POLICY BRIEF

Behavioral Health Paraprofessional Accreditation Standards

Project Team

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Background

Mental health needs have been steadily increasing in the United States, particularly since the onset of the COVID-19 pandemic; however, many adults are not receiving mental health treatment services.[1,2] There are many barriers to receiving mental health treatment, including a shortage of behavioral health providers.[1,3] Paraprofessionals can help meet the increasing need for mental health services by providing access to cost-effective behavioral health services.[4-7] Substance use disorder (SUD) counselors, peer recovery specialists (PRS), and community health workers (CHW) each have unique roles in the behavioral health care system and have different qualifications. However, licensure and certification requirements for these paraprofessionals vary greatly by state, which limits the care they can provide. This study aims to describe the variation in paraprofessional accreditation standards by state and to analyze whether states follow national models, their own models, or a mixture of both.

Methods

To identify the requirements to become a credentialed SUD counselor in a support role, PRS, and CHW in each state, researchers accessed the Behavioral Health Workforce Research Center's scope of practice (SOP) database. An environmental scan was conducted to identify national credentialing models for these three professions. The environmental scan revealed only two national organizations for SUD counselors and PRS: the International Certification & Reciprocity Consortium (IC&RC) and National Association for Alcoholism and Drug Abuse Counselors, the Association for Addiction Professionals (NAADAC). Credentials were then categorized by whether their requirements most closely followed a national model, a state model, or both.

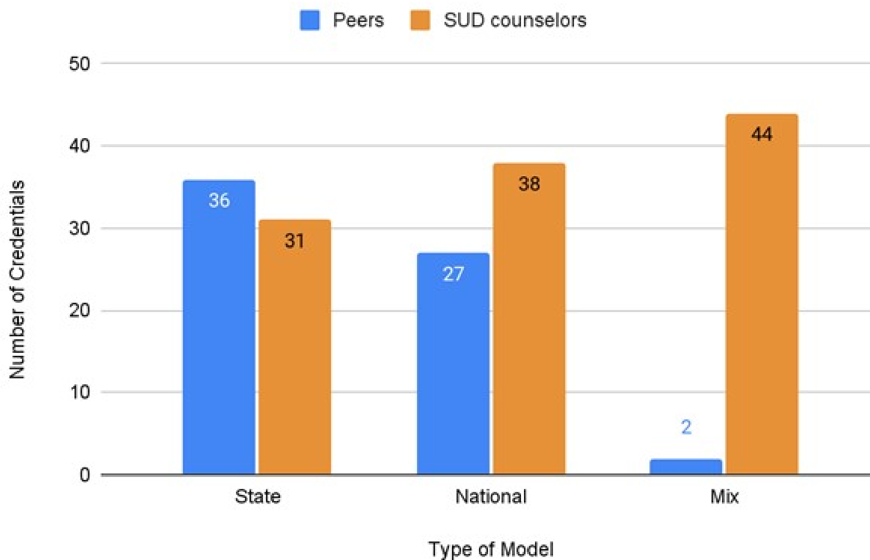
Results

A total of 113 SUD counselor paraprofessional credentials, 65 PRS credentials, and 43 CHW credentials were identified. CHWs do not have a national credentialing model to follow, so all of these credentials followed state-specific requirements. As for SUD counselors, the majority of credentials followed a mixture of both state and national credential standards, while PRSs were more likely to follow state-specific models (Figure 1). Of SUD counselors and PRS credentials that followed a national model, IC&RC was the prevailing model type over the NAADAC model.

Discussion

Across all of the SUD counselor, PRS, and CHW credentials, most followed a state-based model despite the existence of national credentialing models for some. This has led to inconsistencies in

Figure 1. Number of Substance Use Disorder (SUD) Counselor and Peer Recovery Specialist (PRS) Credentials per Model Type



qualifications and scopes of practice among these professions and, consequently, makes it difficult to determine whether the behavioral health workforce is working at their full capacity and meeting mental health needs.[8,9] It is not completely clear why states choose to use their own credentialing models rather than nationally established models for SUD counselors and PRSs. Future research should explore the motivating factors that lead states to follow a national model for their paraprofessional credentials.

Among SUD counselor and PRS credentials that utilize a national model, most tend to follow IC&RC models. This may be because the IC&RC credentials have been recognized for a longer period of time than the NAADAC credentials.[10,11] Currently, there is no national model for CHWs to follow; a lack of national standards for CHWs may exist because community health work is a newer profession with greater variability between individual credentials based on the community in which the CHW serves.[12,13]

To ensure a more competent and uniform paraprofessional workforce, future policies should work toward standardizing a core set of evidence-based paraprofessional credential requirements and scopes of practice. Additionally, a national organization for CHWs should be established to help implement a nationally recognized standard of care, promote reciprocity of credentials across states, and support the CHW workforce. Finally, the establishment of centralized state-level training and technical assistance centers for paraprofessionals could help eliminate ambiguity in credentialing requirements and support these providers as work is being made toward standardizing their credential requirements and scopes of practice.

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