Transcript: The Peer Support Role in Integrated Behavioral Health

December 3, 2025

Webinar support: Welcome to the Mental Health/Substance Use Disorder Integration Technical Assistance webinar, *The Peer Support Role in Integrated Behavioral Health*. Please note our disclosure. This event was produced for the Health Resources and Services Administration, Bureau of Primary Health Care. Participants have entered in a listen-only mode. Submit questions by using the question and answer feature. To open the Q&A (question and answer), click the Q&A icon at the bottom of your Zoom window.

Questions can be submitted to the presenter and technical assistance support staff. You are welcome to submit questions at any time. We offer behavioral health continuing education units for participation in BHSUD (Behavioral Health Substance Use Disorder) integration technical assistance events. If you experience any technical issues during the event, please message us through the chat feature. This event is being recorded. The slides, recording, and transcript will be available on the TA (technical assistance) portal following this webinar.

We're excited to share that we have more continuing education opportunities coming for you. We'll add links to these events in the chat so you can take a closer look. I am pleased to introduce you to today's presenters. Brooke Nipper has 25 years of experience delivering mental health and substance use disorder services. Over the course of her tenure, Brooke has experience in case management, individual and group therapy, family therapy, and has worked in both outpatient and residential services. Brooke joined Grace Health as Director of Behavioral Health in 2022.

Maranda Portwood has provided peer support services at Grace Health since 2023. She partners with individuals to set goals, navigate resources, and build recovery-focused skills with a special focus on compassionate addiction care. She has supported clients within community health centers, drug court programs, and mental health settings. It is now my pleasure to turn the webinar over to Brooke and Maranda. Brooke, please go ahead.

Webinar support: Brooke, over to you.

Brooke Nipper: I'm sorry. I had a little bit of technical difficulty there.

Webinar support: No worries. We can hear you.

Brooke Nipper: We'll start with the agenda. Just covering the background and the foundation of peer support and getting started. We're going to work on defining and structuring the peer support role. We'll talk a little bit about recruitment, onboarding, and training, and how we set up the peer supports for success. At the end, we will close with some lessons that we've learned since we've implemented the peer support process.

For objectives, by the end of the day, you should be able to describe the essential skills and abilities of peer support specialist and identify ways to structure peer

support specialist onboarding, supervision, and feedback so they are successful in their health center roles. Next slide, please. We're going to begin today with the polling question. If you all just take a minute to answer the poll. We'll give you just a little bit to complete that. Then we'll come back to it.

Brooke Nipper: Looks like we have got quite a bit responses back. Are we ready, Kayla, to go forward?

Webinar support: Yes. We have now closed the poll, and you should see the percentages on your screen.

Brooke Nipper: Awesome. Thank you. It says most people have integrated peer support specialists into their mental health and substance use disorder care team. About 58%, and then about 13% are at a no. Then we have about 27% that are considering adding this role to our integrated care team. Then some in the other. We are very excited to be able to go over how we've done things and how we've implemented this today. Hopefully, you all can take that and use that for your own programming. Next slide.

Maranda Portwood: Can you hear me good? I'm Maranda Portwood. I'm a peer support specialist with Grace Health. My focus on the part of this training will be what is peer support, what does it look like at Grace Health, and how we set our standards. The value of peer support in integrated behavioral health. Peer support plays a growing role in helping people find recovery in the community. Peer support workers offer and receive help based on shared understanding, respect, and mutual empowerment between people in similar situations.

Our duties include to advocate and raise awareness for people with mental health and substance use disorders, link to community resources, facilitate, mentor, and educate. Plan to develop groups, services, and activities. Next slide, please. The peer support role at Grace Health. Peer support specialists reference their own recovery journey to inspire hope and recovery. Peer support do warm handoffs to and from other providers as members of the patient's care team.

Unique distinction from other roles. "I understand what's going on with you. It happened to me, and this is what I did about it," which is a common thing with peer support. If you've known or ever worked with peer support, you're going to hear that statement a lot, and that's a lot of what we do here. Next slide, please. Continuing with what peer support looks like at Grace Health. We collaborate across behavioral health, primary care, and community settings. Links to recovery community, partners with other recovery-oriented organizations to promote recovery services. Facilitate peer support groups with patients on numerous topics related to maintaining recovery.

A lot of the focus that we do, we're separated from the therapist, from the primary care provider. A lot of what we focus on is just how do we help this patient? How do we use our recovery, our experience, our background to build that trust with them to be able to help them get to the other services they need? We do a lot of linkage to our local community resources. Myself and the other peer support with our team and our director sometimes, we go out to all of the community events that we get invited to.

We want to know what services do you provide? What do you actually do? How could that benefit our patients? We bring that information back, and we make sure that our patients are well aware of what the community offers and how it could help them. Then, after that, we basically take a day. A lot of our groups are focused on some days, especially once a month, to how can we go to these events? How can we get these patients to these events, whether it's our tech, community services that would take them there? Next slide, please.

Substance Abuse and Mental Health Services, SAMHSA, Core Competencies for Peer Support. We really go off this guide. We want to make sure that we are fulfilling what's asked of us and what's expected of us as peer support. Engages peers in collaborative and caring relationships. Provides support. Shares their recovery journey. Personalizes peer support. Supports recovery planning. Links to resources, help, and support. Shares information about health, wellness, and recovery. Help peers to manage crises, values communication, supports collaboration, teamwork, and network building. Promotes leadership. Models growth and development.

A lot of these we do on a day-to-day basis. We really focus on providing support. That's the main thing when they first come into our clinic. The first thing that they need, they need to know that somebody cares, somebody's there to be on their side. It's not just a, "Hey, go here and do this." We're going to walk with them. We're going to stay with them. Most of the time, when we get that referral in, we're the first face that they see. We're the first face that either they trust or don't trust. Once that happens, then we're able to do that warm handoff too. "This is the provider you're going to be seeing today. This is the therapist that you're going to be seeing today."

Any other issues that they have going on, we walk with them with that. We do a lot of recovery planning with them, especially in our groups. We want them to know where you're at in your recovery. How can we gain from that? How do we start planning goals? We want them to accomplish things. This is not just about, "Hey, I'm abstinent from these drugs and this alcohol." I want them to know you're capable of so much more than just being without drugs and alcohol. What does your life look like without it? It really motivates them to want to do it for themselves when you show encouragement to them.

We value communication. We meet as team members. We meet as a team. No decision is made with their participants in the program, to just one of us say, "Hey, this is what's going to happen." We talk as a team. What's going to benefit them better? What's going to help them? It's not a one-size-fits-all. I would assume in anybody else's facilities, it's not a one-size-fits-all. We really take that serious. What helps one may not help another. We want to get to know them personally enough to know what's going to work for them.

We do manage process on a peer support level. Of course, we stay in our lane. We stay with what we know and what we can do. We are trained in a lot of crisis situations to where to do that handoff. Who do we hand it off to? What situation is going to have us contact the therapist? We're doing a lot of wellness and recovery. Like I said, it's not just about what we do here. We give them a lot of access of where they can go. Self-help meetings outside our facility.

There's a lot of community support that we have here in our town. We encourage them to attend these events to make friends in recovery outside of just what we provide here. This is a lifestyle, not just at your appointment. We want to encourage that. Basically, for me and Grace Health, we use our recovery stories to do that. We've used our recovery stories to let them know what can be done, what can be accomplished. We tell them, "Hey, this is what I did. This is how I did it." That doesn't mean it's going to always work that same way with you, but we do a lot of encouragement, a lot of just personal experience with them, just personal, "Hey, this is what you can do. You can accomplish this."

In a clinical setting, it does get a little bit hectic because there is so many moving parts here. They make sure that when we come in, we know what this works. What does the therapist say? What's everybody's role? We just obviously stay in our lane, but we're well aware of what's the services provided? We make that aware of them. Thank you.

Brooke Nipper: We're ready for the next slide. Recruitment, onboarding, and training. Really, we focus on the recovery journey and recovery maturity. We look for people that are stable in the recovery that we feel like are definitely able to take on that role and do it well. For onboarding, we start with HIPAA (Health Insurance Portability and Accountability Act). We go over the guidelines of HIPAA. We go over all of our SARs (Substance Abuse Recovery) documentation.

Here at Grace, we do call it substance abuse recovery programming. We do have so many pieces to that as far as the documentation, consents, treatment interventions, different change of treatment forms, various things that we have that flows through our program. We do go over that with them, as well as the electronic health record, which is our EPIC, which we went to about a year and a half ago. We really try to onboard them successfully in all those areas, as well as shadowing. We try to make sure that the peer support gets plenty of time with the coordinator, but also other team members, learning their roles and learning workflows that go on day to day.

Next. More training that we do is more around our screening tools. We do have previously done the GPRA (Government Performance and Results Act), which is associated with our core grant. They no longer are using that tool. We have now went to the Assessment of Recovery Capital, which is also known as the ARC. That is our first assessment piece. We have already been doing the Brief Assessment of Recovery Capital, which is the BARC-10, for quite some time. We are going to implement the ARC, have started using that, and we'll be implementing that as their assessment tool with the BARC as follow-up.

Motivational interviewing, we try to teach that as far as listening, clarification, all the skills for motivational interviewing. SAMHSA and other evidence-based trainings. As part of their performance scorecard, we do ask that they attend one behavioral health or SUD (substance use disorder) training that's evidence-based or SAMHSA-related that is per quarter. Then we also have a new hire onboarding training that does not just include peer support but includes all new hires that covers boundaries, de-escalation, crisis intervention, and an overview of cognitive behavioral therapy. When I say overview, I don't mean that we're going out of scope and teaching cognitive behavioral therapy, but just giving a glimpse of what that looks like.

Setting up the peer support for success. Most of our grant-related positions ask for state-certified peer support specialists, but we also look for that as an organization. We do look for the certified peer supports. We also vet pretty rigorously. We are often interviewing one to three times. Usually, Maranda's been here for a while. We recently hired a peer support about six months ago. In that process, she and the coordinator did the first interview. I came in on the second interview. We had been known before to go to three interviews if we have two candidates that are pretty close in contention to get the job.

For experience, we do ask for a minimum of one to two years sober. For me personally, just my motto, it feels like two years or more is probably the ticket. Just because that first year is such a transitional period for someone early in recovery. We do try to go two years or more, but not to say we wouldn't hire somebody that had one year sober if they were available candidate.

I have been known to say in interviews to candidates that I feel like they are a good candidate, but they may not be ready for this level. We do have a large program and a large organization. I have told them in the past, you might be a better benefit at a smaller or lower volume setting just because they are so early in recovery and new to that role. Supervision, we do quarterly one-on-ones. We do frequent check-ins. The coordinator does one-on-ones once a quarter. Then we also do frequent check-ins with our staff. We're present quite often and just checking in to see how they're doing.

Not just the coordinator and myself, but also other therapists that are working in the building, other physicians. They're the physicians that work in our addiction treatment programs, but physicians just generally in the clinic. They're checking in and seeing how they're doing and providing that oversight too. Next slide. At Peer Support, it's like Maranda talked about a little bit ago. We really do emphasize peer supports being involved in our treatment teams. In our case reviews, we have a multidisciplinary treatment team that meets once a month at both of our two SAR locations. We're getting ready to actually have to go to biweekly, because we are increasing in our numbers.

We want that peer support to be able to feel like they can speak freely. We feel like that the peer support often has the most beneficial feedback when we're treatment planning. Leadership also maintains regular feedback and mentorship. I feel like that's important to be able to mentor them, but also to give them feedback on, "Hey, what you're doing good. Hey, what you're not doing so great. What can we improve upon?"

Guidance and transparency to me is key to supervising the peer support specialists. Giving them that guidance, walking them through, helping them learn some of those skills in the professional environment. Then also being very transparent, being very honest, and being able to share with them, even though it may not always be comfortable, but necessary for their improvement and growth.

Continuous quality improvement and data collection. We, of course, have CQI, which is our continuous quality improvement reports. For that, we previously used the GRPA. They were moving away from that, as I said, and using the ARC and the BARC-10. We also used the case management assessments. Those will target a lot

of our substance abuse recovery metrics that we've developed, as well as just general metrics.

Lessons learned. This is probably my favorite slide. Hiring with discernment is so important. I just feel like with the position, you have to focus on the recovery stability, where they are at in the recovery, and not just their past legal charges. I think sometimes organizations get tripped up with that, and this is the only position here that can be hired that has a legal charge. I think it's also important to understand the context. Sometimes people may not have drug-related charges on their record, but they may have a theft or assault, but that may be stemmed from when they were active in drug use.

Just not looking at just the whole picture, and just really trying to use your best judgment and your discernment when working with peer support and interviewing peer support. Active observation, leadership, and teams observe and provide feedback. Again, we really just try to observe how things are going, provide feedback when needed. Increased validation. We want to recognize and celebrate that peer support's impact on our patients. We want to celebrate them and really give them the props when we need to give them the props to.

We increase check-ins. Frequent one-on-ones are vital. Just even a text here and there. Say, just, "I appreciate you. I hope you're doing okay. Is there anything that you need from me?" Those kinds of things. Most importantly is servant leadership. I'm a firm believer in servant leadership. When I am going to hire peer supports, and I'm working with peer supports, I want to say, "How can this person best serve people with substance use disorder? How do I think they're going to fit in our program? How can they best serve our people?" Also, I want to know how I can be a servant leader to my peer support. How can I help you achieve success?

Lisa Jacobs: We have reached the point where we're starting Q&A. I invite everyone to submit your questions through the Q&A feature on Zoom if you haven't already. We do have a question for Brooke and Maranda, which is actually open to everybody, really. Is there an academic center focused on peer support specialist research? Now, I don't know. Brooke and Maranda, have you done any outreach to academic centers for your peer support program at Grace Health?

Brooke Nipper: No, we have not. I'm not sure that there is any as far as an academic center, but that's a great question. We've not been able to coordinate that, Maranda, as far as that goes. We do try to look at the data as far as how peer supports have been successful in other organizations.

Lisa Jacobs: Laurel goes on to ask if peer support specialists are co-facilitating group medical visits in addition to group counseling and/or group psychotherapy in the context of said recovery. Is that something that, Maranda, you're doing at Grace?

Maranda Portwood: We do that on a very limited basis. If the provider is speaking with somebody and has somebody in there that they feel could benefit from peer support, we will come in and co-facilitate and meet together, but we don't cross our other boundary. We don't go over to the primary care part of it. Me and our therapist here, we do co-facilitate some groups. We do those together, but it would be a group where peer support is, you know what I mean? It's not clinical group as much. It

would be focused on things that peer support would be involved in. We're always there to give our opinion or say, "Hey, maybe this would work," but never really to take over any part of it, crossing what peer support's capable of doing.

Lisa Jacobs: Thanks, Brooke. Thanks, Maranda. Are there other questions that people would like to ask? We do have some-- [crosstalk]

Brooke Nipper: I do see some in the Q&A, Lisa.

Lisa Jacobs: We have another one. "How do you get your providers to take peer support seriously?"

Maranda Portwood: With me, that one's tricky. The main thing we have to do, and in other settings, being a peer support, we're not clinical. We don't have the big degrees. We're in a facility, and we're in a business at this point, just from my experience alone. We have to really provide that. We really have to show out with that, but we have to do it in a professional way. In order to get that provider to take us seriously, we have to speak on facts and experience and not cross over into anything else. Anytime that I've done that, in outpatient offices with just outpatient offices and in the clinic, it's stuck to that, only come with facts and only come with what we know about, and we can share on and leave it to that.

I think sometimes when we try to be more than we are, or when we talk on more than we're experienced in, I think that's when some of the issues come, and they don't want to take you seriously. I've not personally had that issue. By doing what I'm doing was just sticking to the facts and what I know, and leave what I don't know to them.

Brooke Nipper: Just to chime in briefly, I do feel like that is a hard thing because they are a command organization, but really just teaching that professionalism, providing that guidance, that transparency as leaders to them, but also they will show it in their time that they can be trusted and depended on, and just their overall skillset shines through.

Lisa Jacobs: Wonderful. Thank you both. Now, related to that question, Hannah has a question about Grace Health having perinatal peer support specialists.

Brooke Nipper: Yes, we do have that. That's actually how we started. We started with the core grant, but we started with just in the perinatal, in the mother's maternal, and the women's care unit. That's how we started at Grace, and we've still maintained that. We still work with that population and have been doing that for a while.

Lisa Jacobs: Wonderful. Now Leah asks, how do you ensure that charges on someone's record don't deter them from becoming a peer, and do you offer to help certify peers?

Brooke Nipper: As far as the charges being that don't deter them, probation and parole sometimes is a trickier one. If they are on probation and parole, we do have to look at that and take that a little bit more - discuss it more with HR (human resources), go over some things, and see where we can go from there. We don't let

that deter us if that's something that someone has on their record. The second part of that question. I'm not sure. Let me see.

Lisa Jacobs: Do you offer to help certify peers?

Brooke Nipper: We do not. Usually, when they come in, they are already certified.

Lisa Jacobs: Just moving along quickly, I know we're getting close to the end. We have time for one more question. How do you define the difference between case management and peer support?

Maranda Portwood: That's a good question. What we focus on here, the case managers focus on a lot of the community, the outreach, the services they can provide. Our case managers here, unless they are dual certified and peer support as well, they don't talk about anything recovery-wise. They wouldn't be involved in any of that. The peer support would lead with anything recovery, "How's your recovery going? Are you struggling with cravings?" Versus the case manager, what needs are we, and do you have enough food, do you have enough clothes, do you have enough stuff for winter, that kind of thing.

It is very different. We work together with both, but it is very different here, two different roles completely. We tend not to blur those as much as possible, not to confuse the patients. Case managers, unless they're dually certified, they will not talk on recovery.

Lisa Jacobs: Thanks, Maranda. Apologies to those that we didn't get to, but we're going to have to close things out. Let's take it home, Kayla.

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Thank you for your attendance. We invite you to stay in touch with HRSA BPHC by subscribing to e-newsletters and following HRSA on social media. This concludes today's webinar. You may now disconnect.