Behavioral Health Paraprofessional Accreditation Standards

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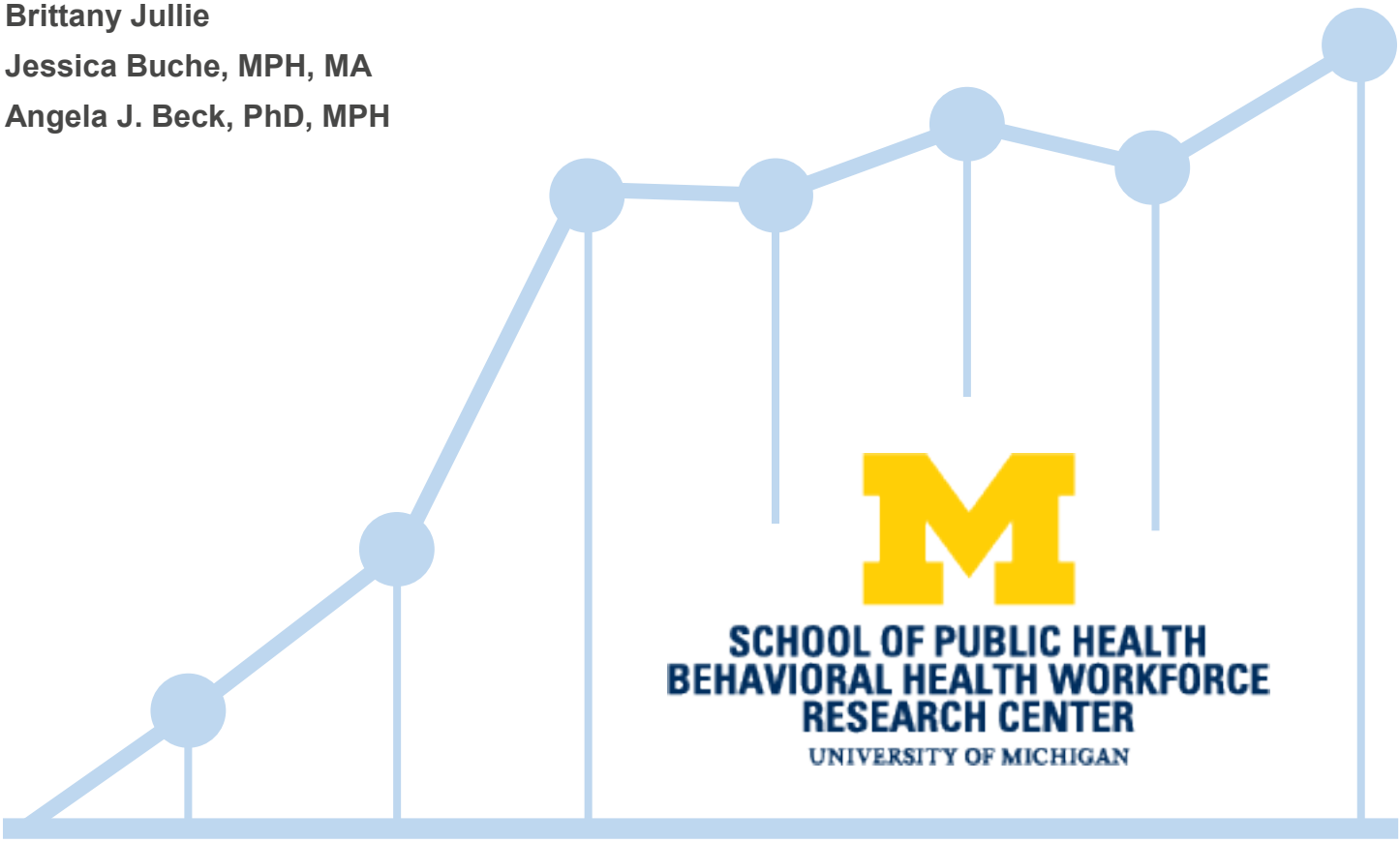

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Key Findings

Mental health needs have been increasing in the United States since the onset of the COVID-19 pandemic; yet many of those in need of care are not receiving the services they need. A complex, interconnected web of factors influence an individual's ability to receive behavioral health services. A shortage of behavioral health providers is one such barrier. Paraprofessionals have the opportunity to help fill these gaps in care, but the lack of national standardization in the credentialing of these providers makes it unclear how they are trained and credentialed across states. This study identified whether substance use disorder counselors, peer recovery specialists or peer providers, and community health workers followed a national accreditation model, a state-specific model, or a mixture of both model types. Results indicate that the prevailing model used by paraprofessionals was a state-based approach followed by a mixed-model approach. However, community health workers must use a state-based model because they lack a national accrediting body that offers a credential. The variation in credentialing guidelines across states has resulted in a paraprofessional workforce that has a diverse set of credentials, training requirements, and scopes of practice. Policy considerations to overcome the lack of uniformity among paraprofessional credentials include the following: (1) standardizing evidence-based minimum paraprofessional credential requirements and scopes of practice, (2) creating a nationally recognized organization for community health workers, and (3) establishing centralized, state-level training, information dissemination, and technical assistance centers for paraprofessionals.

Background

According to the 2019 National Survey on Drug Use and Health, nearly 8% of adults had a substance use disorder (SUD) and approximately 20% had any mental illness in the past year.[1] Further, mental health needs in the country have been drastically increasing during the COVID-19 pandemic, with nearly an additional 80 million adults reporting anxiety and depressive symptoms in 2020.[2] Only 45% of adults with any mental illness and 66% of those with serious mental illness received treatment in 2019.[3] These increasing levels of unmet behavioral health needs are due to a multitude of factors, including but not limited to fear of contracting the virus, the cost of care, a perceived lack of need, lack of access to care, and stigma.[2,4] One of these barriers to care that has become an increasing problem is the shortage of behavioral health care providers in the United States (U.S.).

The Health Resources and Services Administration (HRSA) projects nationwide shortages of adult psychiatrists and addiction counselors in the U.S. by 2030, with some states also experiencing shortages of other behavioral health providers, such as clinical psychologists.[5] The utilization of paraprofessionals, such as SUD counselors, peer recovery specialists (PRS), and community health workers (CHW), can supplement this shortage of behavioral health providers. These professionals are uniquely situated to help increase access to care by limiting treatment barriers and providing cost-effective, quality behavioral health services.[6-9]

Although SUD counselors, PRSs, and CHWs can help address behavioral health provider shortages, each paraprofessional has different qualifications and roles in the behavioral health care system. In 2017, an estimated 91,340 SUD counselors were practicing in the U.S.[5] SUD counselors provide counseling services and support to individuals with SUDs and their families. The SUD counselor credential varies by state and can include licensed clinicians with graduate degrees who practice independently and SUD counselors who work in support roles.[10] SUD counselors working in a support role are usually required to have a high school diploma, the completion of SUD-related education, and two to three years of practical experience in order to obtain a certification.[10,11]

PRSs are individuals who have lived experiences with behavioral health conditions and provide support services, often as a recovery mentor or coach, to assist clients through the recovery process.[12,13] Not all states offer a PRS credential, and their roles and scopes of practice (SOP) in the behavioral health workplace vary across the country.[10] Typically, PRSs are required to have a high school diploma, attest to

being in recovery, and must complete additional educational contact hours.[14] PRSs are often categorized as a subset of CHWs or are not included in national datasets used to enumerate the workforce, so the number of peer providers nationally is unclear.[15]

As of May 2020, the U.S. Bureau of Labor Statistics estimates that a total of 58,670 CHWs are practicing in the U.S.[15] However, this is likely an overestimate because it includes peer providers in the total count.[14] CHWs are community-oriented public health workers who work in underserved communities to decrease health disparities and serve as a link between health services and the community they serve.[16] These providers work in various settings in their community to provide health education, ensure access to health care services, and improve communication between community members and health care providers.[17] Training requirements vary greatly based on the location of practice, but CHWs are generally required to have a high school diploma and additional education and training hours.[18]

The licensure and certification requirements for these three professions vary widely from state to state, with some states not offering a recognized credential.[10] Without a national accreditation standard, providers can take different pathways to earn their credentials. Consequently, credentialed providers in one location may have the authority to deliver behavioral health services a provider in another location may not provide.[20,21] These differing SOPs and lack of uniform training standards for SUD counselors, PRSs, and CHWs makes it difficult to have reciprocal credentials across states and serves as a barrier to understanding these providers' capacity to meet behavioral health demands.

The purpose of this study is to describe the variation in behavioral health paraprofessional accreditation standards by state and to analyze whether states follow national models, their own models, or a mixture of both. This study also examines the required number of training hours to earn a paraprofessional credential under each model type. Based on these findings, policy considerations to improve paraprofessional credentialing pathways and to enhance the capacity of paraprofessionals to provide quality behavioral health care will be discussed.

Methods

This study used data from the Behavioral Health Workforce Research Center's SOP database. Originally created in 2016 and annually updated, the SOP database contains certification and licensure data collected from publicly available state statutes and administrative rules for behavioral health providers in all 50 states and the District of Columbia.[10] A subset of this dataset was collected to assess state accreditation standards for SUD counselor, PRS, and CHW credentials.

If a paraprofessional credential was not found within the SOP database, or there was insufficient detail, researchers supplemented this information by identifying state certification boards and professional organizations for that credential. Once the credential was identified for each state, researchers extracted data on the credential title; number of required education, practice, and supervised practice hours; exam type; and the domains and competencies listed for that credential.

For the purpose of this study, only SUD counselors in a support role were included in the analysis, and independently practicing counselors with a graduate degree were excluded. The credential title for SUD counselors varies by state, but all SUD counselors in a support role, regardless of their title, were included. For example, in some states a SUD counselor may be referred to as a chemical dependency counselor, addiction counselor, or alcohol and drug counselor.

PRSs were included in this study if their credential required them to have lived experiences with a mental illness or SUD in order to work in a support role to assist clients in recovery. Those working in this role may have many different credential titles and names, including but not limited to peer recovery mentor, peer recovery specialist, peer recovery coach, and peer provider. As for CHWs, all credentials with a CHW title were included in the analysis.

In order to evaluate whether state credentials were modeled after national standards, researchers conducted an environmental scan. This environmental scan identified national accrediting organizations for SUD counselors, PRSs, and CHWs to serve as a comparison to the state models identified in the SOP database. Only two national organizations that offer credentials for paraprofessionals in the behavioral health workforce were identified. These national organizations include the International Certification & Reciprocity Consortium (IC&RC) and National Association for Alcoholism and Drug Abuse Counselors, the Association for Addiction Professionals (NAADAC).

The IC&RC and NAADAC provide recognized credentials for both SUD counselors and PRSs, but CHWs have no national standardized model. For SUD counselors at the support level, the IC&RC offers an Alcohol & Drug Counselor (ADC) credential, and NAADAC offers the National Certified Addiction Counselor, Level I (NCAC I) credential. As for PRSs, the IC&RC provides a Peer Recovery credential, and NAADAC offers the National Certified Peer Recovery Support Specialist (NCPRSS) credential. CHWs do not have a national standardized model, but the American Public Health Association (APHA) provides a recognized definition of CHWs. APHA's definition is as follows:

> A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.[22]

The state-level credential information collected for SUD counselors and PRSs was then compared to the corresponding NAADAC or IC&RC credentialing model in order to categorize each state credential as a state model, a national model, or a mixture of both. A state classification identifies states that follow little to no national standards for that credential, while a national classification identifies states that follow a national model for that credential. States that followed some national model standards but also followed their own standards were classified as a mixed model. These classifications were determined by the overall credential requirements, including the type of exam utilized by each state and any reference to the IC&RC or NAADAC models.

These descriptions were used to assess the state-level requirements for SUD counselor, PRS, and CHW credentials and how these requirements compared to national models. Additionally, Welch tests were run to determine whether the number of required education, practice, and supervision hours differed among national and state models for SUD counselor and PRS credentials. The Welch test was used, rather than a one-way analysis of variance, to account for a lack of constant variance in the data.

Results

Table 1 provides an overview of the training requirements and covered domains for the IC&RC and NAADAC SUD counselor and PRS credentials. The two SUD counselor credentials have similar education requirements, practice hours, and domains; however, the IC&RC also requires their providers to complete supervised hours to obtain their credential, while the NAADAC credential does not explicitly require supervised hours. As for the peer credentials, the IC&RC peer recovery credential requires the completion of fewer education hours but requires a higher number of practice and supervised hours as compared to the NAADAC NCPRSS credential.

Table 1: National Credentialing Models for Substance Use Disorder Counselors and Peer Recovery Specialists

Accrediting Body	Credential	Education Hours	Practice Hours	Supervision Hours	Exam	Domains and Commpetencies
International Certification & Reciprocity Consortium (IC&RC)	Alcohol & Drug Counselor (ADC)	300	6000	300	ADC	• Screening • Assessment • Engagement • Treatment planning • Referral • Counseling • Education • Professional and ethical responsibilities
NAADAC, the Association for Addiction Professionals	National Certified Addiction Counselor (NCAC 1)	270	6000	N/A	NCAC 1	• Clinical evaluation • Treatment planning • Referral • Service coordination • Counseling • Client, family, and community education • Documentation • Professional and ethical responsibilities
IC&RC	Peer Recovery	46	500	25	Peer Recovery	• Advocacy • Mentoring and education • Recovery and wellness support • Ethical responsibility
NAADAC, the Association for Addiction Professionals	National Certified Peer Recovery Support Specialist (NCPRSS)	60	200	N/A	NCPRSS	• Documentation • Community and family education • Case management • Crisis management • Recovery-oriented systems of care • Screening and intake • Identification of indicators of substance use disorders • Service coordination • Service planning • Cultural awareness and humility • Basic pharmacology

SUD Counselors

A total of 113 SUD counselor paraprofessional credentials were identified. Only one state, Rhode Island, offered a reciprocal credential for those who already have an advanced credential. Therefore, this credential was excluded from the total number of SUD counselor credentials. Figure 1 displays the total

number of PRS and SUD counselor credentials that use a state, national, or mixed credentialing model. A total of 38 SUD counselor credentials followed national standards, 31 credentials followed a state model, and 44 credentials relied on a mixture of both state and national model components. There was no clear reason as to why states chose to follow a national or state model, but some geographic patterns emerged. States in the northwest were less likely to use a state model, and eastern states that followed a national model were more likely to use the IC&RC credential over the NAADAC credential.

Five states also included the core functions of addiction counselors in their domains and competencies. The 12 core functions have some overlap with both the IC&RC and NAADAC domains, but these functions provide a more detailed outline of the competencies that SUD counselors should learn while in their training programs.[23] These 12 functions include screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, referral, report and record keeping, and consultation.[23] Since a lot of overlap existed between the IC&RC, NAADAC, and the 12 core functions, states referencing the functions were categorized solely using other requirements, such as practice and education requirements, while disregarding the 12 core functions.

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

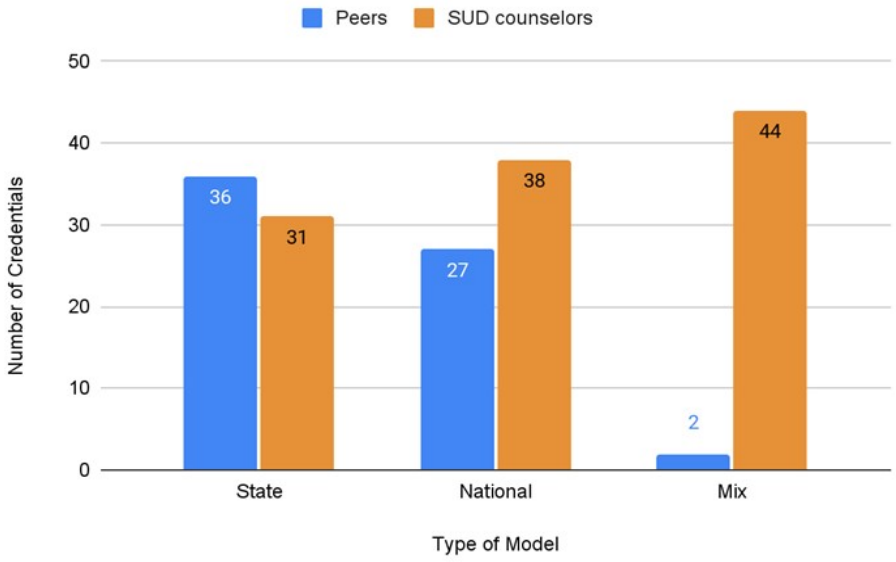


Table 2 describes the credential requirements for the national and state credential models for SUD counselors. The majority of SUD counselor credentials accept the IC&RC exam (n=54) and follow the IC&RC domains (n=48), but many credentials also follow state requirements for education hours (n=67) and practice hours (n=43). There was a near-even split between SUD counselor credentials following a state model and the IC&RC model for supervised practice requirements (n=37 and n=40, respectively). However, it is also important to note that many credentials did not clearly follow a national or state standard for their SUD counselor credentials.

Table 2: Substance Use Disorder Counselor Credential Requirements by Credentialing Model Type

Credential Requirements	Model Type (*n*=113)				
	IC&RC	NAADAC	IC&RC/NAADAC[a]	State	N/A[b]
Exam	54	15	10	9	25
Domains and competencies	48	21	4	35	5
Education hours	27	10	-	67	9
Practice hours	37	4	-	43	29
Supervision hours	40	0	-	37	36

[a] The number of states that accept either the IC&RC or NAADAC exam or reference both competencies and domains when describing a credential.
[b] Credential information not publicly available or this category was not a requirement for the credential.

Table 3 displays the average education, practice, and supervision hours required under each model type for SUD counselor credentials. The average education required for IC&RC credentials (n=32) was 284.0 hours, while the mean education requirements for the other credential models

ranged from 136.0 to 185.8 hours. The average practice hours required for IC&RC credentials was 5750 hours, while the average practice hours required for the other credentialing models was around 3000 hours. However, the standard deviations were large for the mean practice hours required across all model types, which indicates a high amount of variation in these requirements. The average supervision requirement ranged from 145.5 to 276.1 hours across the four model types. For all three credential requirements, credentials following the IC&RC model had the highest average number of hours required.

Table 3: Substance Use Disorder Counselor Education, Practice, and Supervision Requirements by Credentialing Model Type

Credential Requirements	Model Type, mean (SD)				P-Value[b]
	IC&RC (*n*=32)	NAADAC (*n*=32)	Mix[a] (*n*=32)	State (*n*=32)	
Education hours	284.0 (50.5)	144.8 (101.9)	185.8 (113.9)	136 (96.3)	**<0.001**
N/A[c]	-	-	5	8	**<0.001**
Practice hours	5750 (983.7)	3000 (2160.3)	3061.6 (1861.1)	3302.9 (1832.5)	**<0.001**
N/A	-	2	12	19	**<0.001**
Supervision hours	276.1 (72.2)	260 (211.7)	248.6 (78.9)	145.5 (77.2)	**<0.001**
N/A	-	1	20	17	**<0.001**

[a] Indicates the number of states that use a mixture of national and state requirements.
[b] P-values were generated from Welch tests. Bold values indicate significance at an alpha of 0.05.
[c] Credential information not publicly available or this category was not a requirement for the credential.

Peer Recovery Specialists

A total of 65 PRS credentials were identified with 15 states offering more than one PRS credential. Alaska, South Dakota, and Vermont did not offer any peer provider credentials. Overall, 27 peer credentials followed a national model, 36 followed a state model, and two followed a combination of both models (Figure 1). Of the 27 credentials that followed a national model, none of these credentials utilized the NAADAC PRSS model. There were no clear geographic patterns among the states that followed a state or national model.

Table 4 displays the credential requirements for PRS IC&RC and state credentials. PRS credentials were closely split for most categories between IC&RC and state models, except for supervision hours, which were most likely to be unavailable (n=32), or IC&RC (n=24). For credentials that did require an exam, 27 credentials required the IC&RC exam, and 22 credentials required a state exam. Additionally, practice hours and supervision hours were more likely to be unavailable or not required for PRS credentials compared to the other requirements.

One state, Arizona, had their PRS credential classified under the IC&RC model, but the requirements for this credential depend on the organization from which one receives training. Twenty-eight different organizations offer training for Arizona's PRS credential, and some of these training programs are specialized toward youth, adults, and families.[24] Although this credential was classified under the IC&RC model, the large number of organizations that offer this credential makes it difficult to fully understand its specific training requirements.

Table 4: Peer Recovery Specialist Credential Requirements by Credentialing Model Type

Credential Requirements	Model Type (*n*=65)		
	IC&RC	State	N/A
Exam	27	22	16
Domains and competencies	28	34	3
Education hours	26	34	5
Practice hours	24	16	25
Supervision hours	24	9	32

Note: None of the peer credentials followed the NAADAC model.

Table 5 describes the average education, practice, and supervision hours required under each model type for PRS credentials. IC&RC and state credentials were similar in terms of education and practice requirements, but no state credentials required more time spent on supervised practice. Among IC&RC credentials (n=27), there was an average of 53.4 required education hours, 629.2 practice hours, and 28.3 supervision hours. Credentials following a state model (n=36) averaged 54.3 required education hours, 590.5 practice hours, and 52.5 supervision hours.

Table 5: Peer Recovery Specialist Hourly Requirements by Credentialing Model Type

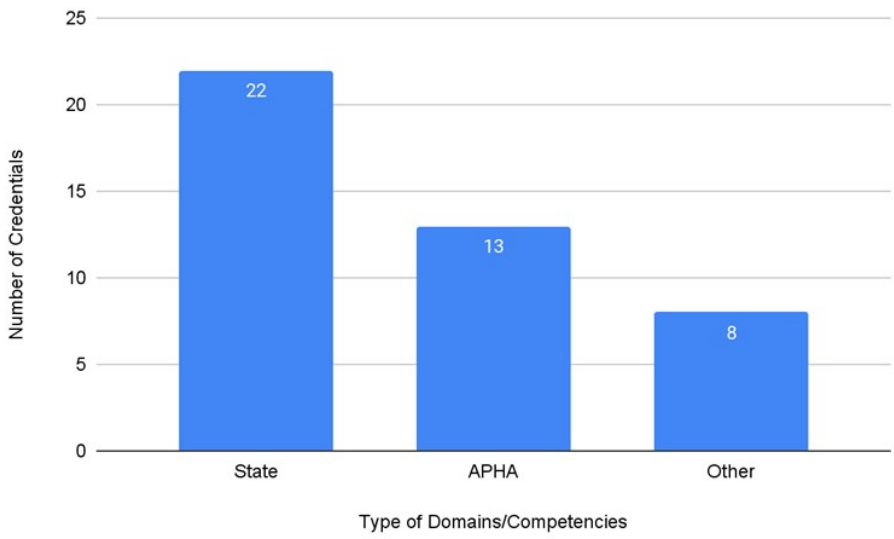
Credential Requirements	Model Type, mean (SD)			P-Value[b]
	IC&RC (*n*=32)	Mix[a] (*n*=32)	State (*n*=32)	
Education hours	53.4 (16.5)	53 (9.9)	54.3 (28.9)	0.952
N/A[c]	2	-	16	0.952
Practice hours	629.2 (442.8)	-	590.5 (616.9)	0.823
N/A	3	2	23	0.823
Supervision hours	28.3 (15.6)	-	52.5 (41.5)	0.218
N/A	4	2	30	0.218

[a] Indicates the number of states that use a mixture of IC&RC, NAADAC, and/or state requirements.
[b] P-values were generated from the Welch tests
[c] Credential information not publicly available or this category was not a requirement for the credential.

Peer Recovery Specialists

Forty-three CHW credentials were available, with two states, Alaska and Nevada, offering more than one credential. Eleven states did not offer any CHW credentials. Since there is currently no national model for CHW credentialing, all CHW credentials must use a state model. Most CHW credentials did not have the required hours of education and practice publicly available and did not require an exam. Therefore, credentials were solely categorized by whether their domains and competencies aligned with the APHA definition for CHWs, a state definition, or another definition. Figure 2 presents the total number of CHW credentials that follow a state model, APHA, or some other model type. One alternative definition used by two states, Arizona and California, is the core competencies and roles created by the Community Health Worker Core Consensus Project.[25] This project aims to provide national consensus in the definition, competencies, and roles of community health workers.[26]

Figure 2. Number of Community Health Worker Credentials per Type of Domains and Competencies



Note: The other category includes credentials following the Community Health Worker Core Consensus Project Competencies.

Discussion

The prevailing model type used across the different SUD counselor, PRS, and CHW credentials was a state-based approach. However, CHW credentials do not have national standards to follow, and SUD counselor credentials often followed a mixed model approach for their credentials. The use of different credentialing guidelines that vary by state has resulted in a paraprofessional workforce with a

diverse set of credentials, training requirements, and SOP.

Despite the IC&RC and NAADAC having nationally recognized credentials for SUD counselors and PRSs, states are still largely following their own guidelines for these credentials. When each state holds the power to determine their own credential and SOP requirements for their paraprofessionals, it creates inconsistencies in how paraprofessionals become credentialed and what services they can provide.[20] For example, Vermont does not offer a PRS credential, while Pennsylvania offers three different peer provider certifications. The varying credential guidelines across states is not an outcome of evidence-based practices; rather, these guidelines are informed by the lobbying of professional organizations.[30,31] A paraprofessional's skills are not fully utilized when they cannot practice to their fullest capability, and consequently, this can make behavioral health care more costly and wasteful.[32] These inconsistencies in paraprofessional credentials across states makes it difficult to assess the true capacity of these providers to meet behavioral health demands.[20,32] Future research should continue to explore why states opt to follow their own guidelines as opposed to adopting the IC&RC or NAADAC SUD counselor and PRS credentials.

SUD counselor credentials stood apart from the other two paraprofessionals because there was a near-even split in the use of national, state, and mixed credentialing models. This shows an acceptance in the use of a national credentialing standard for SUD counselors, yet states still want to use their power in regulating SUD counselor credentials. One possible explanation as to why states prefer to employ their own credential standards is because their requirements are less rigorous than the national models. There were statistically significant differences between the IC&RC, NAADAC, mixed, and state models and their required number of education, practice, and supervision hours to become a credentialed SUD counselor. The IC&RC credential had the largest number of required education, practice, and supervision hours, while states tended to have a lower number of required education and supervision hours. One hypothesis is that lowering the required number of training hours to become a credentialed SUD counselor will encourage more individuals to enter the workforce; this increase in the workforce may be an influential factor for states deciding to follow their own model versus the more rigorous national standards. Continued research should explore whether there are quality of care differences among credentialed SUD counselors that follow state models with fewer required training hours as compared to the national standards.

Of SUD counselor credentials that followed a national model, these credentials were more likely to follow the competencies outlined by the IC&RC rather than NAADAC. It is not explicitly clear why states are more likely to adopt IC&RC credentials; it can be hypothesized that because the IC&RC SUD counselor credential has been recognized for longer than NAADAC's credential, it is more widely used.[27,28] The IC&RC emphasizes the importance of reciprocity in its credentials and conducts outreach to bring states on board with the SUD counselor credential, which may also be contributing to the uptake of the IC&RC credentials.[28]

Although SUD counselor credentials often followed a mixed model approach, PRS credentials typically followed state requirements. There were no statistically significant differences between the IC&RC, mixed, and state models and their required number of education, practice, and supervision hours to obtain a peer credential. Further, none of the PRS credentials that followed a national model used the NAADAC peer credential. It remains unclear why the IC&RC credential is the predominant national model, but the IC&RC peer recovery credential may be the leading national model because it was implemented two years prior to the introduction of NAADAC's credential.[27,28] Another possible explanation as to why the IC&RC credential is the prevailing national model for PRSs is because the IC&RC employs their own standards but administers the peer recovery credential at the jurisdiction level.[29] This means the IC&RC credential ensures the peer recovery competencies are met while also giving state boards the liberty to implement their own unique procedures and requirements.[29] Continued research should focus on exploring why the IC&RC is the preferred paraprofessional credential model over NAADAC.

Unlike SUD counselors and PRSs, no national model currently exists to serve as a guideline for

CHW credentials. All of the CHW credentials followed a state credentialing model, with some states also adopting the APHA definition. There was no decisive factor as to why states chose to follow APHA's competencies, but there was a general acceptance among states with this definition. The acceptance of the APHA definition shows there is national agreement among states surrounding the core competencies of CHWs; nevertheless, a national or standardized CHW model may not currently exist because CHWs are a relatively newly credentialed paraprofessional when compared to other behavioral health providers (e.g., psychologists, psychiatrists), CHWs may use multiple job titles (e.g., case navigator, health educator, community advocator), and these providers must be trained to uniquely serve their own community.[18,11] A CHW's ability to effectively serve their community depends on their training and familiarity with their community's culture, language, and other contexts.[18] This makes it difficult to standardize a CHW's credential requirements and SOP when a CHW's role can vary greatly by the community they serve. Despite a CHW's unique position in their community, a national body that supports and oversees CHWs must be advocated for in order to create a more uniform CHW population that can meet behavioral health demands.

Policy Considerations

To overcome the lack of uniformity among paraprofessional credentials and their model types, the following policy considerations are presented:

1. Standardize evidence-based minimum paraprofessional credential requirements and SOP.

   One of the most effective ways to ensure a competent paraprofessional workforce that shares similar training experiences and SOP is to standardize a set of core credential requirements and practice guidelines for paraprofessionals.[20,32] A number of benefits will result from a standardized set of core paraprofessional credential and SOP guidelines, including but not limited to giving paraprofessionals the ability to practice to their fullest extent, supporting uniformity in the capacity of paraprofessionals to meet behavioral health demands, aiding in the reciprocity of credentials, and ensuring paraprofessionals are fairly reimbursed for their services.[11,32] This concept is not a novel idea for health occupations and can be seen for nearly every other licensed or certified behavioral health provider (e.g., social workers, psychologists). However, the process of standardization is much easier said than done when states have the autonomy to regulate their own health professions, guidelines are heavily influenced by lobbying, and past efforts to merge the IC&RC and NAADAC credentials have been unsuccessful.[30,31,33] Despite these limitations, enforcing a set of minimum evidence-based guidelines for each paraprofessional credential will strengthen the behavioral health workforce's proficiency and fully utilize providers' SOP.

2. Create a nationally recognized organization for CHWs.

   Although CHWs are uniquely trained on the needs of the community they serve, the lack of a national body overseeing CHWs is a detriment to both CHWs and behavioral health care as a whole. Without an established national organization, CHWs do not have a nationally recognized standard of care to follow, which influences their ability to provide quality care. Creating a national CHW organization would support CHWs by implementing a baseline of core CHW competencies, encouraging the use of only one credential title for CHWs, supporting reciprocity across states, and clearly describing the pathway to becoming a CHW. Not only is it important for there to be a standardized minimum

set of credential requirements and guidelines, there must be a national body that can answer CHW questions, supply research, and support training efforts. A nationally recognized CHW organization would make the process of earning a credential easier for CHWs, and it would also create a more standardized CHW population that can be studied to assess the capacity of CHWs to meet their community's needs.

3. Establish centralized, state-level training, information dissemination, and technical assistance centers for paraprofessionals.

   With multiple national and state bodies offering paraprofessional credentials, it can become confusing and complex for individuals seeking a credential to identify the necessary requirements they must complete. Standardizing paraprofessional credential requirements would be the best way to eliminate this ambiguity, but the length of time it would take to accomplish this and the current feasibility of these efforts is questionable. While work is made toward standardizing paraprofessional credential requirements, states should provide centralized training, information dissemination, and technical assistance to paraprofessionals and those seeking to earn a credential. Resources to assist paraprofessionals will aid these workers in earning their credential, determining their credential's reciprocity, and better equipping them to work within their communities.

Limitations

This study is a descriptive study that cannot imply any causal relationship or further explanation as to why a SUD counselor, PRS, or CHW credential may follow a state or national model. Additionally, a large number of credentials either did not have publicly available information or had insufficient information to describe and categorize these credentials into specific model types. Future research should continue to explore why states use their own credentialing model as opposed to a national model and vice versa. Studies could also continue to explore the effect that a credentialing model has on the ability of SUD counselors, PRSs, and CHWs to deliver quality care to the community.

Conclusion

Ultimately, there is wide variation in the types of models that SUD counselors, PRSs, and CHWs follow in order to become credentialed. These paraprofessional credentials typically follow a mixture of national and state models, with individual state models serving as the dominant model across paraprofessional credentials. With states being the deciding model over how paraprofessionals' credentials are regulated, it is difficult to assess the capacity of paraprofessionals to meet behavioral health demands. To counteract this lack of uniformity among paraprofessionals, a standardized set of minimum evidence-based credential requirements and SOP guidelines, as well as centralized training and information dissemination for paraprofessionals, should be implemented.

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