisis Teams	Limited; peer billing may be allowed in specific contexts	Often funded through BHASO, managed care, state, county, or contract funding – peer support may be billable after initial crisis intervention if provider and documentation requirements are met

TIP

Plan ahead for **January 1, 2027**, when peers who bill Medicaid or any insurance carrier for peer services will be required to hold an active CPSS or CPSST credential. If your organization bills Medicaid for peer services and your peers are not yet credentialed, it is recommended to start that process. Washington experts note this transition is coming faster than organizations expect.

Learn more: Certified Peer Specialist FAQ

What is your next step?

- [ ] Review HCA's Operationalizing Peer Support site for billing resources
- [ ] Talk to leaders in your organization about possible funding options, including billing, grants, philanthropy, government funding, value-based contracts, or other types of funding
- [ ] Identify if any parts of your peer role are billable
- [ ] Find out if your organization has a connection to a BHA or other Medicaid-enrolled provider
- [ ] Contact your regional BHASO to talk about funding options
- [ ] Talk with leaders in similar organizations that have peer roles about how they fund their position

NOTE: Tracking Metrics to Support Funding

Tracking a small number of meaningful metrics can help programs show the value of peer roles over time and support conversations with leaders, funders, and partners about the resources needed to continue or expand a peer program. The most useful measures will depend on the setting and goals of the peer role.

Examples metrics could include:

- Number and type of peer contacts, including in-person, phone, or follow-up contacts
- Connection to follow-up care, community resources, benefits, housing, or other supports
- Engagement in follow-up services after a crisis or emergency visit
- Participant feedback about feeling heard, respected, or supported
- Staff feedback about the peer role and its impact on the care team
- Changes in crisis service, emergency department, or inpatient care use, when appropriate and feasible to track

LEARN MORE

- **Billing and Coding**
  - WA HCA: Service Encounter Reporting Instructions (SERI) Guide
  - WA HCA: Peer Billing and Encounter Guidance 101 (May 2026)
  - WA HCA: Crisis Code Guide for Private Insurance Plans
  - WA HCA: Behavioral Health Billing in WA Medicaid (Video, July 2025)
  - WA HCA: Certified Peer Support Specialist FAQ
  - WA HCA: Guidelines for Providing and Billing Medicaid Peer Support Services
  - WA DOH: Peer Support Specialist FAQ, Laws, Resources
- **Grants and Funding**
  - SAMHSA Grant Announcements
  - HRSA Grants
  - Grants.gov - federal grants portal
  - WA State Department of Commerce: Grants and Loans
  - King County MIDD Funding
- **Tribal Billing**
  - WA HCA: Tribal Health Billing Guide
  - WA HCA: Tribal Billing Overview (Video)

Regulatory Considerations for Setting Up a New Peer Program

KEY QUESTION

Does your organization have the regulatory foundation in place to support a peer program?

Before your organization can deploy a peer in a crisis or emergency setting, certain legal and administrative requirements must be in place. This section covers the state regulations that govern peer programs and the organizational policies you need to document before a peer starts. For role structure and scope of practice, see Section 5.

What is a WAC?

A Washington Administrative Code (WAC) is the body of state regulations governing licensed behavioral health agencies and health professions in Washington. Think of it as the rulebook your organization is required to follow. The WACs most relevant to peer programs in crisis and emergency settings are:

- **WAC 246-341:** Community behavioral health program requirements – covers service delivery standards for crisis and outpatient settings
- **WAC 246-929**: Department of Health (DOH) peer-specific credential and ethical requirements – covers CPSS/CPSST credentialing obligations

Policies and Procedures

Every organization deploying peers should have documented policies and procedures in place before the peer's first shift. These are the organizational policies that govern how the program operates legally and administratively. For role structure and scope of practice, see Section 5.

Recommended policies and procedures typically cover:

- Peer role description and scope of practice
- Billing procedures and credential verification for Medicaid or insurance reimbursement, if applicable
- Supervision structure and approved supervisor designation
- Documentation requirements and electronic health record (EHR) access
- Confidentiality and mandatory reporting protocols
- Peer wellness and self-care
- Grievance and feedback processes

LEARN MORE

- **WA Law: Washington Administrative Code (WAC) - searchable database**
- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Align Policies with a Recovery-Oriented Approach, p.35
  - Sample supervision agreement, p.230
  - Sample peer staff function and responsibility statements, p.180

KEY TAKEAWAYS

- Peer support has a strong and growing evidence base, though most research comes from opioid-focused ED programs. The findings are widely considered applicable to crisis care more broadly.
- The human case is just as real as the financial one. Peer support builds trust, dignity, and connection in ways that data cannot fully capture.
- Most sustainable peer programs in Washington rely on braided funding. Medicaid billing alone is rarely sufficient in crisis and emergency settings.
- Plan ahead for January 1, 2027, when only CPSS and CPSST credential holders will be able to bill Medicaid or insurance carriers for peer services.
- Neither Certified Peer Counselor (CPC) nor CPSS credential holders can independently bill Medicaid – both must work for a licensed BHA credentialed to provide peer support services.

SECTION FIVE

Building the Peer Role: Scope, Integration, and Workflow

Defining scope, boundaries, and team integration

IN THIS SECTION

Defining the Role: Scope and Boundaries

In crisis and emergency settings, role ambiguity creates real problems: scope drift, team friction, and burnout. A clearly defined peer role answers three basic questions: What does this peer do? What do they not do? And how does their role connect to everyone else's?

KEY QUESTION

Can everyone on your care team describe what your peer does and doesn't do? Is your team also clear on how the peer role fits alongside the clinical team?

Research on peer integration in hospital and crisis settings consistently identifies role confusion, not resistance, as the primary barrier to successful integration.[24] As discussed in Section 3, this is largely a **Peer Support Worker (PSW) literacy** problem: staff simply don't know who peers are, what they do, or why they're there.

CASE STUDY · NEW MEXICO EMERGENCY DEPARTMENTS

In New Mexico, administrators across multiple hospital Emergency Departments (EDs) described the same gap: staff who genuinely supported the idea of peer integration but could not articulate what the peer was actually there to do. Across sites, the programs that gained traction shared a common approach: clear role descriptions and structured staff orientations.

Source: Earheart, A.S., & Crisanti, A.S. (2019). Peer Support Workers in the Emergency Department: A Report, University of New Mexico.

The pattern shows up in Washington, too. At Harborview's Psychiatric Emergency Services (PES), even staff who were supportive of the Peer Bridger program struggled to explain the role to patients or colleagues in the early days. The confusion wasn't about whether peers belonged, but rather what they were actually supposed to do.

In both these cases, the friction was a knowledge deficit – not resistance.

VOICES FROM WASHINGTON

There's still a lot of confusion, even among social workers, about what the peer role actually is. Peers are not one size fits all. One person might be a great fit in one place and not another.

– Peer

TIP

In some settings, particularly in rural areas, a staff member may hold both a clinical credential and also be a Certified Peer Support Specialist (CPSS). While this reflects meaningful professional development, it can be helpful for organizations to keep those boundaries and scope clear and discourage a person from wearing both hats at the same time. When someone moves between roles – whether a credentialed peer transitioning to a clinical role or a clinician who has completed peer training – the lines can blur easily. Clear role definition can help protect the individual, the team, and the people they serve.

Peer Values and Guiding Principles

SAMHSA's Guiding Principles of Recovery, which Washington has adopted, define what peer support is and how it shows up in practice. These principles are consistent with SAMHSA's Working Definition of Recovery – a foundational framework for recovery-oriented practice across the United States.

In crisis and emergency settings, these principles are particularly important.

In crisis settings, the peer relationship may be one of the most meaningful connections a person experiences during an otherwise clinical encounter following a crisis or traumatic event in their life.

KEY QUESTION

Do your organizational policies and culture actively support these values, or do clinical norms override them in practice?

The Guiding Principles of Recovery are:

Recovery emerges from hope: Hope is the catalyst of the recovery process. In crisis settings, peers carry that message into moments when people may have lost it entirely. Crisis settings can foster hope by creating space for peers to do what they do best: model that recovery is real and possible.

Recovery is person-driven: Self-determination and self-direction are the foundations of recovery. In crisis settings, people can quickly lose a sense of control over what is happening to them. The peer role supports autonomy by helping people understand their options, exercise choice, and stay connected to their own goals even in acute moments.

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds – including trauma experiences – that affect and determine their pathway(s) to recovery. In crisis settings, peers hold space for this complexity, maintaining that recovery is intersectional and highly personalized.

Recovery is holistic: Crisis settings tend to focus on the immediate presenting issue. Peers help keep the whole person in view in addition to what else they might need beyond just the crisis at hand (housing, relationships, faith, community, and long-term wellness).

Recovery is supported by peers and allies: Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. In crisis settings, a support network may feel very far away for the person receiving services. The peer relationship can serve as a bridge.

Recovery is supported through relationship and social networks: Recovery happens in the context of relationships. An important factor in recovery is the presence of people who believe in the person's ability to recover and offer them hope, support, and encouragement. This could be family, peers, providers, faith groups, and community.

Recovery is culturally based and influenced: The peer workforce should reflect the communities it serves.

Recovery is supported by addressing trauma: The experience of trauma is often a precursor to or associated with mental health challenges and substance use. Crisis settings, by their nature, can be retraumatizing environments. Peers bring a trauma-informed lens to their work, recognizing that a person's behavior in a crisis moment is often rooted in past experiences and not just the presenting issue.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.

Recovery is based in respect: Clear role boundaries, ethical practice, and psychological safety for both peers and the people they serve are foundational to respectful peer support in crisis settings.

TIP

Building a shared understanding of recovery-oriented values across the care team strengthens peer integration.

The words we choose can uplift and support individuals on their recovery journey or contribute to stigma and discrimination.

Here are some examples of how to use recovery-oriented language:

- Use ***"a person with a substance use disorder"*** rather than "addict." Person-first language affirms humanity and prevents people from being defined solely by their condition. Other examples include: ***"a person who is experiencing a suicidal crisis"*** and ***"a person who lives with borderline personality disorder."***
- Avoid saying "clean" to describe someone's recovery status. Terms like "clean" imply that people who use substances are dirty or morally compromised. Use ***"in recovery"*** or ***"not currently using."***
- Avoid the word "abuse." This carries negative connotations that reinforce stigma and frames the condition as a moral failing rather than a health issue.
- Similarly, "relapse" can read as a moral failure framing. Recovery is non-linear. Setbacks are a natural part of the process, not evidence that recovery has failed.

LEARN MORE

- **SAMHSA: Working Definition of Recovery (2012)**
- **Recovery Empowered Language Toolkit (Prevention.org)**
- **NAMI SW Washington: Guiding Principles of Recovery**
- **'DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Language evaluation worksheet for role players, p.139
  - Myth or Fact activity and addressing staff misconceptions, p.26

Role Distinction Within Care Teams

Peers draw on lived experience; clinicians draw on clinical training. For peers, selective and intentional self-disclosure of their own recovery experience is a core professional tool. Clinical staff are not expected to operate this way. Building this understanding into team orientation before the peer's first day is critical, especially in emergency and crisis settings where hierarchy is more pronounced and roles are more clinically-oriented.

PEERS DO

- Build rapport and trust with people in crisis
- Help people understand the crisis care process
- Help build a Wellness Recovery Action Plan (WRAP)
- Support connection to outpatient and community resources
- Advocate for the person's needs and preferences
- Share lived experience intentionally and ethically
- Support continuity of care after discharge
- Report suspected abuse or neglect as required mandatory reporters under their Department of Health (DOH) credential, in coordination with their supervisor

PEERS DON'T

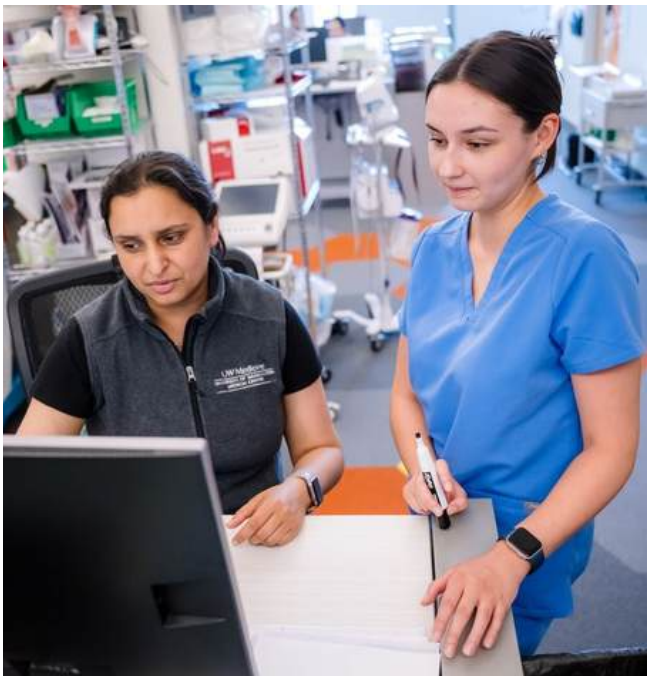
- Conduct clinical assessments or diagnosis
- Make clinical treatment decisions
- Provide therapy or counseling
- Give personal contact information or money
- Supervise clinical staff
- Go to someone's home outside of work hours
- Navigate mandatory reporting situations alone. *When a peer encounters a situation that may require a report, they should notify their supervisor.*

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Integrate peer staff into assessment and service planning processes, p.79
  - Role distinction and peer function statements, p.38

Peer support workers and clinical staff have distinct roles designed to work alongside each other. They are complementary roles that should have clear boundaries.

Research on peer integration in ED and acute crisis settings consistently identifies role distinction as a key implementation factor – particularly distinguishing peer roles from case management and social work functions, which share some surface-level similarities but operate from fundamentally different frameworks.[25]



PEER ROLE ONLY → **GREY AREA** → **CLINICAL ROLE ONLY**

PEER ROLE	SHARED / BOTH ROLES	CLINICAL ROLE
Draw on personal lived experience	Commitment to person's wellbeing	Clinical assessment & diagnosis
Share recovery story intentionally & selectively	Care team communication	Treatment planning
Build rapport, reduce fear or shame	Mandated Reporters	Mandated reporting decisions
Help explain the crisis care process	Documentation	Medication management
WRAP-informed wellness planning	Warm handoffs	Clinical supervision of staff
Community navigation, resource linkage	Advocacy for the person's needs	Credentials-based clinical decisions
Advocacy within and after the crisis	Participation in team huddles	

MISCONCEPTION

"We already have social workers and case managers. We don't need peers." Social workers and case managers perform clinical and coordination functions. The peer role is distinct. It is relational, recovery-oriented, and grounded in shared lived experience. These are complementary, not competing roles. Peers bring something specific: hope grounded in lived experience. The message that recovery is possible lands differently when it comes from someone who has been there. That said, all behavioral health practitioners should be recovery-oriented.

A NOTE ON MANDATORY REPORTING

Per the DOH, credential holders are considered mandatory reporters. That means they are required to report suspected incidents of abuse or neglect against a child or vulnerable adult, as well as misconduct from other DOH credential holders. Reports should go to Child Protective Services (CPS) or Adult Protective Services (APS) within 48 hours. Reports against other providers who hold a DOH credential can be filed with the department online.

LEARN MORE

- WA DOH: Peer Support Specialist, FAQ (mandatory reporting)

What Peers Do: Tools, Interventions, and Settings

The peer role looks different depending on the setting. What stays consistent is the foundation: lived experience, recovery-oriented values, inspiring hope, and a relational approach that complements the clinical team. The functions in the table below are drawn from national guidance and are widely applicable, though it's important to note that specific responsibilities vary by organization, Behavioral Health Administrative Services Organization (BHASO) region, and program model.

VOICES FROM WASHINGTON

Peers bring a sense of calm to the milieu, balance, support. By supporting the people who are here, they make it easier for the nurses and the care team.

– Peer

SETTING	WHAT THE PEER DOES
Emergency Settings (including EDs and PES)	Works alongside clinical staff as part of the care team. May greet people upon arrival, helping them feel oriented and less alone from the start. Engages people who are waiting or post-evaluation. Provides emotional support and offers coping skills (grounding exercises). Helps people understand what is happening in the ED process. Provides information about community resources. Facilitates warm handoff to community services at discharge. May provide post-discharge follow-up depending on setting policy.
Crisis Receiving and Stabilization Facility	Provides peer-led support and connection to resources in a short-term stabilization setting. Supports transition planning and connection to community services.
Mobile Crisis Team	Works alongside a mental health provider as part of a two-person or multi-person team. Often takes the lead on engagement while the clinician conducts a clinical assessment. Offers hope, builds trust, and provides emotional support. Draws on lived experience to help people feel heard.
Post-Crisis Follow-Up	Extends support beyond the crisis episode. This might include a follow-up call within 48 hours of discharge, help identifying and connecting to community mental health services, assistance navigating housing resources, or checking whether a referral actually happened.

Tools and interventions:

The following are examples of tools and approaches peers may draw on in crisis and emergency settings. These tools are not specific to peer support. Many are used across behavioral health settings and can be adapted to support peer roles. The foundation from which they are applied (lived experience, mutual connection, and recovery-oriented values rather than clinical training or assessment frameworks) makes their use distinctive in the peer context.

WRAP (Wellness Recovery Action Plan)

An evidence-based, structured plan in which individuals design their own plan for sustained wellness. WRAP helps people identify their own wellness tools, early warning signs of becoming unwell, and a course of action for a crisis situation. It also includes roles for supporters and healthcare providers if the individual desires. Peers can support people in creating or updating their WRAP in stabilization and post-crisis settings.

DBHIDS Peer Support Toolkit, Wellness Recovery Action Plan, p.86

Motivational Interviewing (MI)

A person-centered approach used to help people explore their own readiness for change and next steps. In crisis settings, peers have used MI as part of engagement and linkage models. Involves rapport building, a structured conversation to understand the person's situation and identify potential barriers to connecting with support, and one or two conversations focused on strengthening the person's own motivation to engage in next steps.

Peer Support Workers in the ED (University of New Mexico, 2019), p.21

Grounding exercises

Practical, in-the-moment techniques can help people manage acute distress and feel more grounded – named explicitly for use in emergency and crisis stabilization settings.

DBHIDS Peer Support Toolkit, Grounding Exercise Facilitator's Guide, p.207

Warm handoff

A structured, supported transition between providers or settings where the peer directly introduces the person to the next provider rather than simply giving a referral. This is considered a best practice peer function at ED, PES, and Crisis Receiving and Stabilization (CRS) service settings.

Shared lived experience and recovery storytelling

Peers intentionally draw on their own recovery story to build connection, reduce stigma, and model that recovery is possible. This includes knowing when, how, and with whom to disclose and is not the same as general conversation.

DBHIDS Peer Support Toolkit, Storytelling Tips and Framework, p.75 & p.203

Recovery coaching

A strengths-based approach that helps people identify their own recovery goals, explore barriers, and develop action steps. Uses recovery capital assessment, motivational enhancement, and problem-solving techniques.

Community resource identification and linkage

Actively identifying resources relevant to the person's specific situation including housing, treatment programs, peer support groups, transportation, and financial assistance. Includes making direct connections and follow-up, not just providing a list.

Example: DBHIDS Peer Support Toolkit, Elements of a Memorandum of Agreement, p.224

De-escalation through presence and connection

Peers use empathy, active listening, nonjudgmental presence, and shared experience to de-escalate distress. This is distinct from clinical de-escalation techniques and is grounded in relational engagement rather than intervention protocols.

FROM THE FIELD: Harborview Medical Center PES Peer Bridger Program:

The PES Peer Bridger program offers a full range of peer services across patient contacts. The following is a snapshot of what peer support looks like day-to-day in the PES.

TYPE OF SUPPORT	EXAMPLES
Emotional and relational	Emotional support, coping skills, active listening, crisis de-escalation
Education and navigation	Housing resources, harm reduction, patient rights, case management locations, PES behavior rules, hospital transfer protocol
Basic needs and tangible	Food, clothing, hygiene products, sensory items, shoes, water bottles
Connection to resources	Peer support program enrollment, LGBTQIA+ support, legal information, banking, birth certificates, 12-step programs
Care coordination	Relaying care needs to nursing staff, appointment escorts, phone and television access

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Sample menu of supports for peer-based services, p.91

Peer Drift: When the Lines Get Blurred

Peer drift happens when peers take on tasks outside their scope. In crisis settings, this might look like peers doing care coordination, making clinical referrals, or being asked to cover gaps in clinical coverage. This undermines program effectiveness and increases the risk of burnout and turnover.[26]

VOICES FROM WASHINGTON

When people can't stay in their role as a peer, that leads to burnout.

– Clinician

- **For the peer:** it creates moral distress, burnout, and role confusion. Further, when peers take on clinical functions, it risks shifting the power dynamic from a mutual peer-to-peer relationship.
- **For the program:** it blurs accountability and can create liability.
- **For the person being served:** they lose the unique value of what peer support actually is.

Washington crisis program leaders interviewed for this toolkit described this pattern as well. In crisis settings, peer drift often emerges from genuine motivation to help. Peers who care deeply about the people they serve can find themselves pulled beyond their role boundaries because the need is right in front of them and their instinct is to respond (i.e., offering personal contact information, meeting patients outside of work, following on social media).

Without clear role structure and regular supervision, peers can drift in two directions: toward friendship and informal personal connection on one end, and toward clinical functions like care coordination and case management on the other. Both represent a departure from the peer role and carry real risks for the peer and the people they serve. This is one of the most consistent implementation challenges documented across crisis peer programs nationally.

The two most reliable protections against drift are:

- Clear role description
- Regular supervision with a supervisor who understands the peer role.

VOICES FROM WASHINGTON

It's easy to have lines blurred because of compassion. They see a need and want to meet the need.

– Clinician Administrator / Leader

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Watch for and redirect peer drift, p.127
  - Assessing role clarity and readiness for integrating clinical and peer support staff, p.172
  - Role definition tools and sample function statements, p.38

Integration Into the Team: Day-to-Day Practice

Hiring a peer is one thing, but building the conditions where peers can successfully do their job is another. In crisis and emergency settings, it's important for the peer to be part of the daily rhythm of the team. Integrating a peer into a crisis or emergency setting is a change for the whole team, not just for the peer. Clinical staff may have questions, uncertainties, or even discomfort about how the peer role fits alongside their own. This is normal and worth naming directly. Supporting successful integration means attending to both sides: (1) ensuring the peer has the structure, supervision, and role clarity they need to thrive, and (2) ensuring clinical staff have the information, space, and leadership support to address questions and potential issues.

KEY QUESTIONS

Do staff know how and where to raise questions or concerns about the peer role? Does your team know how a peer fits into the day-to-day? For example, including peers in daily shift huddles has been shown to strengthen integration and give clinical staff regular, structured contact with the peer as a colleague rather than as a resource they call when needed.

VOICES FROM WASHINGTON

Consistent messaging across leadership matters as much as the policies themselves. When policies are enforced unevenly, the uncertainty becomes a barrier for peers and clinical staff alike.

– Clinician Administrator / Leader

Does your team know the following?

- ☐ What the peer role includes, what it doesn't, and why
- ☐ How self-disclosure works and why it is intentional
- ☐ How referrals to the peer work
- ☐ What to do if they have a question or concern

CASE STUDY · NEW MEXICO EMERGENCY DEPARTMENTS

A qualitative assessment of peer support programs across New Mexico emergency departments and reports from local interviewees in Washington found that the most common day-to-day integration questions were practical ones:

- **Where is the peer physically located?**
- **How do peer workers get notified when there is a patient who wants to be seen?**
- **Is the position part-time or full-time?**
- **What does follow-up look like and how long does it last?**

These questions came up consistently across programs and the answers varied. What the research found was that in most programs, ED staff were the first to introduce patients to peer services, even when peers had access to ED admissions and could identify patients on their own. Several peer workers also noted that building personal relationships with ED staff directly shaped how well they were able to engage with patients. The stronger the working relationship, the more referrals came their way.

VOICES FROM WASHINGTON

Peers are treated as a core component of the team. The peer is the first person a client interacts with and the last person they see. In that role, they break the ice, explain the process, collect collateral information during the crisis visit, review referrals together, and serve as a contact point.

– Clinician Administrator/Leader

Staffing Models and Caseload Considerations

Never Just One: The Case for Peer Staffing Depth

When possible, the recommendation is to hire more than one peer. A sole peer embedded in a clinical environment has no internal peer consultation, no coverage support, and is more vulnerable to absorbing the surrounding clinical culture rather than contributing their own perspective.

One Washington crisis center plans to use a team of five – one Mental Health Practitioner, two care coordinators, and two peer support specialists – to support approximately 40 people during the 30 to 90 days following a crisis episode. Each peer is expected to connect with about 20 people for weekly one-to-two hour sessions.

VOICES FROM WASHINGTON

Peers working in high-acuity environments are vulnerable to secondary trauma and vicarious stress; they need each other to process it. Having only one peer is strongly discouraged.

– Peer Leader & Educator

Caseload size matters, too. Peer work runs on relationship and rapport, not volume. Practitioners in Washington suggest keeping peer support specialist caseloads lower than typical case management ratios to allow adequate time for relationship-building and reduce burnout risk.

VOICES FROM WASHINGTON

Peers need time to build rapport. The individual may need more 1:1 support than a case management model allows.

– Clinician Administrator/Leader

MISCONCEPTION

"One peer is enough to start." One peer is a starting point, but also a setup for isolation and burnout. Planning for two from the start is the stronger model. Consider the number of people to be seen and the hours of coverage needed across shifts when determining how many peers your program requires.

LANGUAGE

Use ***"peer specialist"*** or "peer support worker" rather than "peer volunteer" or "peer helper." Language signals how the role is valued within the organization.

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Hire more than one peer, p.59

Referral Pathways and Workflow

The referral pathway answers two basic questions: who decides a peer is needed, and how that decision is made. Peer referrals need to be simple, documented, and built into existing workflows. It shouldn't be a separate step someone has to remember under pressure.

KEY QUESTION

Does your team have a clear, documented process for when and how peers get involved?

In some settings, peers also proactively identify patients through the electronic health record (EHR) or by being present on the floor. In others, they work exclusively through referrals from clinical staff. The research consistently shows that programs with clear, documented referral processes have stronger peer utilization than those relying on informal norms.[27,28]

TIP

Before the peer starts, prepare a simple one-page document covering what the peer does, what they don't do, who they report to, and how referrals work. Share with the full team before the peer begins working.

Building Your Referral Process: Five Questions to Answer:

- [ ] What triggers a referral? Clinical event? Staff observation? EHR alert?
- [ ] Who can make a referral? Any staff? Designated roles only?
- [ ] How do peer workers get notified? On-site, on-call, or off-site? What is the expected response time?
- [ ] How is the patient introduced? Who makes the introduction? Is there a standard script?
- [ ] What does follow-up look like? How many contacts? Over what time frame?

Sources: Richardson & Rosenberg, National Council (2019), p.7-8; Earheart & Crisanti, UNM (2019), p.15; McGuire et al., Journal of Substance Abuse Treatment (2019)

Keep the following in mind:

1 Consent before engagement

Peer support is voluntary, always.

No referral results in peer engagement without the patient's explicit agreement. This should be a documented step, not an assumption.

2 Stabilization before engagement

A peer should not engage with someone who hasn't been medically or behaviorally stabilized.

Someone revived from an overdose or in acute psychiatric crisis may be confused, frightened, or physically unwell. The referral process should include a stabilization checkpoint.

3 A warm introduction, not a cold handoff

Transitions are important.

The most effective referrals involve a brief introduction from a clinical team member before the peer steps in.

4 Meeting people where they are

The goal of peer engagement is not always a treatment referral.

Peer services are grounded in stages of change and should meet people at their point of readiness. The primary goal is establishing a relationship and ongoing engagement, so support is available when the person is ready.

CASE STUDY · CHRISTIANA CARE HEALTH SYSTEM IN DELAWARE

Project Engage at Christiana Care Health System in Delaware is a hospital-based peer support program that integrates peers into ED and inpatient settings for patients with substance use challenges. Rather than waiting passively for staff referrals, peers had access to the EHR to proactively identify patients who might benefit. This shift from *reactive* to *proactive* helped expand reach significantly.

Sources: Pecoraro, A., et al. (2012). Early data from Project Engage. Addiction Science & Clinical Practice, 7(20); Richardson, J., & Rosenberg, L. (2022). Peer Support Workers in Emergency Departments, p.8. National Council for Mental Wellbeing.

CASE STUDY · HARTFORD HEALTHCARE IN CONNECTICUT

Hartford HealthCare in Connecticut employs peer support workers (called recovery coaches) across several hospital EDs through a partnership with the Connecticut Community for Addiction Recovery (CCAR). Their coaches are contractually required to connect with patients at least ten times in the first two weeks following discharge. Consider building a follow-up standard into your program from the start; even a simpler version sets expectations and improves continuity.

Sources: Richardson, J., & Rosenberg, L. (2022). Peer Support Workers in Emergency Departments, p.9. National Council for Mental Wellbeing; Better Care Playbook. (2022). Recovery Coaching In and Out of Emergency Departments: An Overview of CCAR's Emergency Department Recovery Coaching Program.

MISCONCEPTION

"The goal of peer support in crisis settings is to get people into treatment." The primary goal is to establish a relationship and meet people where they are. Peer support focuses on following the person's readiness before a program's timeline.

LEARN MORE

- **Peer Support Workers in Emergency Departments (National Council for Mental Wellbeing, 2022)**
  - Workflows and processes, p.7
- **Peer Support Workers in the ED (University of New Mexico, 2019)**
  - Referral notification and day-to-day integration questions, p.14
- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Integrate peer staff into assessment and service planning processes, p.79

KEY TAKEAWAYS

- Role clarity is the foundation of everything. If the team cannot describe what the peer does and does not do, the program will drift.
- Recovery-oriented values are not background context. They shape how peers show up in practice every day.
- The peer role is distinct from clinical, case management, and social work functions. This distinction is more than philosophical. It protects the peer, the people they serve, and the program.
- Peer drift comes from good intentions. Clear role boundaries, documented expectations, and regular supervision are the primary safeguards.
- Referral pathways and workflow structures determine how much the peer role is utilized. Build them before day one.

SECTION SIX

Setting a Peer Up for Success: Hiring, Onboarding, and Training

Recruiting, onboarding, and supervising peer staff

IN THIS SECTION

Finding the Right Fit: Hiring and Human Resources

Hiring the right person is the first step. Getting them ready to walk onto the unit is the second. This section covers what needs to happen before and during a peer's first weeks on the job – from credentials and background checks to team orientation and day-one preparation.

KEY QUESTION

Are your hiring practices aligned with what the peer role in a crisis setting actually requires?

Standard hospital and health system human resource (HR) policies are often not designed with the peer role in mind, though this is starting to change as the peer role becomes increasingly recognized as an essential part of crisis care teams. Crisis and emergency settings add another layer. These environments move faster, involve higher acuity, and expose peers to acute distress at a level most community-based peer roles do not. Most peers enter the workforce through community-based settings (outpatient agencies, recovery community organizations, peer-run respites) where the pace and acuity are very different from a crisis or emergency environment. Crisis-specific experience is still relatively rare in the peer workforce, which makes intentional hiring and onboarding even more important. Washington has a growing peer workforce, but the pool of credentialed peers with crisis-specific experience remains small. As one Washington leader noted, hiring delays are common; the pool of people with both the credential and comfort in these environments is still small.

NOTE

In Washington, a certified peer specialist is defined as a person with a substance use disorder and/or mental health condition, or the caregiver of someone with either of those. This means you can qualify as a peer specialist even if you do not have your own mental health or substance use history; being the parent or caregiver of someone who does still qualifies. This is particularly relevant for programs serving youth and families.

CASE STUDY · PROJECT POINT (INDIANA)

Project POINT is an Emergency Department (ED)-based peer recovery program in Indiana that deploys peer recovery coaches to individuals who have experienced an opioid overdose. They built their hiring process around fit for a high-intensity clinical environment; every applicant shadows a current peer before receiving an offer because the work "can be chaotic, stressful, and trauma-activating."

Sources: Richardson, J., & Rosenberg, L. (2022). Peer Support Workers in Emergency Departments, p.7. National Council for Mental Wellbeing; Watson, D.P., et al. (2021). Evaluation of an emergency department-based opioid overdose survivor intervention. Drug and Alcohol Dependence.

Washington State Credentialing Requirements

Washington's certification requirements establish a strong foundation for peer support work in crisis settings. In peer contexts, the terminology "peer counseling" refers to non-clinical supportive, recovery-oriented relationships in which a person with lived experience uses their experience, training, and mutual connection to provide emotional support, encouragement, practical assistance, and hope to someone facing similar challenges. In Washington, this practice has historically been associated with the Certified Peer Counselor (CPC) certificate – an HCA-issued training certificate, not a DOH credential, which does not expire. The State has now also established a Certified Peer Support Specialist (CPSS) credential through the Department of Health. Becoming a CPSS is voluntary.

Peers must hold a CPSS or Certified Peer Support Specialist Trainee (CPSST) credential through the WA DOH in order to bill Medicaid, or have an Agency-Affiliated Counselor (AAC) credential until January 1, 2027. Neither CPCs nor CPSS/CPSST credential holders can bill Medicaid or insurance carriers for peer services unless they are working for a licensed behavioral health agency (BHA) credentialed to provide peer support services. CPCs with a registered AAC credential may currently bill for Medicaid peer support services if working for a licensed and credentialed BHA. Per SSB 5555, a person who engages in the practice of peer support services and bills a health carrier or medical assistance (or whose employer bills a health carrier or medical assistance for those services) must hold an active credential as a CPSS or CPSST.

Obtaining the CPSS credential requires completing an 80-hour HCA-approved training course, passing oral and written examinations, and completing 1,000 supervised hours as a trainee. The peer role remains distinct from licensed clinical counseling, therapy, or treatment.

LEARN MORE

- **WA DOH: Peer Support Specialist FAQ, Laws, Resources**
- **WA HCA: Organizations with Peer Support Programs**
- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Recruiting and hiring peer staff, job description and qualification tips, p.47
  - Guidelines for running a productive recruiting and hiring committee, p.174
  - Common questions about managing accommodations for employees, p.198
  - Understand and manage accommodations for employees with disabilities, p.63
  - EAP and benefits navigation, p.62
- **Peer Support Workers in the ED (University of New Mexico, 2019)**
  - Hiring considerations and peer qualities for ED settings, p.21
- **SAMHSA Peer Integration and Stages of Change Toolkit (NY, 2018)**
  - Personnel and legal considerations, p.41

In Summary:

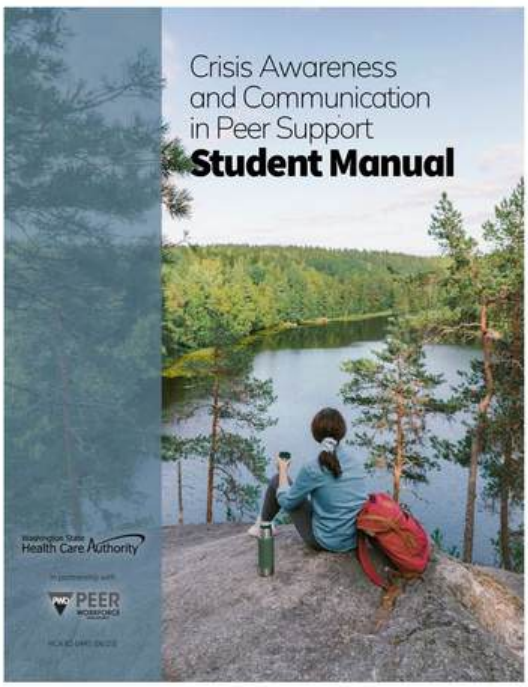
- If your employer bills a health carrier or medical assistance, you are required to get the certified peer specialist certification.
- If your employer does *not* bill a health carrier or medical assistance, you are not required to get the peer specialist certification.
- A credential is not required to practice peer support services, but *is* required to use the title of Certified Peer Specialist or Certified Peer Specialist Trainee.

If you are new to the credentialing process, the Washington DOH CPSS Packet is a good place to get acquainted. It walks through credential certification requirements, including what peers formally attest to regarding their lived experience and what documentation is required. Note that the experience verification (also called the attestation) must be completed and submitted by the employer. Medicaid reimbursement requires appropriate credentialing and that supervision requirements, which vary by credential type, are met.

LEARN MORE

- WA DOH: Certified Peer Support Specialist Application Packet
- WA HCA: Certified Peer Specialist FAQ (June 2025)
- WA DOH: Peer Support Specialist FAQ
- WA DOH: Certification Requirements
- WA HCA: Creating the Profession of Certified Peer Specialists, Listening Session (April 2025)
- WA HCA: Crisis Awareness and Communication in Peer Support (CACPS) Student Manual
- WA HCA: How to Become a CPSS
- WA HCA: CPSS Certification Pathway Visual Map
- WA HCA Organizations with Peer Support Programs

Peers working as crisis responders are additionally required under SSB 5555 to complete the **Crisis Awareness and Communication in Peer Support (CACPS)** training. This is a separate legal requirement from the base credential and is in effect as of January 1, 2026. Any entity using certified peer specialists as peer crisis responders may only use peers who have completed the CACPS training. The training consists of an online prerequisite followed by a 40-hour training that is available both in person and virtually. Both are provided at no cost. The CACPS training was developed by the Washington HCA and contains valuable information for any peer, even if they aren't in a crisis role. It's important to maintain records of completion. Behavioral health agencies (BHAs) are required (SSB 5555) to make training completion records available to the state agency for auditing or certification purposes.



LEARN MORE

- **WA HCA:**
  - Crisis Awareness and Communication in Peer Support (CACPS) training
  - SSB 5555: WA Legislature – Certified Peer Specialists

Additional Credentialing Considerations

Organizations with existing CPCs on staff do not need to repeat the full 80-hour training. CPCs can complete a 12-18-hour online Gap training to transition to the new CPSS credential at their own pace. The CPSS credential fee is capped at $100 until 2030. There is no fee for the CPSST trainee credential. This is a low-cost credentialing pathway for peers and organizations.

Organizations in Washington hiring peers credentialed in other states should note that out-of-state training applies, but additional Washington training is required. Out-of-state peers must complete the HCA Gap Training and the HCA Peer Prerequisite Training, both available online at no cost. One exception: applicants who hold a national certification as defined in WAC 246-929-190 meet the education and experience requirements of Washington, provided the certification is active and in good standing.

LEARN MORE

- **WA HCA:**
  - Gap training for existing CPCs transitioning to CPSS credential, p.3
  - Reciprocity for peers credentialed in other states, p.5
  - Gap Training LMS

VOICES FROM WASHINGTON

You can't hire the right people instantaneously. The pool of people with both the credential and the comfort in these environments is still small.

— Clinician Administrator / Leader

TIP

Stay current on Washington peer workforce updates. HCA publishes a monthly Peer-to-Peer newsletter with training announcements, policy updates, and workforce news. Subscribe and access resources at: https://www.hca.wa.gov/billers-providers-partners/program-information-providers/peer-specialists

Navigating Background Checks

A history of involvement with the legal system is not an automatic disqualifier to becoming a CPSS. Many peer candidates with meaningful lived experience (the people most qualified for peer roles) may have prior involvement with the legal system. In most cases, the specificity of lived experience this reflects is an asset. The key question is whether this person can function as a credible role model and coach for the people they will be supporting. Applicants with a history of involvement with the legal system may be asked to provide court documents as part of the Washington DOH credentialing review process, which considers each application independently on a case-by-case basis.

LEARN MORE

- **WA HCA: Creating the Profession of Certified Peer Specialists, Listening Session (April 2025)**
  - Am I disqualified due to a criminal conviction, p.16
- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Hiring peers with incarceration history, p.53
- **Peer Support Workers in Emergency Departments (National Council for Mental Wellbeing, 2022)**
  - Criminal background considerations and creative hiring structures, p.6

Under Washington DOH policy, there are no automatic disqualifying convictions for the CPSS credential. Each application is reviewed independently on a case-by-case basis by a case management team that considers conviction history, the applicant's explanation, and subsequent life changes. In some cases, conditions or limitations may be placed on a credential, but automatic disqualification does not occur.

Organizations should work with HR to allow for case-by-case review rather than automatic disqualification. Organizations may also consider developing an internal hiring policy that reflects this approach, ideally with a sample policy to reference. Contracting with a recovery community organization (RCO) to employ peers, with the crisis setting hosting them under a memorandum of understanding (MOU), can be an effective approach. The RCO employs and supervises the peer, which can reduce administrative and liability concerns for the clinical setting while providing the peer with peer-specific supervision and support.

Equitable Compensation

Peers are professionals doing skilled, emotionally demanding work in high-acuity environments. Compensation that doesn't reflect this signals to peers (and to clinical colleagues) that the role isn't valued. Low pay is consistently identified as a barrier to recruiting and retaining qualified peers in emergency and crisis settings. Peer salaries vary widely based on factors such as experience, role, setting, and geography. Based on salary information available online and input from community sources at the time this toolkit was developed, peer pay ranged from approximately $22 to $45 per hour. Research shows that replacing an entry-level employee costs between 30% and 50% of their annual salary – a significant financial loss before accounting for lost relationships and institutional knowledge.[29] These costs include recruiting, onboarding, training, and the reduced productivity that comes with any new hire. Consider reviewing peer compensation within your organization's pay structure and advocating for wages that reflect the intensity and demands of crisis work.

LEARN MORE

- **The Wages of Peer Recovery Workers: Underpaid, Undervalued, and Unjust (Smith, 2024)**
- **National Survey of Compensation Among Peer Support Specialists (College for Behavioral Health Leadership, 2016)**
- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Offer competitive pay and other benefits, p.61
- **SAMHSA Peer Integration and Stages of Change Toolkit (NY, 2018)**
  - Paid vs. unpaid peers, p.17
- **Peer Support Workers in the ED (University of New Mexico, 2019)**
  - Compensation as barrier to recruitment, p.9

Job Descriptions and Interview Practices

A job description for a crisis peer role should describe the realities of the environment in addition to the duties. Be specific about the pace, the clinical culture, the emotional demands, and what supervision looks like. Poorly defined job roles are one of the most commonly cited barriers to successful peer integration in multidisciplinary teams. When writing your job description, be honest that the peer may encounter clinical staff who have not fully embraced recovery-oriented values. This is a real challenge that comes up frequently in peer supervision. Organizations that name this upfront signal that recovery principles are an organizational value (not just the peer's job to remind staff). This sets peers up for success and reduces the isolation that can come from navigating that tension.

Lived experience is essential, but it's not the only requirement for the role. In addition to peer certification, characteristics that support success in crisis and emergency settings include:

- Effective self-awareness and self-management skills, which includes understanding factors that may affect their wellbeing, maintaining their own recovery and wellness, and having appropriate supports in place
- Experience navigating the behavioral health or crisis system as a service user
- Comfort with ambiguity and rapidly changing situations
- Ability to work alongside clinical staff across power differentials
- Alignment with recovery-oriented, person-centered values

MISCONCEPTION

"The longer someone has been in recovery, the better the hire." Recovery time requirements across programs range from several months to four years. The more relevant question is whether the candidate has sufficient stability, self-awareness, and support to work in a high-acuity crisis setting.

CASE STUDY · NEW MEXICO EMERGENCY DEPARTMENTS

A qualitative assessment of peer support programs in New Mexico emergency departments found that the ED environment requires a particular kind of person. EDs operate at higher pressure, with heavier workloads and higher patient acuity than most other healthcare settings. Peers working in this environment need to be flexible, comfortable with multidisciplinary teams, and skilled at staying calm in fast-moving, unpredictable situations. Self-management (including actively tending to one's own recovery and wellness) is especially important for peers in emergency settings, where the pace and intensity can be activating.

Source: Earheart, A.S., & Crisanti, A.S. (2019). Peer Support Workers in the Emergency Department: A Report. University of New Mexico

LEARN MORE

- **SAMHSA Peer Integration and Stages of Change Toolkit (NY, 2018)**
  - Sample job description, p.38
- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Sample peer staff function and responsibility statements, p.180
  - Interview questions for peer staff, p.185
  - Certified Peer Specialist interview questionnaire, p.187
  - Sample scenarios to navigate when hiring, p.191
  - Applicant score sheet, p.190
- **Peer Support Workers in Emergency Departments (National Council for Mental Wellbeing, 2022)**
  - ED-specific hiring considerations, p.6

Setting Up for Success: Onboarding

Onboarding a peer into a crisis or emergency setting means **preparing the peer** for the environment and **preparing the team** for the peer. Research consistently shows that intentional onboarding pays off. Employees who experience exceptional onboarding are 2.6 times as likely to be extremely satisfied with their workplace and far more likely to stay.[30]

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Creating a positive onboarding experience, p.67
- **Gallup: 8 Practical Tips for Leaders for a Better Onboarding Process**

Crisis settings can be activating environments, particularly for peers with their own experience of using crisis or emergency services. Before the peer's first shift, onboarding should cover what to expect from the environment, such as the pace, the clinical culture, how power dynamics show up, and how to navigate disagreements. Research on peer integration in clinical settings found that friction arose specifically when staff were not prepared for the inclusion of a peer colleague.[31] Every peer should be offered the opportunity to create a wellness plan before their first shift. For more on sustaining peer wellness over time, see Section 8.

What needs to happen before the peer's first shift?

We recommend building a team orientation into the onboarding plan, ideally led by the peer's clinical champion or supervisor. See Section 3 for role education and outreach and Section 5 for team integration.

For the peer, practical orientation should cover introductions to key roles and personnel, physical layout and safety protocols, locked and unlocked unit protocols, crisis care workflows, documentation requirements, and supervision structure.

Furthermore, building in dedicated time to shadow current staff across several shifts before taking on their own caseload may help the peer get a realistic preview of the environment. Several peers interviewed for the toolkit recommended that new peers spend at least one week shadowing and orienting to the setting before carrying a caseload. Project POINT, an ED-based peer recovery program in Indiana, built a shadowing period into their standard hiring process for exactly this reason.[32] Also worth consideration is cohort-style onboarding (joining alongside other new staff), which provides a built-in peer connection from day one while normalizing the peer role within the broader team.

Documentation can also be a common early stumbling block. A simple cheat sheet for note-writing style and electronic health record (EHR) navigation makes a real difference. Consider working with your electronic health record team to build note templates and flowsheets that reflect the peer role in order to reduce documentation barriers from day one. This is also a good moment to identify what data your organization will track to demonstrate program value over time. Programs can track value in several ways, such as reduced use of emergency services, increased engagement in community-based care, and the number or type of peer interactions.

LEARN MORE

- WA HCA: Documenting Peer Suppiort (free online training)

VOICES FROM WASHINGTON

Onboarding was critical and there was a lack of it. HR needed a toolkit: how to support the manager, how to support the peer. That gap affected everything downstream.

– Administrator / Leader

MISCONCEPTION

"Peers in recovery are at risk of relapse on the job, and that's a liability." Research shows the persistent misconception that peer support workers will inevitably relapse should be addressed and dispelled and that meaningful employment may actually support recovery rather than threaten it. Peers experiencing difficulty should be supported like any other employee - for example, being encouraged to use sick time and wellness days. Make sure the peer is aware of any benefits in your Employee Assistance Program (EAP).

Training and Ongoing Learning

Ongoing training for peers is important for their success. Peers in crisis settings benefit from regular opportunities for professional development through supervision, peer learning communities, and continuing education. Research supports including peers in shared team trainings rather than separate tracks; peer support workers and behavioral health practitioners showed no difference in post-training satisfaction or comfort when trained together.[33] Some interviewees noted that certain trainings, such as physical restraint training, can be activating for people with lived experience in psychiatric care. Peers should have support from a supervisor and a peer cohort to process any questions or feelings that come up during training. Building in that space – whether through supervision, peer cohort meetings, or peer community resources – supports retention and role sustainability.[34]

Peers also contribute informally to team learning over time. Through their presence and day-to-day interactions, peers can help clinical staff better understand recovery-oriented engagement, person-centered communication, and what it feels like to navigate a crisis system as a patient. This informal modeling is a less visible but more meaningful way peers strengthen team culture.

KEY QUESTION

What does your peer need to know to be effective in this specific setting, and does your training plan reflect that? Does your training approach create space for peers to reflect on questions and how the training applies to their role?

Some Washington crisis programs have put this into practice by including peers in all relevant team trainings (such as motivational interviewing, suicide prevention, lunch and learns, and setting-specific topics) alongside clinical staff. Peers working in crisis and emergency settings consistently identify training gaps between foundational certification and what the job requires. A study drawing on peer and administrator interviews found that 89% of peer support workers believed additional training in specialized topics would improve their professional experience.[35]

The training topics most commonly identified:

- Motivational Interviewing (MI) as a valuable tool for meeting people at varying stages of readiness
- How to function within a multidisciplinary crisis or emergency team
- Working effectively in high-acuity, high-stress environments
- Safety policies and protocols specific to the setting
- Self-care and self-monitoring in high-exposure work

Source: Earheart, A.S., & Crisanti, A.S. (2019). Peer Support Workers in the Emergency Department: A Report, p.21. University of New Mexico.

TIP

Consider including a stigma awareness or recovery-oriented values training for clinical staff who will be working alongside peers. Staff who understand the history and evidence base of peer support and who have examined their own assumptions about lived experience and recovery are better prepared to be effective colleagues and champions for the peer role. For resources on staff bias and culture change, see Section 3.

LEARN MORE

- **WA HCA: CPSS Curriculum and Training Modules Resource List**
- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Training overview, p.22
- **Peer Support Workers in the ED (University of New Mexico, 2019)**
  - Shared training findings, p.20

KEY TAKEAWAYS

- Hire not just for the credential, but for the specific demands of crisis and emergency work. The environment matters as much as the person.
- CACPS training is required for peer crisis responders as of January 1, 2026. Confirm training completion before the peer's first shift.
- Build EHR templates, referral processes, supervision structures, and wellness plans before the peer starts.
- Prepare the team before the peer arrives. Onboarding the team is as important as onboarding the peer.
- Ongoing training, peer community connection, and career growth opportunities are among the most meaningful ways to support retention.

SECTION SEVEN

Supporting Peers in Practice: Supervision, Ethics, and Documentation

The role of supervision and documentation

IN THIS SECTION

Peers need ongoing support after they are hired and trained, especially in fast-moving crisis and emergency settings. This section covers supervision, professional and ethical considerations, documentation, and information sharing, including mandatory reporting and duty-to-warn obligations. Supervision and clear ethical and legal guidance help protect peers professionally, guide their practice, and support their success as part of the care team. They also protect the organization from preventable mistakes such as Health Insurance Portability and Accountability Act (HIPAA) violations.

The Supervision Role

Interviews with Washington crisis program leaders and peers consistently identified supervision as a critical role in peer success, retention, and sustainability in crisis and emergency settings. Across the literature, inadequate supervision is cited as a primary driver of peer drift, burnout, and program failure.[36] In crisis and emergency settings where the peer role is relatively new in the field, effective supervision is especially critical.

Washington State Supervision Requirements

Peer support roles fall into two credential levels: Certified Peer Support Specialist Trainee (CPSST) and the full credential, Certified Peer Support Specialist (CPSS). Supervision requirements differ depending on which credential the peer holds. Qualified supervisors are regulated under SSB 5555.

Per WAC 246-929-170:

"An approved supervisor who is eligible to supervise certified peer support specialist trainees must be either:

***(a)** a behavioral health provider with at least two years of experience working in a behavioral health practice that employs peer specialists as a part of their treatment teams (until July 1, 2028)*

***(b)** a certified peer specialist who has completed at least 1,500 hours of work as a fully certified peer specialist, at least 500 hours of joint supervision, and the peer specialist supervisor training course provided by Health Care Authority (HCA)."*

TIP

If a peer is functioning as a peer crisis responder under SSB 5555, confirm that their Crisis Awareness and Communication in Peer Support (CACPS) training completion is documented in addition to verifying their CPSS or CPSST credential.

See Section 6 for CACPS training details.

LEARN MORE

- Medicaid and DOH Peer Support Supervision Requirements.pdf
- WA Law: Approved Supervisor Definition (RCW 18.420.010)
- WA HCA: Creating the Profession of Certified Peer Specialists, Listening Session (April 2025)
- National Practice Guidelines for Peer Specialists and Supervisors (NAPS, 2013)
- WA HCA: How to Become a Certified Peer Support Specialist flowchart
- WA HCA: requirements to obtain the CPSS credential (video, 2026)

What are your next steps?

- [ ] Confirm which credential your peer holds and whether an approved supervisor is in place before their first shift.
- [ ] Confirm that your approved supervisor meets the definition under SSB 5555 and WAC 246-929-010.
- [ ] If you are currently relying on a behavioral health provider as an approved supervisor, develop a transition plan before July 1, 2028.

The table below covers the three supervision scenarios your organization is most likely to encounter. Note that this reflects requirements as of the date of publication.

New requirements go into effect July 1, 2028.

PATHWAY	WHO IT APPLIES TO	WHAT IS REQUIRED
Becoming fully credentialed: CPSST to CPSS	A peer working toward their full CPSS credential	Must complete 1,000 hours of supervised peer work under an approved supervisor. Must have completed the 80-hour HCA-approved training. Supervision must be in place before the peer begins working.
Becoming an approved supervisor	A fully credentialed CPSS who wants to supervise other peers	Must complete 1,500 total hours of peer work, with at least 500 of those hours spent jointly supervising other peers alongside another approved supervisor. Must also complete the HCA supervisor training developed under SSB 5555
Temporary exception: Licensed behavioral health providers can be approved supervisors until July 1, 2028	Behavioral health providers who are not peers	A licensed behavioral health provider with at least two years of experience working alongside peers can currently serve as an approved supervisor. After July 1, 2028, this exception ends.

Supervision Models

Administrative demands can oftentimes crowd out the relational and developmental supervision that can be highly valuable for peers. Supervision varies across organizations. Some peers report receiving little formal supervision, while others meet with a supervisor every week.

Supervision of peers is most effective when supervisors:

- Have completed the HCA Peer Support Supervision training or equivalent peer-specific supervisor training
- Are trained in quality supervisory skills
- Understand and support the role of the peer specialist
- Understand and promote recovery in their supervisory roles
- Advocate for the peer specialist across the organization
- Promote the professional growth of peers

? KEY QUESTION

Does your organization have what it needs to supervise, support, and protect the peer role over time?

Supportive supervision provides a space for peer staff to discuss workplace challenges, reflect on their experiences, and identify strategies that support both effective practice and personal wellbeing.

Peer staff benefit from at least three types of supervision:

Administrative (paperwork, logistics, and compliance) – includes things like scheduling, documentation, credentialing, and organizational policies

Formative (professional growth and learning) – focuses on skill development, training, and expanding the peer's knowledge and effectiveness, including guidance on role boundaries and peer drift

Supportive (wellbeing and role sustainability) – addresses the emotional and relational dimensions of the work, self-care, and preventing burnout

? KEY QUESTION

Does your organization provide all three types of supervision your peer needs to stay effective, grounded, and sustainable in this role? Is there capacity?

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Supervision frameworks, p.110

Another approach is co-supervision, where peers work as a group without a formal supervisor present to reflect on professional strengths and challenges. Co-supervision can be a valuable supplement to individual supervision in crisis settings. Additionally, it builds camaraderie, reduces dependency on a single supervisor, and creates peer-to-peer accountability.

? KEY QUESTION

- Does the peer have a documented supervision working agreement?
- Is there a co-supervision structure or peer learning group available to supplement individual supervision?

TIP

Supervision for peers should not default to case review only. Build in structured time for role reflection, self-care check-ins, and professional development.

TIP

In crisis and emergency settings, the pace of work can make it easy to cancel or shorten supervision. Build supervision into the schedule as a protected block to prevent it from being dropped when the unit gets busy.

LEARN MORE

- **WA HCA: Washington State Supervision of Peer Specialists Handbook (2025)**
- **SAMHSA BRSS TACS: Supervision of Peer Workers (Video)**
- **National Practice Guidelines for Peer Specialists and Supervisors (NAPS, 2013)**
- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Why invest in supporting and supervising peer staff, p.108
  - Co-supervision model and guidelines, p.111
  - Help peer staff develop time-management and documentation skills, p.122
  - Supervision Agreement Template, p.231
  - Developing a Co-Supervision Working Agreement, p.234
  - Group Supervision Tips, p.233
  - Documentation Self-Assessment Tool and Facilitator's Guide, p.258
- **SAMHSA Peer Integration and Stages of Change Toolkit (NY, 2018)**
  - Supervision tips, p.56
  - Supervision template, p.59
- **VHA Peer Specialist Toolkit: implementing peers in Veterans Health Administration (VHA)**

Professional and Ethical Considerations

Being trained in ethical and professional practice helps peers navigate difficult situations and protects the peer, the people they serve, and the organization. It is also an important compliance requirement in crisis and emergency settings. The peer role carries unique ethical complexity, as peers draw on personal experience and build close relational connections in ways that clinical staff do not. Washington's 80-hour CPSS certification training includes ethics as a required topic, covering professional boundaries, self-disclosure, dual relationships, and mandatory reporting. Organizations should build on that foundation by reinforcing ethics training through onboarding and regular supervision.

Two key professional ethics obligations in Washington, mandated reporting and duty to warn, are addressed in the content below.

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Examine and create shared expectations related to boundaries and ethics, p.31
  - Ethics training tools and activities, p.164
- **WA HCA: Ethics and Boundaries in Peer Services (free online training)**

Mandated Reporting and Duty to Warn

Peers with a Certified Peer Support Specialist (CPSS) or Certified Peer Support Specialist Trainee (CPSST) credential through the Department of Health (DOH) are mandated reporters. This means they must report suspected abuse or neglect of a child or vulnerable adult. They must also report misconduct by other DOH-credentialed providers.

This is especially important in crisis and emergency settings. Peers may hear about safety concerns, family conflict, abuse, neglect, exploitation, or misconduct while supporting someone in crisis. Clear training and supervision can help peers understand when reporting is required, how to make a report, and how to balance reporting duties with the values of trust, transparency, and peer support. Peers should be trained to identify reportable incidents and follow your organization's established reporting protocol. In most settings, this means notifying their supervisor immediately, but the specific process should be defined and documented before the peer's first shift. Organizations should not assume peers know what to do in these situations without explicit guidance.

Before peers begin support with someone:

Peers should explain what is and is not confidential. This means telling the person upfront that most of what they share stays between them and the peer, but there are specific situations where information must be reported. For example, suspected abuse or neglect of a child or vulnerable adult, or a serious and credible threat of harm to themselves or others.

OBLIGATION	WHAT IT MEANS	WHO IT APPLIES TO
Mandatory reporting	Required to report suspected abuse or neglect of a child or vulnerable adult, as well as misconduct from other DOH credential holders	CPSS and CPSST credential holders
Duty to warn	Required to warn when there is a credible threat of harm to an identifiable third party	CPSS and CPSST credential holders

NOTE

Non-credentialed peers are not designated mandatory reporters under Washington statute, and organizations employing non-credentialed peers should confirm their obligations with Health Care Authority (HCA) or legal counsel.

KEY QUESTION

- Have all credentialed peers been trained on mandatory reporting obligations before their first shift?
- Is said training documented?
- Do peers know the duty to warn threshold and your organization's escalation process?
- Have people supported by peers been informed of the limits of confidentiality before support begins?
- Have you confirmed reporting obligations for any non-credentialed peers in your setting with HCA or legal counsel?

TIP

In emergency and crisis settings, peers may encounter disclosures of abuse or threats of harm more frequently than in community-based settings. Having a clear, practiced protocol is especially important. Consider walking new peers through a scenario before their first shift.

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Duty to warn guidance, p.37
- **WA DOH: Peer Support Specialist Frequently Asked Questions**
- **WA HCA: Crisis Awareness and Communication in Peer Support (CACPS) Student Manual**

Code of Ethics

Washington has developed peer-specific ethics guidelines through the Washington HCA and the DOH. These guidelines address boundaries, self-disclosure, dual relationships, and professional conduct specific to peer roles.

KEY QUESTION

Does your organization have a process for reinforcing ethics training beyond initial certification? For example, through supervision or ongoing professional development?

Peer support also has deep roots in substance use recovery, so many peers and organizations also reference national standards such as the National Association for Addiction Professionals (NAADAC) Code of Ethics. While not required for Washington peer credentialing, it is a widely recognized and practical reference for peers working in emergency and crisis environments – particularly in settings where substance use disorder presentations are common. Both of these resources provide a comprehensive foundation for ethical peer practice in crisis and emergency settings.

KEY QUESTION

Has your peer completed ethics training specific to the peer role? Is your peer familiar with both Washington peer ethics guidelines and national standards?

LEARN MORE

- WA DOH Ethical Guidelines for Peer Support Specialists
- National Association for Addiction Professionals (NAADAC) Code of Ethics

Documentation and Information Sharing

In crisis and emergency settings, documentation is both a compliance requirement and a peer role integrity issue. The focus here is not on clinical documentation, but on whether peers are oriented to your organization's documentation expectations, trained on your systems, and supported to document in a way that reflects the peer role rather than clinical assessment language.

KEY QUESTION

Does your peer know what your organization expects them to document, and are they trained to do it?

Peer services billed under H0038 must meet Medicaid documentation requirements. Services must be medically necessary, part of a covered behavioral health service, included in a treatment plan, and properly documented.

Peer documentation should reflect the peer role, not the clinical role. Peers document interactions in plain, recovery-oriented language describing what occurred, what resources were discussed, and what next steps were identified. They do not document clinical assessments, diagnoses, or risk assessments.[37] Information shared with the care team should follow organizational policy, be limited to what is required, and shared with the person's knowledge (except in mandatory reporting situations).

Well-designed electronic health record (EHR) note templates and flowsheets that reflect the peer role can reduce documentation burden, prompt the right level of detail, and help peers document consistently without defaulting to clinical language. This is also an important opportunity to identify what program evaluation data your organization will collect (such as peer interaction volume, referral completion rates, or reduced Emergency Department (ED) utilization) and build those fields into your documentation system from the start. Be mindful that documentation requirements should not be burdensome to the peer role. Overly complex or clinically oriented documentation expectations can undermine peer role integrity and contribute to burnout.

Documentation is consistently identified as a challenge for peers new to crisis and emergency settings. As one peer noted in an ED study at the University of New Mexico, current training does not include enough information on reporting or documentation.[38]

The Crisis Awareness and Communication in Peer Support (CACPS) Student Manual notes: remember that the medical record is a legal document. It will protect the peer and their employer, as long as they are writing accurate and timely notes.[39]

Important things to document in crisis settings include:

- Threats to self, staff, other peers, or anyone else
- Changes in behavior or mood
- Attempts to de-escalate the person receiving services

LEARN MORE

- **WA HCA: Crisis Awareness and Communication in Peer Support (CACPS) Student Manual**
  - Documentation guidance for crisis settings, p.51

What are your next steps?

- [ ] Has your peer been oriented to your organization's documentation standards and requirements?
- [ ] Has your peer received EHR training specific to your setting and peer specific documentation?
- [ ] Is there a clear policy on what peer interactions require documentation?
- [ ] Is there a clear policy on what information can and cannot be shared across the care team?

TIP

In fast-paced emergency and crisis environments, documentation often happens after the fact rather than in real time. Peers should know whether same-day documentation is required and what to do if pulled away mid-shift. A simple cheat sheet or smart phrase for common documentation scenarios specific to your setting can prevent errors and reduce anxiety for new peers.

The table below gives program leaders and supervisors a quick reference for what peer documentation should and should not look like. Each row covers a different aspect of documentation and information handling.

DOCUMENTATION AREA	PEERS DO	PEERS DO NOT
Interaction notes: What peers write when they document a peer interaction	Write in plain, recovery-oriented language about what happened in the interaction	Write clinical assessments, diagnoses, or treatment recommendations
Information sharing: What peers can share with the rest of the care team	Share what your organization's policy requires and only with the person's knowledge, except in mandatory reporting situations	Share information beyond what is required or without the person's knowledge, except in mandatory reporting situations
Use of EHR: How peers access the electronic health record	Access only what they need to do their job	Access records beyond what is needed for their role
Confidentiality: The general principle	Keep what is shared in peer interactions confidential, except in mandatory reporting situations	Disclose information shared in peer interactions, except in mandatory reporting situations

KEY TAKEAWAYS

- Confirm your supervision structure meets WAC 246-929-170 requirements before the peer begins.
- Plan ahead for **July 1, 2028,** when the behavioral health provider exception for approved supervisors ends.
- Peers are mandatory reporters under Washington DOH. Make sure they know what that entails and who to report to.
- Documentation should reflect only the peer role. Overly clinical documentation expectations undermine role integrity and contribute to burnout.
- Supervision, ethics, and documentation are not administrative checkboxes. They protect the peer, the people they serve, and the organization.

SECTION EIGHT

Supporting Long-Term Success for Peers in Crisis Settings

Peer Wellness, Self-Care, and Burnout Prevention

IN THIS SECTION

Peer Wellness, Self-Care, and Burnout Prevention

The hard work of peer integration does not end at onboarding. What happens afterward determines whether the peer stays, thrives, and remains healthy and effective in the role. The risk of burnout and secondary trauma for peers is real. This section focuses on what organizations can do to protect peer wellbeing, prevent burnout, and build the conditions for long-term sustainability.

? KEY QUESTION

What does your organization do to support the peer role beyond the first 90 days?

Peers working in crisis and emergency settings are frontline workers, too. Research on crisis-exposed workers consistently shows that peer support and organizational support structures reduce the risk of post-traumatic stress injuries and that frontline workers are significantly more vulnerable without these supports.[40]

Crisis and emergency settings are high-exposure environments. Peers in these settings encounter acute distress, trauma histories, and behavioral health emergencies on a daily basis. Their lived experience is both their professional asset and a potential source of vulnerability. Research on peer support workers in emergency and high-acuity settings consistently identifies burnout, secondary traumatic stress, and role-related moral distress as significant risks.[41] These risks are not unique to peers, but the nature of peer work (relational, lived-experience-based, and emotionally present) can make peers particularly susceptible. This makes attention to self-care particularly important.

Peer Washington offers regionally focused community spaces specifically for peer specialists to connect with community and support. Their resources include free training, office hours, support groups, and activities. These peer spaces can be a valuable addition to organizational training, especially for peers who work alone and may have fewer opportunities for peer-to-peer support.

LEARN MORE

- **Peer Washington: peer community groups and resources**
- **Washington Peer Network: statewide hub for peer connection and training**
- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Promote self-care, p.128

The Impact of Work Culture on Peer Wellbeing

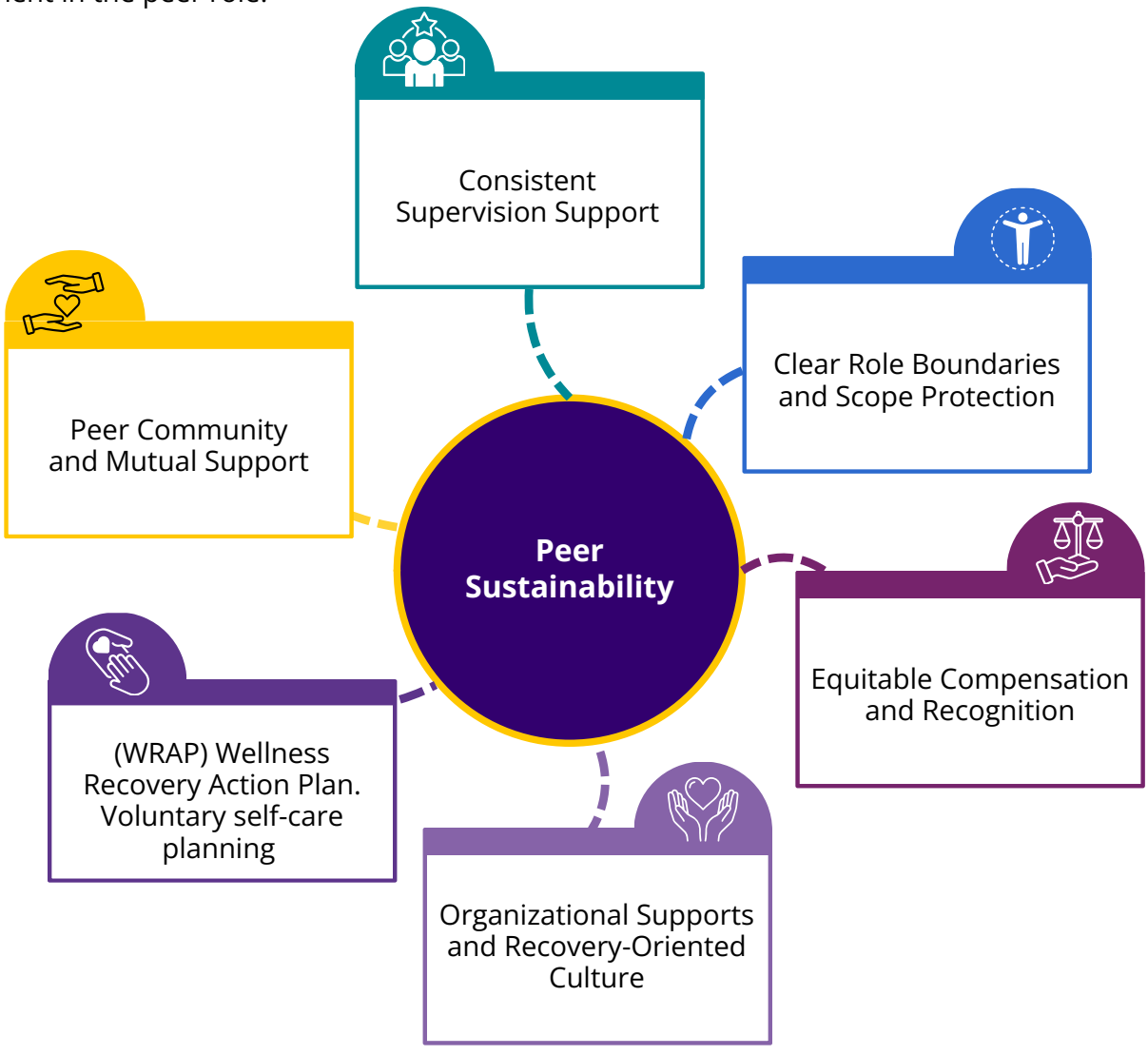
Research on peer integration in clinical settings identifies organizational culture as one of the most consistent barriers to peer role sustainability, alongside role clarity and supervision structure.

Peers working in crisis and emergency settings may encounter language or practices that conflict with recovery-oriented values – for example, diagnostic language used dismissively or assumptions about peers that feel stigmatizing. In interviews with Washington crisis program leaders, they discussed that this kind of repeated exposure creates a distinct form of moral distress that can be harder to name than general burnout and tends to build quietly. As discussed in Section 3, organizational culture is a critical part of maintaining a healthy workplace environment and addressing stigma and misconceptions proactively.

Maintaining clear role boundaries is a peer wellbeing issue in addition to a program integrity issue. When the work culture does not actively protect the peer role, scope drift becomes more likely and the peer bears the cost. For more on scope drift and role boundaries, see Section 5.

Peer Sustainability: Six Dimensions

The six dimensions below reflect peer role sustainability themes that came up consistently across Washington interviews and are supported by the broader literature. Continual opportunities for growth are one of the most meaningful ways organizations can support the long-term success of peers. Consider creating clear career pathways such as moving from Certified Peer Support Specialist Trainees (CPSST) to Certified Peer Support Specialists (CPSS), transitioning into peer supervisor roles, or pursuing apprenticeship and wellbeing specialist models. These are meaningful forms of organizational investment in the peer role.



Organizational Supports and Self-Assessments

Sustained wellness support goes beyond supervision. Beyond structured supervision, voluntary self-care and wellness planning tools can assess and strengthen peer wellbeing and self-awareness.

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Continuing Education and Career Mobility p. 125
  - Recovery Wellness Cafes, p.128
  - Workplace Wellness WRAP, p.86
  - Self-Care Assessment, p.262
  - ProQOL (Professional Quality of Life Scale), p.264

Navigating Peer Fit and Problem Solving

When a peer is struggling, the first question should not be whether to let them go. Supervisors and leaders should ask whether the environment, role structure, and support is setting them up for success. Peers can also contribute meaningfully to identifying both concerns and solutions. Building in regular structured opportunities for peers, supervisors, and team members to surface concerns early and on an ongoing basis is more effective than responding after the fact. Common challenges documented across programs nationally include scope drift, team friction, documentation burden, and unclear referral pathways.

Distinguishing between a peer who needs more support and a peer who is genuinely not suited for the role takes time and requires honest assessment from multiple angles. The peer's own perspective, team input, and program leadership review should be considered. Every person and situation is different. What matters is that the process is structured, transparent, and grounded in care for the peer and the program. For the supervisory role in this process, see Section 7.

QUESTION	WHAT TO LOOK AT	WHO OWNS IT
Is the role clearly defined?	Job description, referral process, team orientation	Program leadership
Is the team culture supportive?	Staff attitudes, language, inclusion in team activities	Clinical leadership
Are there structured opportunities for team dialogue about the peer role?	Team discussions, onboarding, supervision, workflow clarification, and space for staff questions or concerns about peer integration	Clinical leadership and program leadership
Are organizational supports in place?	Employee Assistance Program (EAP) access, wellness check-ins, peer networks	Human Resources (HR) and program leadership
Is the peer able to sustain in the high-acuity environment?	Signs of activation, stress, or burnout; peer self-report; team observations on whether the peer is managing well	Supervisor and team, in collaboration with the peer

LEARN MORE

- **DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)**
  - Addressing staff concerns, p.18
  - Peer staff concerns assessment tool, p.255
  - Collaboratively assess strengths and areas for growth, p.119
  - EAP and benefits navigation, p.62

Washington crisis program leaders emphasize that peers are often the first to identify what is not working and that creating a genuine feedback loop is one of the most practical investments a program can make.

Practical approaches may include:

- Regular structured check-ins that go beyond case review
- A standing agenda item in team meetings for peer role questions
- Brief quarterly program reviews that include the peer's perspective

TIP

When a peer raises a concern about their role or the environment, treat it as program data. Peers have a unique perspective and may notice things about the culture or the experience of people in crisis that the clinical or administrative team do not.

MISCONCEPTION

"If a peer is struggling, it means we hired the wrong person." Struggles in the peer role often reflect environmental factors, such as unclear boundaries, inadequate supervision, or a clinical culture that has not fully integrated the peer role. Visit environmental and systemic factors first.

KEY TAKEAWAYS

- Burnout, secondary traumatic stress, and moral distress are real and documented risks for peers in crisis and emergency settings. Plan for them proactively.
- When a peer is struggling, start by examining the environment, role structure, and support systems before drawing conclusions about fit. Wellness is an organizational responsibility.
- Having more than one peer is strongly recommended. Isolation is one of the most consistent drivers of burnout and turnover.
- Regular supervision, peer community connection, and voluntary wellness planning are key strategies for sustainability and infrastructure.

SECTION NINE

Tribal Context, Considerations, and Resources

Peers working in Tribal crisis and emergency settings

IN THIS SECTION

This information has been developed by the Washington State Health Care Authority (HCA), Office of Tribal Affairs, to provide general guidance and support related to peer crisis services and coordination with Tribal communities. It is intended as a resource only and does not represent the views, policies, or endorsement of any Tribal Nation or Tribal health organization.

The Roots of Peer Support: Peer support has deep roots in Indigenous communities. Tribal leaders formed "Sobriety Circles" as early as 1799, predating modern peer support models by nearly two centuries and drawing on traditions like the Handsome Lake Movement, the Red Road, and the Native American Wellbriety Movement. The peer specialist role is not new to Indian Country. For generations, Native Americans have shared lessons, traditions, and stories to support others through their recovery experience.

LEARN MORE

Southern Plains Tribal Health Board Peer Support Toolkit (2024), p.1-2

Tribal Sovereignty and Tribal Crisis Response in Washington State

Washington is home to 29 federally recognized Tribes, each a sovereign government with inherent authority to govern its people, lands, and healthcare. Each Tribe has cultures, customs, and traditions that are unique. All Tribes are the original possessors of land in Washington and many still hold reservation lands in addition to their ceded lands.

A critical piece to understanding the state-tribal relationship is recognizing Tribal governments, their jurisdictions, and their operations. Every Tribe is different, including their organization, processes, programs, and cultures. The Centennial Accord (1989) and Millennium Agreement (1999) formalized the government-to-government relationship between the state and Tribes. These agreements require state agencies to consult and collaborate with Tribes when developing policies, programs, or legislation that may impact Tribal communities or rights.

Tribal Nations in Washington have long demonstrated resilience and leadership in responding to emergencies that impact their communities and land. Effective crisis response requires coordination among Tribal and local governments, state agencies, and federal partners to ensure that culturally informed and locally driven solutions guide action. By centering Tribal sovereignty and traditional knowledge, Washington can build a more effective system for addressing all kinds of crises.

TIP

If you have experience working with one Tribe, your knowledge may not be applicable to other Tribes. When engaging with Tribal communities, connect with the relevant Tribe or Indian Health Care Provider (IHCP) early and maintain communication throughout to ensure effective care coordination and continuity of support.

MISCONCEPTION

"State and county crisis frameworks apply in Tribal settings." Tribal nations are sovereign governments with their own crisis systems, governance structures, and timelines. State and county frameworks do not automatically apply. Always verify directly with the relevant Tribe before assuming any state process applies.

Tribal Crisis Services

Tribes are taking a lead in expanding and formalizing their crisis response services within their communities. In partnership with the American Indian Health Commission (AIHC), the State, and other Tribal partners, many priorities that support American Indian and Alaska Native (AI/AN) equitable access to timely and life-saving crisis response services have been realized across the crisis continuum. Through House Bill 1877, Senate Bill 6251, and Senate Bill 6259, there are currently a number of crisis services available and on the horizon to support Tribal communities in Washington.

> **VOICES FROM WASHINGTON**
>
> ***Tribes in Washington State are standing up their own mobile crisis teams and designated crisis responders. Lummi has established Secure Withdrawal Management services. Jamestown S'Klallam is opening an Evaluation and Treatment facility. Lummi and Tulalip Tribes have peers working on mobile crisis teams. The Washington State Tribal Opioid and Fentanyl Task Force has identified expanding peer support in emergency departments as a priority.***
>
> Peer Administrator / Leader

TIP

Recovery for American Indian populations often includes the entire community or family, not just the individual. Peer support in Tribal settings should reflect this. Participation in cultural activities, traditional practices, and spiritual connection are recognized protective factors that support long-term recovery. *Southern Plains Tribal Health Board Peer Support Toolkit (2024)*

Tribal Crisis Coordination Protocols

Tribal Crisis Coordination Protocols are community-specific procedures outlined by individual Tribes to guide how non-Tribal crisis responders, providers, and agencies work with Tribal authorities, members, and IHCPs to deliver crisis services on Tribal lands. These protocols ensure culturally sensitive, effective, and coordinated care while respecting Tribal sovereignty.

Tribes are at different stages in developing protocols. Some have them in place, others are in the process of implementation or planning, while some Tribes have no plans to move forward. Tribes work on a different timeline than the state.

TIP

When a Tribe does not have a Tribal Crisis Coordination Protocol in place, best practices for engaging with AI/AN individuals in crisis include ensuring culturally appropriate responses and coordinating with Tribal governments, IHCPs, and Tribal health service entities.

LEARN MORE

- Navigating a Crisis without a Tribal Crisis Protocol in Place

Conducting Culturally Appropriate DCR Investigations

The guidance for conducting culturally appropriate Designated Crisis Responder (DCR) investigations was developed to supplement the Washington HCA protocols for DCRs to support the work of Tribal Nations, AI/AN-serving organizations, DCR staff, and community partners. DCRs are trained crisis professionals designated to conduct involuntary treatment investigations when someone is in a serious behavioral health crisis. The intent of this guidance is to provide skills and context to DCRs serving Tribal Nations, AI/AN people, and Tribal-serving organizations in Washington.

This guidance addresses AI/AN cultural and trauma-informed care considerations in the DCR evaluation and investigation process. The protocol is about far more than just collecting enough information to inform the evaluation and investigation. It's about ensuring the evaluation/investigation process itself is respectful, ethical, and beneficial to Tribal communities and their citizens. This guidance is currently being developed.

Tribal Designated Crisis Responders

As Tribes have the sovereign authority and jurisdiction to address the need for involuntary treatment for their Tribal and community members, initiatives to support DCR implementation and recognition by the state crisis system are needed.

Tribal DCRs, as part of the Washington Indian Behavioral Health Act of 2020, created a pathway for Tribal DCRs to be designated by the State operating in state superior court, along with their Tribal designation. Since Tribes are rooted in their community, Tribal DCRs provide care that is culturally responsive, respectful, and timely. Tribes decide how and when their DCRs serve – whether only within their community or more broadly.

Tribal DCRs can be appointed by the Tribe, the state, or both. Tribal DCRs have the same duties as county and regional DCRs. The Health Care Authority (HCA) works alongside Tribes to ensure the DCR process respects and upholds Tribal sovereignty, self-determination, and health equity – recognizing that Tribes have the authority and expertise to guide crisis response efforts to care for their own people.

LEARN MORE

- **Review the Tribal DCR FAQs or contact HCA's Regional Tribal Liaison**
- For all other Tribal Affairs inquiries, contact the HCA Office of Tribal Affairs at **HCADLTribalAffairs@hca.wa.gov** or visit **WA HCA: Tribal Affairs**.

Resources

The following resources have been identified by the HCA Office of Tribal Affairs.

Crisis Services

- House Bill 1877 Patient Privacy Document
- Implementation of House Bill 1877 in facilities
- Washington State Department of Social and Health Services, Services for American Indians and Alaska Natives
- Volunteers of America 988 Tribal Services
- Washington State Department of Social and Health Services: Services for American Indians and Alaska Natives | DSHS
- Mother Nation **-** A non-profit organization that delivers social and cultural healing services, mobilize and help search for MIPs and support their families.

Educational

- Diversity Goals for Evaluation and Treatment of American Indians and Alaska Natives by B. Jabbari National Institutes of Health (NIH)
- Emerging Tribal Models for the Civil Commitment of American Indians by Spero M. Manson Et al. American Indian and Alaska Native Mental Health Research Centers for American Indian and Alaska Native Health Colorado School of Public Health/University of Colorado Anschutz Medical Campus.
- Indian Health Manual, Chapter 14 – Mental Health Program, Part 3 – The Indian Health Manual (IHM) is the reference for IHS employees regarding IHS-specific policy and procedural instructions.
- In Search of Cultural Competence in Evaluation Chapter 3: Culturally Competent Evaluation in Indian Country by Joan LaFrance
- Steps for Conducting Research and Evaluation in Native Communities NACE, Native American Center for Excellence, Substance Abuse Prevention

To learn more about overdose response and recovery resources available to Tribal communities in Washington:

- For Our Lives
- WA Tribal Opioid Resource Exchange
- WA State Tribal Opioid & Fentanyl Task Force
- The American Indian Health Commission | AIHC
- Northwest Portland Area Indian Health Board
- Native & Strong Lifeline: **Dial 988 and press 4**
- Native Resource Hub: nativehub.org or call 866-491-1683 Monday through Friday, 8 a.m. to 5 p.m. If after hours, call 866-789-1511 or visit the Washington Recovery Help Line: warecoveryhelpline.org.

Additional Resources for Tribal Settings:

- Rural Recovery Fact Sheet SAMHSA (2024)
- Tribal Behavioral Health Agenda SAMHSA
- Rural Peer Recovery Support Services Program Development and Implementation Considerations (2024)
- HCA Tribal Health Billing Guide
- HCA Tribal Billing Overview (Video)

REFERENCES

Frequently Cited Resources

- Crisis Awareness and Communication in Peer Support (CACPS) Student Manual (WA HCA, 2023)
- Behavioral Health and Crisis Response Systems in Washington (Prevention Alliance, 2022)
- SAMHSA Peer Support Services Across the Crisis Continuum (2024)
- SAMHSA National Guidelines for a Behavioral Health Coordinated System of Crisis Care (2025)
- SAMHSA Advisory: Peer Support Services in Crisis Care (2022)
- DBHIDS Peer Support Toolkit (Philadelphia Department of Behavioral Health, 2012)
- Peer Support Workers in the ED (University of New Mexico, 2019)

National Frameworks

- SAMHSA: National Guidelines for Behavioral Health Crisis Care (2025)
- SAMHSA: Advisory: Peer Support Services in Crisis Care (2022)
- SAMHSA: Peer Support Services Across the Crisis Continuum (2024)
- Bazelon Center: When There's a Crisis, Call a Peer (2024)

About This Toolkit

[1] SAMHSA. (2012). Working Definition of Recovery.

Section 2: Background and Foundational Context

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Section 3: Preparing Your Organization

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Section 4: Sustaining the Peer Role

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FIGURE, TABLE, CASE STUDY SOURCES

The Crisis Care Continuum

Sources: SAMHSA. (2025). National Guidelines for Behavioral Health Crisis Care. Washington State Health Care Authority. BH-ASO County Map.

Misconception vs. Reality table:

Sources: Peer Support Specialists' Experiences of Microaggressions (PMC, 2019); Benigno, B. (2023). Stigma Toward Peer Specialists on Inpatient Units. Psychiatric Services.

Building Your Referral Process: Five Questions to Answer:

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Training Topics table:

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Case Study: Peer Integration in New Mexico Emergency Departments

Source: Earheart, A.S., & Crisanti, A.S. (2019). Peer Support Workers in the Emergency Department: A Report, University of New Mexico.

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