

**Minnesota Peer Support Implementation
Consultant's Report**

Submitted to

**Mental Health Program Division
Department of Human Services**

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Background

Other States

Since 2001, when Georgia and Arizona included Peer Support in their Medicaid programs, approximately 20 states have included Peer Support in their Medicaid programs. This data is incomplete but is the best available based on informal surveys conducted by NASMHPD and by this consultant. The methodology varies from state to state but generally falls into three distinct approaches:

1. Peer Support is included and reimbursed as a discrete service. Examples include:
 - A. Arizona. Since 2001 Peer Support (H0038) is reimbursed when provided by paraprofessionals in a licensed behavioral health agency or credentialed Community Service Agency.
 - B. Georgia. Since 2001 Peer Support is reimbursed as “Adult Peer Supports.” Y3022, when provided in a Peer Support Center, may be free-standing, a program within an existing clinical provider program, or a program within a human service agency.
 - C. Pennsylvania. Since 2007 Peer Support (H0038) is reimbursed when provided by a Certified Peer Specialist (CPS) in a county/agency approved by OMHSAS to deliver Peer Support. CPS must graduate from one of two OHMSAS approved training vendors.
 - D. Washington. 1915(b) managed care waiver. Regional Support Networks are capitated, and may choose to provide Peer Support as a discrete service when provided by a “Peer Counselor” who has completed the 40-hour state training, has passed the state “Certified Peer Specialist” written/oral exam, and has completed a background check and registered as a counselor with the Department of Health.
2. As part of another Medicaid reimbursed service. Examples include:
 - A. Georgia. A Peer Specialist certified by the state of Georgia may have services reimbursed as part of an Assertive Community Treatment (ACT) team.
 - B. Hawaii. CPS services are embedded in ACT when provided by a HCPS (Hawaii Certified Peer Specialist) who has completed the Hawaii Certified Specialist Training and passed a written and oral exam.
 - C. North Carolina. ACT and Community Support teams may have Peer Specialists. Effective Jan 2008, only those Peer Specialists who had completed a training approved by the state would be considered Certified Peer Specialists eligible for reimbursement. NC uses a curriculum checklist developed through a “role delineation” study to evaluate/approve curriculums.
 - D. Maine. Included in ACT. Also, services can be reimbursed as a “Specialized Group Service” which includes WRAP, Recovery Workbook Groups, Trauma Recovery and Empowerment Groups, and DBT.
 - E. Illinois. Certified Recovery Support Specialists (CRSS) (peers) are required on ACT and Community Support Teams. CRSS require 100 hours of training, 100 hours of supervision, 2,000 hours of paid work experience, and completion of a written exam.

- F. Wisconsin. Peer Specialist services are included in “Comprehensive Community Services” when provided by a Peer Specialist who has completed a 30 hour training program in the past two years.
 - G. South Carolina. Services are reimbursable when provided by a Certified Peer Specialist who has completed the 30 hour State training (which is modeled after the Georgia training) and has passed a written and oral exam with a 70% score.
 - H. Michigan. Details are not available at this time.
 - I. Oregon. Through “Personal Care Services,” a Medicaid member needing assistance with activities of daily living can employ a personal care assistant of their own choosing, including a peer. H0038, Peer Support, is an “encounter code” only, with no state reimbursement, although some Managed Care Organizations may elect to reimburse.
3. When provided through a licensed or credentialed “Peer Support organization.” Examples include:
- A. New Hampshire. Created “Peer Support Agencies,” with extensive credentialing requirements, but they do not certify Peer Specialists.
 - B. Georgia. Peer Support Centers are credentialed with extensive credentialing requirements.
 - C. Arizona. Community Service Agencies provide “Peer Support” (H0038) and must meet extensive credentialing requirements.

See more detailed information for each state in *Attachment C State Summaries of Certified Peer Specialist Programs*.

Minnesota

Through legislation enacted in 2007, Minnesota chose to include Certified Peer Specialists:

- 1. As part of the existing Medicaid services of ACT, Adult Rehabilitative Mental Health Services (ARMHS), and Intensive Residential Treatment Services (IRTS).
- 2. In certified Peer Support Specialist programs either freestanding or within existing mental health community provider centers.

In reviewing the various state approaches to implementing Medicaid reimbursed Peer Support services, it seems clear that not only is there great variation from state to state, but there does not appear to be one state after which Minnesota could easily model its program. Illinois and North Carolina are perhaps the closest in approach.

- 1. In Illinois, “a person in recovery” is required on ACT and Community Support Teams. The IL regulations state that a Certified Recovery Support Specialist is preferred. After a great deal of study, work and then community debate, Illinois adopted a very rigorous set of rules recommended by the Office of Consumer Affairs that in the opinion of some, included this consultant is excessive. One year of paid work experience in which at least 51% was providing “recovery supports” is required before an individual can apply for the certification program. It excludes too many with valuable peer experiences from having the opportunity to become credentialed/certified.
- 2. In North Carolina, ACT teams must include one Certified Peer Specialist and Community Support teams may include one CPS. There is the beginning of a state certification

process for individuals who have completed a training program that has been approved by the state.

Both Pennsylvania and Georgia, with Medicaid reimbursed Peer Support services under the Medical Rehab option, have elements that can be adapted for the Minnesota program. The Pennsylvania program requires provider (counties) to submit a Peer Support implantation plan which must be approved by OMHSAS, peer training by one of two state approved training vendors, and a specific training for supervisors of Peer Specialists.

On August 15, 2007, the Centers for Medicare and Medicaid Services published a guidance document for states interested in implementing Peer Support services under the Medicaid program. At a minimum, the Minnesota plan should thoroughly address the key points of the CMS document, including provisions covered under the following statements:

States are increasingly interested in covering Peer Support Providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance use disorders. Peer Support services are an evidenced-based model of mental health care which consists of a qualified Peer Support provider who assists individuals with their recoveries from mental illnesses and/or substance use disorders. CMS recognizes that the experiences of Peer Support providers, as consumer of mental health and substance use services, can be effective components in the state's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services.....

Peer Support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of Peer Support services. Additionally Peer Support providers must be sufficiently trained to deliver services.....

Supervision must be provided by a competent mental health professional (as defined by the State)....

Care coordination: As with many Medicaid funded services, Peer Support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a Person-Centered Planning process to help promote participant ownership of the plan of care.....

Training and Credentialing: Peer Support providers must complete training and credentialing as defined by the State. Training must provide Peer Support providers with a basic set of competencies necessary to perform the Peer Support function. The peer must demonstrate the ability to support the recovery of others from mental illnesses and/or substance use disorders. Similar to other provider types, ongoing continuing education requirements for Peer Support providers must be in place.

Discussion

Peer Support Definition: The definition of Peer Support in the new Minnesota statute appears to cover many of the key components of Peer Support that have been identified by other states (for more detail see the attached “Program Requirements for Peer Programs.”)

The MN statute says:

1. Non-clinical Peer Support counseling
2. Wrap around continuum of services.
3. Individualized to the consumer
4. Promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, maintenance of skills learned in other support services.

Since MN chose to imbed Peer Support in existing Medicaid services, does this definition provide sufficient guidance and detail to preserve the essence, value, and contribution of the Peer Support service? In the opinion of this consultant, it is essential that Peer Support maintain its unique status as a discipline and not be co-opted, with peer providers becoming junior clinicians or case-aides.

What then is unique about Peer Support, and does the existing Peer Support definition need to be developed further in the MN Peer Support Bulletin? Definitions from some other states may provide guidance. See details in the attached document on “State Summaries and Questions.”

One of the most important components of Peer Support is the sharing of one’s personal experiences of recovery to inspire hope and recovery in others. Washington, in their definition, describes Peer Support as follows:

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor’s own life experiences related to mental illness will build alliances that enhance the consumer’s ability to function in the community.

The focus of Peer Support services is recovery. The Pennsylvania definition includes this language:

Services are self-directed and person-centered with a recovery focus. Peer support services facilitate the development of recovery skills. Services are multi-faceted and include, but are not limited to, individual advocacy, crisis management support, and skills training.

Person-centered and recovery focused services for adults 18 years and older. The services are provided by individuals who have utilized services in the behavioral health system. These individuals are trained and certified to offer support and assistance in helping others in their recovery and community integration process. The service is multi-faceted, including such activities as advocacy, education, development of natural supports, support of work or other meaningful activity of the person’s choosing, crisis support, effective utilization of the service delivery system, and coordination of and linkage to

other service providers. It is the purpose of Peer Support to inspire hope in individuals that recovery is not only possible, but probable.

Another important component is that the Peer Specialists must be valued and equal contributing members of the service teams. North Carolina describes this as follows:

A Certified Peer Specialist is a fully integrated team member who provides highly individualized services in the community and promotes individual self-determination and decision making.

Peer Support Values and Competencies

Do Peer Support values and competencies need to be further defined? This represents a deeper exploration of the question of how to define Peer Support. Some good work in this area is already done. Three examples are provided in Appendix A by: The National Association of Peer Specialists (initial work group results); META Certification requirements; and Georgia's competency requirements.

Certified Peer Specialist Requirements

What should the MN CPS requirements include?

The MN statute says an individual should:

1. Be 21 years old
2. Have a High School degree or equivalent
3. Have a primary diagnosis of a mental illness
4. Have a current or former consumer of mental health services
5. Demonstrate leadership and advocacy skills
6. Have a strong dedication to recovery

Washington State has similar requirements. Their CPS application outlines these requirements in more detail. See Attachment B: "Certified Peer Specialist Application."

Some states have adopted work experience requirements. Illinois is the most rigorous, with the requirement that for certification, an individual needs 2,000 hours of paid work experience, at least 51% of which is in providing "recovery supports." Verification and supervisory references are required. Pennsylvania requires the equivalent of one year of employment during the past three years in any job or field. In IL, Peer Support services can be provided by peers who are not certified. The regulations state that the Certified Recovery Support Specialist certification is preferred. In PA, Peer Support can be provided by peers who are not certified; however these services are then not reimbursable under Medicaid.

META Certification requires three months of supervised Peer Support work experience, with supervisor references, following completion of the training program.

The work experience requirement is a legitimate method of determining competence, which is commonly used by other disciplines in their licensing/credentialing procedures. For mental

health Peer Specialists there are two competing issues raised by the work experience requirement:

1. How can competency be established by training/testing alone? How can it be determined that an individual who has never provided Peer Support can actually apply the skills of Peer Support in a job setting? A period of Peer Support work experience with supervisory references can validate the competence of the peer provider.
2. On the other hand, individuals with lived mental health experience have often not had recent work experience, and certainly often not Peer Support work experience. They often may have a great contribution to make, but the work experience requirement may exclude them from the opportunity to do so.

Other disciplines have addressed the issue of work experience by creating certification/licensing levels; i.e., “Associate X” and “Independent X.” This creates a career advancement ladder that honors advanced practice experience and solidifies the validity of the profession. *Minnesota may have the opportunity to consider a new “tiered” credential modeled after Minnesota’s already established “mental health rehabilitation worker,” “mental health practitioner,” and “mental health professional.”*

Certified Peer Specialists Training

The MN statute says:

1. Initial training must teach specific skills relevant to providing Peer Support.
2. Ongoing continuing education workshops on pertinent issues related to Peer Support and counseling should be available.

A few states have developed their own unique training curriculums. Washington, in 2005, contracted with the University of Washington, The Washington Institute for Mental Illness Research and Training to develop a Peer Support training curriculum. This resulted in a 40-hour training program that has resulted in the delivery of eight classes. Maine developed a 58-hour curriculum for “Certified Intentional Peer Support Specialists.” Many other states (Hawaii, Michigan, South Carolina, Washington DC, Iowa, and others) have used or adapted a version of the Georgia 40-hour training. Two states have adopted/approved the Recovery Opportunity Center (META) training, which is now affiliated with the Recovery Innovations training (Pennsylvania and North Carolina). In Arizona, over 700 students have graduated from 58 classes using the Recovery Innovations Peer Employment Training curriculum since the first class graduation in October 2001. In addition Recovery Innovations, through its Recovery Opportunity Center (ROC), has graduated Peer Support Specialists in 16 states and three countries abroad. This is the largest and most comprehensive peer training program in the world. The ROC Peer Employment Training is an 80 hour course with 16 modules that uses the 227-page *Peer Employment Training Workbook, 3rd Edition*. The ROC Peer Employment Training has been evaluated by the Boston University Center of Psychiatric Rehabilitation. A study of the Peer Employment Training program, published in the Winter 2006 issue of the *Psychiatric Rehabilitation Journal*, found the following:

Participants experienced gains in perceived empowerment, attitudes toward recovery and self-concept. Trainees went on to obtain peer provider positions

within the mental health agency in which they received the training and 89% of those trained retained employment at 12 months.¹

As discussed in the March 12-13, 2007 consultation in Minnesota with the Consumer Survivors Network leadership and the Adult Mental Health Division staff, there was preliminary agreement that MN will use the Recovery Opportunity Center training curriculum, *Peer Employment Training Workbook, 3rd Edition*. An initial class, to be scheduled in the late summer, will be attended by CSN leadership and staff to explore specific additions that Minnesota might make to the curriculum. Following the initial peer training classes provided by the Recovery Opportunity Center, the ROC “Train the Trainer” program will create a base of well-trained facilitators to continue the delivery of the training throughout the state.

A recent development of the ROC Peer Employment Training is an on-line web-based three-module “pre-qualification” course. This new feature will help orient students to the course, help interested students obtain an initial base of knowledge that will speed that classroom learning, and serve as a screening tool for Peer Employment Training enrollment. This product will be extremely useful for individuals living in rural and remote geographic settings. MN state officials also expressed an interest in supporting the development of a blended learning model, which would include web-based component for content and knowledge acquisition, and live classroom time for experiential learning and skill practice. This approach will improve access to the course and reduce costs. This consultant is available to facilitate exploration of this approach.

Certification Testing

Some States chose to develop their own certification test. Examples include Washington, Georgia, Illinois and Hawaii. These tests are written exams and may include an oral component. Other States (Pennsylvania, North Carolina) require only proof of completion of the training course and exams included in that training program.

As with any testing, the challenge is to assure that the test adequately measures with the knowledge and skills required of the profession. To the knowledge of this consultant, the only exam which has been evaluated to any extent is the test for the Recovery Opportunity Center Peer Employment Training. In 2007, three ROC PET classes were administered pre- and post-tests to determine if the Peer Support competencies established by the ROC program were met by the training, and properly evaluated by the test. The Boston University evaluation team found “a highly significant gain of correct answers in all items in the test from pre- to post-test, suggesting that the trainees mastered the material to a high degree.”²

If MN does decide to use the ROC Peer Employment Training as its Peer Support training program, the testing provided in that program may be considered sufficient to grant certification to those successfully completing the course. This is the approach currently used by Pennsylvania. Another alternative that could be considered is to use the certification program of the

¹ Hutchinson, D., Anthony, W., Ashcraft, L. & Johnson, E. (2006). The personal and vocational impact of training and employing people with psychiatric disabilities as providers. *Psychiatric Rehabilitation Journal*, Vol. 29, 3.

² Boston University Center for Psychiatric Rehabilitation (2007). Program evaluation results peer employment training, Unpublished report, October, 2007.

independent company, META Certification, Inc. This is the only non-state sponsored certification program in the country. META Certification is built on the competencies established through the ROC Peer Employment Training program (see Attachment A, META Certification Competencies). META Certification requires successful completion of the Peer Employment Training course, three months of supervised Peer Support work with supervisory references, and the completion of an exam.

Additional Considerations

As part of the Minnesota implementation, additional research and consultation will be required in the following areas:

1. What county and provider organization requirements should be expected before implementation of Peer Support programs?
2. Should additional requirements be established for supervisors of Peer Specialists?
3. How should Peer Support Specialist Programs as required by the new statute be credentialed to assure the fidelity and quality of Peer Support programs?

Attachment A

Examples of Peer Support Values and Competencies

National Association of Peer Specialists Values and Competencies – Working Draft, 2006	
Value	Competency
Mutual Responsibility	<ul style="list-style-type: none"> • Ability to demonstrate the equality in a relationship even though there is power involved. • Self awareness. • Ability to own one’s part • Ability to negotiate the rules of the relationship • Ability to self reflect (demonstrate critical awareness of patterns) • To be able to see perspectives as just that (rather than seeing things as right or wrong) • Communicating respectfully and responsibility.
Mutual Learning and Growing Together	<ul style="list-style-type: none"> • Knowledge and value of many paths to recovery • Communication skills • Conflict resolution • Demonstrate learning from each other • Be able to challenge each other • Being able to transcend roles of helper and helpee • Understanding that when “Help” is one-sided, it can perpetuate learned helplessness. • Understanding that “help” is best when it is born out of a relationship that both people have nurtured (like a pot latch). “We have both added capital to this supportive relationship. We can both draw on it for support when we need it. We are both responsible for continuing to add to it.” • Whether or not one of us is a paid employee, we are equal... <ul style="list-style-type: none"> ○ in our ability to contribute to the relationship ○ in our ability to share personal experience and feelings ○ in the way we contribute strengths and ideas ○ in the way we help one another learn and grow
Respect	<ul style="list-style-type: none"> • Ability to hold multiple perspectives • Demonstrate acceptance of each individual. • Demonstrate understanding that all “truths” are equal • Ability to communicate in a way that someone else can hear • Use language that is positive and strength based and that presumes recovery will happen. • Use language that reflects, “You are the expert in your own experience.” • Use language that is non-clinical, natural and human. • Use language that is individualized to the person’s uniqueness, avoids labels, and does not perpetuate stigma or double standards.
No Assumption of a Problem. Being with You and not Having to Fix You	<ul style="list-style-type: none"> • Strengths based recovery. • Wellness and well-being • Self awareness of need to problem solve • Understanding that others have learned to focus on problems • Ability to shift problem into vision
Self Awareness and Continuous Critical Learning (and unlearning)	<ul style="list-style-type: none"> • Flexible boundaries and setting limits • Sharing my story • Recognize the presence of power • Ability to use feedback and supervision. Demonstrate ability to “step back” from one’s perspective • Willingness to try on other views • Ability to acknowledge patterns and old notions of help • Ability to celebrate resistance and multiple viewpoints

**National Association of Peer Specialists
Values and Competencies – Working Draft, 2006**

Value	Competency
	<ul style="list-style-type: none"> • Understanding that each person has the best knowledge about him or herself.
Shared Risk	<ul style="list-style-type: none"> • Avoiding extremes when there seems to be risk concerning a person’s life or livelihood --not abandoning people when there may be such risk and not “taking over” either <ul style="list-style-type: none"> ○ Being with people when the waters are rough ○ Reflecting the strengths we see in them, showing that we believe they can navigate tough times. ○ Relating/reminding them that they are not alone ○ Inviting their choices about how to navigate rough waters ○ Partnering with people as they identify tools, supports, and resources that could be useful to them ○ Being honest when we feel uncomfortable ○ Being honest with people about what we need in order to be with them during the challenging time. • Celebrating a person’s willingness to take risks toward new growth. <ul style="list-style-type: none"> ○ Avoiding the impulse to “protect” people from taking risks that “we think” might not work out. ○ Remembering that people grow from trial and error learning.
Creating Community	<ul style="list-style-type: none"> • Diversity • Recovery environment • Focus on community type relationship as opposed to service/provider type relationship • Demonstrate Flexible boundaries • The relationship is about 2 valuable experts. You are the expert on yourself and I am the expert on myself. We can orchestrate our strengths, learn and grow from one another, and both be wiser from the process. • Because we believe we are both experts who are strong, we don’t try to fix one another or make conclusions about one another.
Trauma Informed	<ul style="list-style-type: none"> • The power of resilience. • Not see things from a diagnostic perspective • Demonstrate an understanding of the impact of trauma and abuse on actions, beliefs, behaviors and relationships
Hope	<ul style="list-style-type: none"> • Believes in anyone’s recovery/healing/growth • Ability to create hope inducing conversations (but not patronizing)
Holistic	<ul style="list-style-type: none"> • Understand the extent to which the mental health system has reinforced reductionism • Be able to advocate beyond reductionism • See things as interconnected (mental health connected to physical, emotional, spiritual etc)
Empowerment	<ul style="list-style-type: none"> • Knowledge of the power dynamics that exist in various settings and contexts. • Ability to negotiate and share power. • Avoids arbitrary rule making and protectionism that denies others their power and right to choose. • Role models personal responsibility and accountability avoiding the attitude of entitlement.
Cultural Competence	<ul style="list-style-type: none"> • Know that culture is a very encompassing concept • Be self aware of ethnocentrism • Demonstrate ability to understand someone else’s cultural experience

**National Association of Peer Specialists
Values and Competencies – Working Draft, 2006**

Value	Competency
Staying Peer	<ul style="list-style-type: none"> • Ability to negotiate power/conflict/safety • Have awareness of falling into assessment mode • Staying out of treatment meetings unless peer is also there • Not getting co-opted or slipping into the dominant cultural practices of clinical management. <ul style="list-style-type: none"> ○ speaking from our own experience, ○ sharing our stories, ○ not replicating clinical approaches.
Education/Knowledge	<ul style="list-style-type: none"> • Always increasing knowledge • Participates in supervision • Understand the difference between maintenance and change

META Certification Competencies for Peer Support Specialists

META Certification strives for individuals to be champions of recovery. To be champions of recovery, individuals must have the competency level required to achieve META Certification. The competencies delineated within META Certification are consistent with the values and ethics practiced by Peer Support Specialists.

META Certification requires a Peer Support Specialist to integrate the core pathways of recovery into their daily lives and interactions with others.

- 1.1 Understand recovery and wellness principles, practices and pathways.
 - A Peer Support Specialist applies knowledge of the five pathways of recovery, including; Hope, Choice, Empowerment, Recovery Environment and Spirituality.
 - A Peer Support Specialist will assist others in recovery by supporting their choices for personal wellness and development of self-efficacy.
 - A Peer Support Specialist will assist people with discovering their meaning and purpose in life.
- 1.2 Recognize mutuality and empowerment as underlying components of supporting people .
 - A Peer Support Specialist will be an equal partner with people to inspire recovery.
 - A Peer Support Specialist will support people to find his/her own solutions.
 - A Peer Support Specialist will understand and utilize the power of listening.
- 1.3 Understand the philosophy of strengths based recovery.
 - A Peer Support Specialist assists people in identifying their strengths as part of recovery.
 - A Peer Support Specialist will empower people to identify their contribution to their recovery.

META Certification requires a Peer Support Specialist to be aware of their physical surroundings to ensure a recovery-oriented environment:

- 2.1 Create a safe environment that promotes recovery.
 - A Peer Support Specialist will connect with their community and culture to create a safe environment.
 - A Peer Support Specialist will be flexible and identify ways that will open up new possibilities for others in recovery.
 - A Peer Support Specialist will identify and navigate around barriers that interfere with recovery.
- 2.2 Be knowledgeable of community resources that can assist with the needs of those in recovery.
 - A Peer Support Specialist can identify community resources specific to recovery.
 - A Peer Support Specialist will create a community with valued social roles for everyone.

META Certification requires a Peer Support Specialist to have knowledge of and possess strong recovery skills.

- 3.1 Understand the power of resilience.
 - A Peer Support Specialist will have knowledge of the effects of trauma in recovery, inclusive of abuse issues.
 - A Peer Support Specialist will understand resilience “bounceback.”
- 3.2 Understand the importance of self-advocacy for others in recovery.
 - A Peer Support Specialist will support people by allowing them to take the lead in their recovery.
 - A Peer Support Specialist will have knowledge of the positive aspects of resistance in the recovery process.
- 3.3 Endorse the general principles of ethics and boundaries to create a secure environment for recovery.

- A Peer Support Specialist will honor confidentiality of information received when working with people, while also having knowledge of state and local mandatory reporter regulations.
- A Peer Support Specialist will understand the appropriate relationship guidelines when working with people.
- 3.4 Understand the significance of self worth/self-esteem in the recovery process.
 - A Peer Support Specialist will convey the importance of increased self-esteem.
 - A Peer Support Specialist will be aware of the benefits and challenges of “self-talk.”
- 3.5 Have knowledge of effective communication skills specific to recovery.
 - A Peer Support Specialist will practice the use of positive communication with others by using encouraging words and phrases, and maintaining a positive attitude.
 - A Peer Support Specialist will practice effective listening.
 - A Peer Support Specialist will practice reflective listening skills.
 - A Peer Support Specialist is knowledgeable of different ways to handle conflict.
 - A Peer Support Specialist will avoid blocking a person’s choices and development of self-efficacy.
 - A Peer Support Specialist will be effective using recovery language.
 - A Peer Support Specialist will have the ability to be a part of a team and engage in complimentary partnerships with community resources and other entities.
 - A Peer Support Specialist will be effective in self-directed documentation.
- 3.6 Promote self-determination as a guiding force behind those in recovery.
 - A Peer Support Specialist will encourage people to be the experts of their own care.
 - A Peer Support Specialist will convey the healing aspects of recovery through self-determination.

META Certification requires a Peer Support Specialist to be a positive role model while promoting the recovery of others:

- 4.1 Identify positive and influential ways to provide support to those in recovery.
 - A Peer Support Specialist will be authentic with others in the recovery process.
 - A Peer Support Specialist will understand the way of being in a relationship that shows people they have the power to recover.
 - A Peer Support Specialist will offer help and support as an equal.
 - A Peer Support Specialist will work with a people by teaching, learning and growing together.
 - A Peer Support Specialist will value each person’s experience.
- 4.2 Recognize the importance of cultural competence and social diversity and their roles in recovery.
 - A Peer Support Specialist will be open-minded and respectful of other cultures.
 - A Peer Support Specialist will not push their own values and beliefs onto peers that are in the recovery process.
 - A Peer Support Specialist will not judge others and will accept people for who they are.
 - A Peer Support Specialist will be open to new ideas.
- 4.3 Understand the importance of self-wellness as an active Peer Support Specialist.
 - A Peer Support Specialist will recognize the value of taking care of him/herself.
 - A Peer Support Specialist will maintain a positive focus while promoting the recovery of others.
 - A Peer Support Specialist will recognize the importance of ongoing education as a tool for recovery.
- 4.4 Understand the significance of using/disclosing personal experience as a tool for others in their recovery.
 - A Peer Support Specialist will share personal experience of recovery in a way that inspires hope.
 - A Peer Support Specialist will understand that situations will require different levels of self-disclosure and will make these determinations.

Georgia

The Peer Specialist Certification Training Program should give the trainees a solid introduction to the following competencies:

1) -An understanding of their job and the skills to do that job

- Understand the basic structure of the state MHS and how it works
- Understand the CPS job description and Code of Ethics within the state MHS
- Understand the meaning and role of Peer Support
- Understand the difference in treatment goals and recovery goals
- Be able to create and facilitate a variety of group activities that support and strengthen recovery
- Be able to do the necessary documentation required by the state
- Be able to help a consumer combat negative self-talk, overcome fears, and solve problems
- Be able to help a consumer articulate, set and accomplish his/her goals
- Be able to teach other consumers to create their own Wellness Recovery Action Plan
- Be able to teach other consumers to advocate for the services that they want
- Be able to help a consumer create a person-centered plan

2) -An understanding of the recovery process and how to use their own recovery story to help others

- Understand the five stages in the recovery process and what is helpful and not helpful at each stage
- Understand the role of Peer Support at each stage of the recovery process
- Understand the power of beliefs/values and how they support or work against recovery
- Understand the basic philosophy and principles of psychosocial rehabilitation
- Understand the basic definition and dynamics of recovery
- Be able to articulate what has been helpful and what not helpful in his/her own recovery
- Be able to identify beliefs and values a consumer holds that works against his/her recovery
- Be able to discern when and how much of their recovery story to share with whom

3)-An understanding of and the ability to establish healing relationships

- Understand the dynamics of power, conflict and integrity in the workplace
- Understand the concept of 'seeking out common ground'
- Understand the meaning and importance of cultural competency
- Be able to ask open ended questions that relate a person to his/her inner wisdom
- Be able to personally deal with conflict and difficult interpersonal relations in the workplace
- Be able to demonstrate an ability to participate in 'healing communication'
- Be able to interact sensitively and effectively with people of other cultures

4)-An understanding of the importance of and have the ability to take care of oneself

- Understand the dynamics of stress and burnout
- Understand the role and parts of the Wellness Recovery Action Plan (WRAP)
- Be able to discuss his/her own tools for taking care of him/herself

Attachment B
Certified Peer Specialist Application
Washington

ATTACHMENT C

STATE SUMMARIES OF

CERTIFIED PEER SPECIALISTS PROGRAMS

The following are excerpts and synopses from several states that currently reimburse Certified Peer Specialists through Medicaid.

Washington

In the 1915b waiver, Peer Support is defined as:

Peer Support: Services provided by peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumers who visit, including their Medicaid eligibility.

Peer counselors are responsible for the implementation of Peer Support services. Peer counselors may serve on High Intensity Treatment Teams.

The State Plan

The State Plan says, "These services will not be billed until the peer counselors have passed all the requirements and are registered with the Department of Health."

Documentation

Drop-in centers are required to maintain a log documenting identification of the consumers who visit, including their Medicaid eligibility.

Services provided by Peer counselors to the consumer are noted in the consumers' Individualized Service Plans, delineate specific goals that are flexible, tailored to the consumer, and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, but treatment goals may not yet be achieved.

Certified Peer Specialist requirements

“Peer Counselor” means the individual who: Has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Mental Health Division; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Mental Health Division; and is registered as a counselor with the Department of Health.

Peer Counselors should:

1. Be well grounded in recovery for one year.
2. Demonstrate qualities of leadership including governance, advocacy, and creation, implementation or facilitation of peer-to-peer groups or activities.
3. Be willing to share personal story of recovery to assist others.

This information was obtained from: <http://www.dshs.wa.gov/mentalhealth/waivers.shtml>

Georgia

The Medicaid service available is called “Adult Peer Supports,” and is defined as:

Adult Peer Supports: This service provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, under the direct supervision of a mental health professional. A Consumer Peer Support Center maintains adequate staff support to enable a safe, structured environment in which consumers can meet and provide mutual support.

Typically, [programs] will operate during day/evening/weekend hours near public transportation or access to transportation services. A Peer Supports service must be operated for no less than twelve (12) hours a week, no less than four (4) hours per day, and no less than three (3) days per week.

Authorization and Utilization Management (UM)

Service authorization is required with initial authorization of 900 hours. Admission criteria, continued stay, and discharge criteria are specified.

Services may be offered with Community Support or ACT.

Governance

The Governing Board of a free standing Peer Center must be 75% consumers. A Peer Support program operated as part of larger organization that is non peer-run, must have an Advisory Board that is 75% consumers.

Supervision and Staffing

1. The program must be under the clinical supervision of a Mental Health Professional (MHP), preferably a consumer who is a Georgia certified Peer Specialist, and preferably who is credentialed by IAPSRS....
2. Services must be provided and/or activities led by staff who are Georgia certified Peer Specialists or other consumers, under the supervision of a Georgia certified Peer Specialist....
3. There must be at least two Georgia Certified Peer Specialists on staff either in the Peer Supports Program or in a combination of Peer Supports and other programs and services operating within the agency.
4. There must be a maximum face-to-face ratio of an average of not more than thirty (30) consumers to one (1) Certified Peer Specialist, based on average daily attendance of consumers in the program.
5. There must be a maximum face-to-face ratio of an average of not more than fifteen (15) consumers to one (1) direct service/program staff, based on the average daily attendance of consumers in the program.

Documentation

1. Weekly progress notes must document consumer progress relative to functioning and skills related to goals identified in his/her Individual Service Plan (ISP). Daily attendance of each consumer participating in the program must be documented for billing purposes.
2. When this service is used in conjunction with Psychosocial Rehabilitation and ACT, documentation must demonstrate careful planning to maximize the effectiveness of this service, as well as an appropriate reduction in service amounts. Utilization of this service in conjunction with these services will be subject to UM/UR review.

Organization Plan Approval

This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities may take place off-site in natural community settings.

The program must have a Peer Supports Organizational Plan addressing the following:

1. A service philosophy reflecting recovery principles as articulated by the Georgia Consumer Council, August 1, 2001.
2. A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily curriculum and schedule. If offered, meals should be described as an adjunctive peer relationship building activity rather than as a central activity.
3. A description of the staffing pattern, plans for staff who have or will achieve Peer Specialist and APRP credentials, and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated.
4. A description of how consumer staff within the agency will be given opportunities to meet with or otherwise receive support from other consumers (including Georgia Certified Peer Specialists) both within and outside the agency.
5. A description of how consumers will be encouraged and supported to seek Georgia certification as a Peer Specialist, e.g., participation in training opportunities; peer or other counseling regarding anxiety about test-taking, assistance with study skills, information about training and testing opportunities, opportunities to hear from and interact with consumers who are already certified, additional opportunities within the agency after certification, etc.
6. A description of how the consumer staff will participate in clinical team meetings at the request of a consumer and the procedure for the Program Leader requesting a team meeting.
7. A description of the hours of operation, the staff assigned, and the types of services and activities provided for and by consumers as well as for families, parents, and/or guardians.
8. A description of the program's decision-making processes, including how consumers direct decision-making about both individual and program-wide activities, and about key policies and dispute resolution processes.
9. A description of how consumers participating in the service at any given time will be given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, and

- about the schedule of those activities and services, as well as other operational issues.
10. A description of the space, furnishings, materials, supplies, transportation, and other resources available for consumers participating in the Peer Supports services, and a description of the governing body and/or advisory structures indicating how this body/structure meets requirements for consumer leadership and cultural diversity.
 11. A description of how the plan for services and activities will be modified or adjusted to meet the needs specified in each consumer's ISP.
 12. A description of how consumer requests for discharge and change in services or service intensity are handled.

Certified Peer Specialists

Candidates for Certification Training will:

1. Identify themselves as former or current consumers of mental health or dual diagnosis services. Candidates must be well grounded in their own recovery experience for at least one year. Certification is not open to consumers exclusively diagnosed with addiction diseases.
2. Hold a high school diploma or GED. Documentation may be requested.
3. Take a pretest for reading comprehension and language composition.
4. Demonstrate qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.

In addition to attending the trainings, each participant must pass an exam that is offered about one month following the training. The exam includes both written and oral components. Following successful completion of the exam, and agreement to accept the Code of Ethics set out by the Georgia Peer Specialist Certification Project, the candidate officially becomes a Certified Peer Specialist.

North Carolina

Rules provide for Certified Peer Support Specialists (CPS) providing services as part of Assertive Community Treatment or Community Support Teams.

A Certified Peer Support Specialist is an individual who is or has been a recipient of mental health or substance abuse services. A Certified Peer Specialist is a fully integrated team member who provides highly individualized services in the community, and promotes individual self-determination and decision making. This must occur *under the supervision of a Qualified Professional (QP)*

CST's consist of three staff, including one QP, the team leader; one QP or AP; and one paraprofessional or CPS. All staff must have at least one year of documented experience with adults.

An ACT is a team of 10 full-time employees (FTEs) serving 100 consumers or 6-8 FTEs serving 50 consumers, with the typical staff, and must include a minimum of one CPS as described above.

NC uses a "Training Curriculum Guideline" developed through a role delineation study conducted by the School of Social Work, UNC Chapel Hill. They determined four major performance domains:

1. Professional responsibility and ethics. 7 tasks.
2. Relationship building. 11 tasks.
3. Education and other Peer Support Interaction. 11 tasks.
4. Systems competencies. 3 tasks.

"Beginning January 01, 2008, we will only be able to accept hours from peers applying for certification from training curriculums certified by the state of North Carolina containing the knowledge and skills established by a committee of representatives, including administrators, professional providers, and Peer Support Specialists during our Role Delineation Study held in Winston-Salem, North Carolina. We have included an Executive Summary in this packet for your review" (included in a letter to training providers from UNC Chapel Hill).

Pennsylvania

Definition of Peer Support:

Peer Support services are specialized therapeutic interactions conducted by trained professionals who are self-identified current or former consumers of behavioral health services. On an ongoing basis, individuals receiving the service are given the opportunity to participate in and make decisions about the activities conducted. Services are self-directed and person-centered with a recovery focus. Peer Support services facilitate the development of recovery skills. Services are multi-faceted and include, but are not limited to, individual advocacy, crisis management support, and skills training.

The purpose of Peer Support is to:

1. Provide opportunities for individuals receiving services to direct their own recovery and advocacy process.
2. Teach and support acquisition and utilization of skills needed to facilitate the individual's recovery.
3. Promote the knowledge of available service options and choices.
4. Promote the utilization of natural resources within the community.
5. Facilitate the development of a sense of wellness and self worth.

Peer support services:

Person-centered and recovery focused services for adults 18 years and older. The services are provided by individuals who have utilized services in the behavioral health system. These individuals are trained and certified to offer support and assistance in helping others in their recovery and community integration process. The service is multi-faceted, including such activities as advocacy, education, development of natural supports, support of work or other meaningful activity of the person's choosing, crisis support, effective utilization of the service delivery system and coordination of and linkage to other service providers. It is the purpose of peer support to inspire hope in individuals that recovery is not only possible, but probable. The service is designed to promote empowerment, self-determination, understanding, coping skills and resilience through mentoring and service coordination supports that allow people with severe and persistent mental illness and co-occurring disorders to achieve personal wellness and cope with the stressors and barriers encountered when recovering from their disabilities.

Provider requirements:

A Peer support service may operate as:

1. A service component within Medicaid approved mental health provider agencies specified by the Department; or
2. A freestanding peer support service that has been approved for Medicaid funding; or
3. A program that is affiliated with an approved Medicaid provider, as specified by the Department, which provides clinical and administrative Medicaid oversight.

The program shall have a peer support service description and organizational plans addressing the following:

1. A description of the population served, types of services offered, referral process and consumer empowerment models or tools utilized.
2. A description of the training plan for program staff (Peer Specialists, Peer Specialist supervisors & mental health professionals) related to knowledge and competency in the areas of recovery and Peer Support.
3. A description of the staffing pattern plans for how staff will be deployed to ensure that the required consumer-to-Certified Peer Specialist ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated.
4. A description of how Peer Specialists within the agency will be given opportunities to meet with or otherwise receive support from other Peer Specialists both within and outside the agency.
5. A description of how the Peer Specialist staff will participate in clinical team meetings at the request of a consumer, and the procedure for requesting a team meeting.
6. A description of the hours of operation, the staff assigned, and the types of services and activities provided by Peer Specialists.
7. A description of the governing body and advisory structures.
8. A description of how the plan for services and activities will meet the needs specified in each consumer's recovery/individual service plan, as well as how consumers may request changes in services or service intensity.
9. A service philosophy reflecting recovery principles as articulated by the OMHSAS vision and guiding principles.

Providers of peer support services are responsible for:

Submitting for approval to the Department an initial description of program services and any subsequent changes to include:

1. A description of particular Peer Supports utilized, types of intervention(s) practiced, typical program day or services, and expected outcomes.
2. Written protocols for the Peer Support services which describe their agency policies and program guidelines
3. Service delivery patterns including average frequency of service received (days per week, month) intensity (hours), and duration of services (length of stay) provided by each Peer Specialist.
4. Agency table of organization which includes staffing patterns, staff to consumer ratios and program capacity, staff qualifications, and cultural diversity reflective of the population.
5. Populations served including diagnoses, age and any specialization.
6. Program philosophy.
7. Staff training plan.
8. Linkages with treatment, rehabilitation, medical and community resources.
9. Days and hours of program operation.
10. Physical plant description, including physical space/floor plan utilized by Peer Support program and copies of all applicable licenses/certificates including Labor and Industry, fire, health and safety.
11. Continuous quality improvement procedures and reports of findings and actions taken to enhance or improve the quality of services.

12. Agency commitment to collect and report cost, service and consumer data, as required by the Department to monitor and evaluate the Peer Support program.

Authorization and UM:

1. Four hours per day and 900 hours per year may be provided.
2. Admission, continued stay and discharge criteria are defined.

Peer Specialist qualifications:

1. Be a self-identified individual who has received or is receiving state priority group services as defined in the Mental Health Bulletin OMH-94-04, Serious Mental Illness: Adult Priority Group.
2. Have a high school diploma or GED
3. Have maintained, within the last three (3) years, at least 12 months of successful full or part time paid or voluntary work experience or one year post secondary education experience totaling 24 credit hours.
4. Complete and pass a peer specialist certification training program, including written examination, which is offered in accordance with guidelines defined by the Department.
5. Continuing education. 18 hours per year with 12 hours specific to peer support.

Requirements to supervise Peer Specialists:

1. Mental health professional who has completed approved Peer Specialist supervisory training.
2. BA degree, two years of experience, and completion of supervisory training.
3. HS degree, four years experience, and completion of supervisory training.

Maine.

From MaineCare Benefits Manual Chapter II, Section 17, Community Support Services

- 17.01-3 **Certified Intentional Peer Support Specialist (CIPSS)** means an individual who has completed the DHHS Office of Adult Mental Health Services (OAMHS) curriculum for CIPSS and receives and maintains certification. The training is 58 hours.
- 17.01-14 **Peer** means an individual who is receiving or who has received services related to the diagnosis of a major mental illness and is willing to self-identify with peers on this basis in the community.

Part of the definition of ACT team composition requires,

One full time equivalent CIPSS if CMS approves a state plan amendment requiring one full equivalent CIPSS (The requirement is effective one (1) year from the date of CMS approval of the state plan amendment. The Department will notify all Community Service Providers within thirty (30) days of CMS approval or denial)

- 17.04-8 **Specialized Group Services.** Specialized Group Services consist of education, peer, and family support provided in a group setting to assist the members to focus on recovery, wellness, meaningful activity, and community tenure. When co-facilitated by two non-licensed mental health professionals, a licensed mental health professional must supervise the co-facilitation.

Effective
2/1/08

Specialized Group Services fall into the following four (4) groups:

- A. **Wellness Recovery Action Planning (WRAP)** Wellness Recovery Action Planning is a curriculum-based recovery group, co-facilitated by peers, that explores the foundational concepts of recovery and wellness, including hope, personal responsibility, and education; increases the understanding of personal experiences; encourages the use of natural supports; and utilizes the development of tools for a personal plan that promotes an improved quality of life focusing on relapse prevention, personal growth, and recovery. The group meets for a maximum of twelve (12) sessions of two (2) hours each. The service is facilitated by individuals who have received a certificate for successful completion of “Mental Health Recovery WRAP: Facilitator Certification” or other training, as specified by the Office of Adult Mental Health Services.
- B. **Recovery Workbook Group.** A Recovery Workbook Group is a co-facilitated, curriculum-based recovery group designed to increase awareness and understanding of the recovery process. This service includes the development of coping and empowerment strategies, skills for rebuilding connections with self or others, and skills needed to strengthen and maintain the recovery process and to create opportunities for living fuller lives. The group meets for a maximum of thirty (30) consecutive sessions. The service is facilitated by individuals who have

received a certificate for successful completion of the course “PDP 703-REC: Facilitating a Recovery Workshop” through the Boston University Center for Psychiatric Rehabilitation. The Recovery Workbook Group is co-facilitated and requires at least one peer facilitator. The second co-facilitator may be a peer, mental health professional, or other qualified individual.

- C. **Trauma Recovery and Empowerment Group (TREM).** A Trauma Recovery and Empowerment Group utilizes a skills-based group treatment approach to address issues of sexual, physical, and emotional abuse. The co-facilitated group meets for a maximum of thirty-three (33) consecutive weeks. Thirty (30) sessions focus on empowerment, trauma recovery, and advanced trauma recovery issues. The remaining three (3) sessions serve as the conclusion, or termination, for the group. Each session is seventy-five (75) minutes long and includes a combination of discussion and experiential exercises. The format for the group is based upon “*Trauma Recovery and Empowerment – A Clinician’s Guide for Working with Women in Groups*” authored by Maxine Harris, PhD, and The Community Connections Trauma Work Group, and may include utilization of the workbook entitled “*Healing the Trauma of Abuse*” co-authored by Mary Ellen Copeland, MA, MS, and Maxine Harris, PhD.
- D. **Dialectical Behavior Therapy (DBT).** Dialectical Behavior Therapy is a skills training group conducted in a psychoeducational format. The co-facilitated group focuses on the acquisition and strengthening of skills. Skills training consists of four (4) modules: mindfulness, distress tolerance, interpersonal effectiveness in conflict situations, and emotional regulation. Groups meet weekly for two (2) to two and a half (2 1/2) hour sessions for up to one (1) year, but may meet more frequently for a shorter duration. Format for the group is based upon “*Skills Training Manual for Treating Border-Line Personality Disorder*” authored by Marsha M. Linehan.

Rates: H0038, Self Help, Peer Support: \$11.45/15 min

H2019, Therapeutic Behavioral Services (Specialized group): \$10.50/15 min.

Illinois

These comments were provided by the Illinois office of consumer affairs, Nanette Larson.

Mental health Medicaid services are covered in Illinois under the rehabilitative and targeted case management options in the State Plan. Illinois chose to incorporate Peer Support services into its broad array of services rather than developing a separate unique service. Peer services are incorporated in several ways:

1. Illinois' mental health delivery system recognizes the significant contribution of individuals with life experiences, not just professional licenses. Many of the mental health services may be provided by a rehabilitative services associate (RSA) who is under the clinical direction of a qualified mental health professional (QMHP). An RSA must be 21 years of age, and be able to take direction and work effectively with others. This allows individuals in recovery from mental illness to be employed. Additionally, a Certified Recovery Support Specialist (CRSS) with an additional year of experience in the provision of mental health services qualifies as a mental health professional (MHP).
2. The two team services - Assertive Community Treatment and community support teams - require that at least one of the team members be a person in recovery from mental illness, preferably a CRSS.

There is a document on the Illinois website that describes each service and defines the requirements and rates for each of the services. It is located at:

http://www.hfs.illinois.gov/assets/070107_cmph_guide.pdf

You will note that most services reimburse for the level of practitioner who is providing the service.

Assertive Community Treatment Teams:

Each ACT team shall consist of at least six FTE staff, including a licensed clinician as team leader and at least one RN. The team must be supported by a psychiatrist and program/administrative assistant. At least one team member must have training or certification in substance abuse treatment, one in rehabilitative counseling and one person in recovery.

Community Support Teams:

Teams may be no fewer than three FTEs. A full-time team leader, who is at least a QMHP, is required. Sufficient staff is also necessary to maintain the required client staff ratio. Preferably one team member should be a person in recovery.

Certified Recovery Support Specialists:

www.iaodapca.org

(From the "Illinois Model of Certified Recovery Support Specialist" prepared by the Illinois Certification Board, Inc.).

Performance Domains:

ICB measures competency through the four Performance Domains, as defined by, the Recovery Support Specialist, Role Delineation Study, Final Report, March 2007, prepared by Comprehensive Examination Services (CES). CRSS professionals perform the Core Functions of

each Performance Domain to various degrees. CRSS professionals are not required to be experts in the Core Functions, but are expected to gain proficiency in these functions as they advance in their careers.

ICB certification focuses on the evaluation and demonstration of professional competency, with emphasis on professional competency. Competency is defined as the ability to perform the job and to perform the required tasks. The professional competencies are cumulative as an individual moves through their professional development.

Advocacy Roles for the CRSS:

1. Serve as the consumer's individual advocate.
2. Advocate within systems to promote consumer-centered recovery support services.
3. Assure that the consumer's choices define and drive the recovery planning process.
4. Promote consumer-driven recovery plans by serving on the consumer's recovery-oriented team.

Professional Responsibility for the CRSS:

1. Respond appropriately to risk indicators to assure the consumer's welfare and physical safety.
2. Immediately report suspicions that the consumer is being abused or neglected.
3. Maintain confidentiality.
4. Communicate personal issues that impact one's ability to perform job duties.
5. Assure that interpersonal relationships, services and supports, reflect the consumer's individual differences and cultural diversity.
6. Document service provision as required by the employer.
7. Gather information regarding the consumer's personal satisfaction with his/her progress toward recovery goals.

Core Functions of Certified Recovery Support Specialists:

Mentoring

1. Serve as a role model of a consumer in recovery.
2. Establish and maintain a "peer" relationship rather than a hierarchical relationship.
3. Promote social learning through shared experiences.
4. Teach consumers life skills.
5. Encourage consumers to develop independent behavior that is based on choice rather than compliance.
6. Assure that consumers know their rights and responsibilities.
7. Teach consumers how to self-advocate.

Recovery Support

1. Serve as an active member of the consumer's recovery-oriented team(s).
2. Assure that all recovery-oriented tasks and activities build on the consumer's strengths and resiliencies.

3. Help the consumer identify options and participate in all decisions related to establishing and achieving recovery goals.
4. Help the consumer develop problem-solving skills so they can respond to challenges to their recovery.
5. Help the consumer access the services and supports that will help them attain their individual recovery goals.

Advocacy

1. Define system-level advocacy.
2. Explain why self-advocacy is the foundation of recovery.
3. Identify the consumers' individual support systems.
4. Promote the principles of individual choice and self-determination.
5. Explain how and why consumers should establish Advanced Directives.
6. Explain how to advocate within the mental health system.
7. Define consumer-driven recovery.
8. Use "person-centered" language that focuses on the individual, not the diagnosis.
9. Demonstrate non-judgmental behavior.

Professional Responsibility

1. Explain the ten fundamental concepts of recovery as defined in the National Consensus Statement on Mental Health Recovery, which is published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).
2. Define the concept of a wellness-focused approach to consumer recovery.
3. Explain the fundamental concepts related to cultural competency.
4. Understand the concept of accountability.
5. Explain basic federal, state, and employer regulations regarding confidentiality.
6. Explain what, where, when and how to accurately complete all required documentation activities.
7. Explain the concept of de-compensation.
8. Identify the consumers risk indicators, including individual stressors, triggers and indicators of escalating symptoms.
9. Explain basic de-escalation techniques.
10. Explain basic suicide prevention concepts and techniques.
11. Identify indicators that the consumer may be experiencing abuse and/or neglect.
12. Identify and respond appropriately to personal stressors, triggers and indicators.

Mentoring

1. Explain the concept of mentoring.
2. Explain the concept of role-modeling behaviors.
3. Define social learning.
4. Define self-advocacy.
5. Define life skills.
6. Understand basic adult learning principles and techniques.
7. Use adult learning techniques to teach life skills.
8. Explain the concept of healthy, interdependent relationships.
9. Use active listening skills.
10. Use empathetic listening skills.

11. Demonstrate non-judgmental behavior.
12. Demonstrate consistency by supporting consumers during ordinary and extraordinary times.
13. Promote the development of Advanced Directives.

Recovery Support

1. Explain the ten fundamental concepts of recovery as defined in the National Consensus Statement on Mental Health Recovery, which is published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).
2. Explain the concept of a strength-based approach to recovery.
3. Promote self-determination and consumer choice-driven recovery.
4. Use active and empathetic listening skills with the consumer.
5. Use Motivational Interviewing skills with the consumer.
6. State the stages of change.
7. State the stages of recovery.
8. Identify the consumer's current stage of change and/or recovery.
9. Help the consumer develop problem-solving skills by working together to identify and discuss options, alternatives, and possible consequences.
10. Explain the typical process that should be followed to access and/or participate in community mental health and related services.
11. Identify circumstances when it is appropriate to request assistance from other professionals to help meet the consumer's recovery goals.
12. Identify the consumer's strengths, resiliencies, and challenges to recovery. Promote the consumer's empowerment by assuring that they are informed of their options and participate in all decision-making that will affect their lives.

Minimum Requirements for CRSS Certification:

The following chart details the minimum requirements for board certification based on work experience, supervised practical experience, and training/education:

Board Certification Level	Degree	Hrs of Training	Supervised Practical Experience	Work Experience	Required Examination
CRSS	High School Or GED	100 clock hours <ul style="list-style-type: none"> • 40 hours* CRSS Specific • 6 hours Professional Ethics and Responsibility • 54 hrs Core Functions 	100 clock hours of supervision received in the CRSS Domains	2000 hours (One Year)	Successful score on the CRSS Written Examination

*Minimum of 10 hours in each of the domains

Degree Requirement:

1. Must be documented to meet the criteria for board certification.
2. The applicant for CRSS must have a High School Diploma, GED, or higher degree.

Training / Education:

1. The applicant for CRSS certification must document a minimum of 100 clock hours of education.
2. Sources of education are the Illinois Recovery Support Specialist Training Program, Wellness Recovery Action Plan orientation/seminar/courses, PRCP college courses, seminars, conferences, in-services, and lectures.
3. One college semester hour equals 15 clock hours.
4. One college quarter hour equals 10 clock hours.
5. One college trimester hour equals 12 clock hours.

Supervised Practical Experience:

1. In order to meet the experience requirements for the CRSS, the applicant must submit a completed Supervisor Evaluation Form from a work/internship experience, which was maintained for at least one year.
2. The supervision must be documented. The supervisor does not need to be ICB certified.
3. Supervision is broadly defined as in the SAMHSA Technical Assistance Publication Number 21 (TAP 21). It defines supervision/clinical supervision as the administrative, clinical and evaluative process of monitoring, assessing and enhancing counselor performance.
4. The applicant must submit verified documentation of supervision covering the CRSS four Performance Domains.
5. Supervision includes the hours the individual spends being observed, either directly or indirectly (audio/video tapes, chart review, etc.) performing these services, time spent discussing topics related to the CRSS role and responsibilities in staff meetings, or time spent with a designated supervisor discussing the CRSS professional's work performance.
6. Realizing that supervision may take place in a variety of settings and have many faces, ICB has determined not to place limiting criteria on either the areas of supervision, or qualifications of a supervisor.

Supervised work experience is defined as paid, supervised employment in a position where an applicant spends at least 51% of his or her time providing mental health recovery support services. Volunteer work is not applicable. Applicants minimally must have primary responsibility for providing recovery support services to an individual and/or group, preparing recovery plans, documenting clients' progress, and be clinically supervised by an individual who is knowledgeable in the Recovery Support Performance Domains.

A non-resident of Illinois pursuing a credential as a Mental Health CRSS is eligible for ICB Certification if at least 51% of the applicant's work experience in the last 90 days prior to application was performed in an Illinois MH setting.

Certification Maintenance and Recertification:

ICB believes that CRSS professionals must be committed to ongoing personal and professional growth. This commitment results from CRSS professionals' recognition of the necessity to offer the consumer the best and widest range of currently accepted recovery support services. The ever-changing research findings, particularly in the areas of mental health recovery, rehabilitation, addiction recovery, and wellness management require ongoing attention and study.

CRSS professionals are responsible for maintaining their own certification, and they are responsible for completing the necessary work in regard to certification maintenance. Unless it is renewed, their certification shall expire annually on their certification anniversary date. CRSS professionals will be notified that their certification is about to expire no fewer than 30 days prior to the expiration date. To maintain certification, they will submit their annual certification fee and documentation of a total of 40 continuing education units (CEUs) every two years to ICB by their expiration date. Forms for the documentation of CEUs will accompany the notification and must be completed, signed, and submitted with proof of attendance. Documentation of continuing education should not be submitted, and will not be accepted or maintained by ICB until notification of expiration is received by the CRSS professional.

Continuing Education Policy:

The purpose of continuing education is to promote ongoing professional development. It benefits the consumers served, the CRSS professional, and the CRSS profession. Through the pursuit of continuing education, the CRSS professional will build upon his/her previously demonstrated competencies and demonstrate his/her professional development.

Forty (40) continuing education units (CEUs) are required to maintain board certification, and must be earned within the two-year certification period. An average of 20 CEUs should be obtained each year. CEUs are not transferable to any other certification period. CEUs earned prior to initial certification are not eligible to be used for maintaining certification. The CRSS professional may receive CEU credit only once for a training event, even if repeated during different certification periods. A CEU is equivalent to one clock hour. Non-program hours, such as breaks, social hours, registration time, and meal times, are excluded. One college semester hour of credit is equivalent to 15 CEUs, one college trimester hour of credit is equivalent to 12 CEUs, and one college quarter hour of credit is equivalent to 10 CEUs.

All 40 CEU's required to maintain certification must be recognized by ICB or petitioned for ICB approval. Continuing education is broken down into two categories. Some continuing education may be recognized by the ICB for both categories.

1. Category I - Minimum 15 CEUs of education specific to knowledge and skills related to mental health recovery and the role of peer support in the recovery process

Examples of Category I education are: Advocacy, Professional Responsibility, Mentoring and Recovery Support

2. Category II – Minimum 25 CEUs of education specific to knowledge and skills related to the Core Functions of CRSS professionals, but do not have to be specific to mental health recovery and peer support. This education covers support services skills, competencies, and the knowledge base.

Examples of Category II education may include evidence-based practices, leadership skills, communication skills, Trauma-Informed Care, alternative therapies, conflict resolution, confidentiality, legal systems, crisis intervention, health and safety, roles/boundaries, relapse prevention, cultural competency, and interventions.

Wisconsin

From the Wisconsin Department of Health and Family Services rules, HFS.36.10, “Comprehensive Community Services for Persons with Mental Disorders and Substance Use Disorders, Subchapter IV, Personnel.”

A peer specialist is a staff person who:

1. Is at least 18 years old,
2. Shall have successfully completed 30 hours of training during the past two years in recovery concepts, consumer rights, consumer–centered individual treatment planning, mental illness, co–occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, and consumer confidentiality.
3. Has a demonstrated aptitude for working with peers.
4. Has a self–identified mental health disorder or substance use disorder.

New Hampshire

Provides for Peer Support Agencies (PSA) in PART He-M 402 PEER SUPPORT, Statutory Authority: RSA 126-N:4. Following are some key aspects.

The purpose of a PSA is to provide support and programming that:

1. Fosters recovery from mental illness by helping individuals identify and achieve personal goals while building an evolving vision of their recovery;
2. Foster self-advocacy skills, autonomy, and independence;
3. Foster the ability of people with mental illness to:
 - a. Fully participate in their families;
 - b. Fully participate in their communities; and
 - c. Be employed;
4. Emphasizes mutuality and reciprocity as demonstrated by:
 - a. Shared decision making;
 - b. Strong conflict resolution;
 - c. Non-medical approaches to help; and
 - d. Non-static roles, such as, staff who are members and members who are educators;
5. Offers alternative views on mental health, mental illness and the effects of trauma and abuse;
6. Encourages informed decision-making about all aspects of people's lives;
7. Supports people with mental illnesses in challenging perceived self-limitations, while encouraging the development of beliefs that enhance personal and relational growth; and
8. Emphasizes a holistic approach to health that includes a vision of the "whole" person.

He-M 402.03 Composition and Responsibilities of a PSA:

1. A PSA shall be incorporated and shall have an established plan for governance.
2. The plan for governance shall comply with the following:
 - a. A PSA's Board of Directors shall:
 - i. Have responsibility for the entire management and control of the property and affairs of the corporation; and
 - ii. Have the powers usually vested in the board of directors of a nonprofit corporation, except as regulated in He-M 402;
 - b. The responsibility and powers described in (1) above shall be stated in a set of bylaws maintained by the PSA board;
 - c. A PSA's Board of Directors shall not allow more than 20% of the board members to serve for more than 6 consecutive years;
 - d. A PSA's Board of Directors shall specify in its bylaws a procedure by which inactive PSA members are removed from the PSA board;
 - e. The size and composition of the board of directors of a PSA shall be as follows:
 - i. The number of persons serving as board members shall be no fewer than nine (9);
 - ii. Consumers shall comprise a minimum of 51% of the membership of

- the PSA Board;
- iii. No more than 20% of board members shall be related by blood, marriage or cohabitation to other Board members;
- iv. Board membership shall not be open to the following individuals:
 1. Employees of a PSA, the spouses or significant others of employees, or anyone living in the same household as an employee, except that the executive director shall be eligible as an ex officio member;
 2. Employees of the New Hampshire department of health and human services or their spouses; and
 3. Individuals or the spouses of individuals who are under contract with a PSA;
- f. By-laws shall include term limits for Board of Director officers;
- g. By-laws shall include a nominating process that actively recruits diverse individuals whose skills and life experiences will serve the needs of the agency;
- h. The PSA's Board of Directors shall establish policies for the governance and administration of the PSA and all services provided through contract with the PSA.
- i. Policies shall be developed to ensure efficient and effective operation of the PSA and adherence to requirements of federal funding sources and rules and contracts established by the department.
- j. The PSA shall be responsible and accountable for all PSA services whether administered directly by a PSA or provided under contracts with other organizations.
- k. Upon dissolution of the PSA or upon the event that the PSA no longer contracts with the bureau of behavioral health, ownership and possession of all assets and property obtained with funds granted by the bureau shall revert to the bureau of behavioral health.

He-M 402.04 Fiscal Management:

1. A PSA shall utilize federal, third party and other public and private sources of funds that are available for the agency to carry out the purposes of the PSA.
2. The Board of Directors shall establish and document an orientation process for educating new Board members regarding:
 - a. Fiduciary responsibilities of Board membership.
 - b. Trainings for treasurer and all Board members regarding reviewing and analyzing financial statements and general financial oversight.
 - c. The bureau of behavioral health shall conduct announced or unannounced reviews of PSAs and audit PSAs including all or part of any services, finances or operations of the PSAs, whether operated directly by the PSA or for services contracted through or with another organization.
 - d. A PSA shall submit annually to the bureau of behavioral health an independent audit of the PSA and an independent audit of any subcontractor of the PSA that provides Peer Support services. The independent audits shall be performed by a certified public accountant and

be submitted together with a management letter, if issued, by September 30 for the previous fiscal year ending June 30.

He-M 402.05 Staff Training, Staff Development and Orientation:

(Information was not readily available, but can be obtained if necessary/useful)

He-M 402.06 Peer Support Services:

1. PSAs shall provide the following supports and services:
 - a. Peer support, consisting of:
 - i. Supportive interactions based on shared experience among members, participants, staff and volunteers that are:
 1. Face-to-face or by telephone;
 2. Intended to assist people to understand their potential and ability to achieve their personal goals and recovery; and
 3. Based on acceptance, trust, respect and mutual support.
 - b. Outreach, consisting of any community-based activity, face-to-face or by telephone, that:
 - i. Is designed to contact people meeting membership criteria; and
 - ii. Includes, at a minimum, the following:
 1. Providing support to members and participants who are unable to attend activities of the peer support agency;
 2. Visiting people who are psychiatrically hospitalized; and
 3. Reaching out to people who meet membership criteria and are homeless.
 - c. Telephone Peer Support, consisting of Peer Support provided to members and participants of a PSA or to others who contact the agency during business hours.
 - d. A monthly newsletter published and distributed by the PSA that describes:
 - i. Agency services and activities;
 - ii. Social and recreational opportunities;
 - iii. Other community services that might be of interest to members and participants; and
 - iv. Other relevant topics;
 - e. Wellness training, consisting of training provided by or sponsored by a PSA intended to enhance members' and participants' abilities to attain and maintain their emotional health and recovery from mental illness.
 - f. Monthly educational events, which over the course of a year shall include:
 - i. Rights protection;
 - ii. Peer advocacy;
 - iii. Recovery;
 - iv. Wellness management; and
 - v. Community resources.
 - g. Individual peer assistance provided to adults to:
 - i. Locate, obtain and maintain services and supports through referral, consumer education and self-empowerment;
 - ii. Provide support for individuals who are identifying problems to be addressed or resolving grievances; and

- iii. Promote self-advocacy.
- 2. PSAs may provide additional services not identified in (a) above including the following:
 - a. Crisis respite, which shall:
 - i. Consist of a 24-hour, short-term, non-medical program designed as an alternative to hospitalization; and
 - ii. Be operated by PSA staff trained in methods designed to address the needs of consumers experiencing psychiatric crises;
 - b. Residential services, which shall consist of support and assistance provided by a PSA to a member or participant in his or her home or apartment;
 - c. Vocational support, which shall consist of the provision of Peer Support intended to promote a member's or participant's competitive employment;
 - d. Warm line, which shall:
 - i. Be a separate program within the PSA;
 - ii. Offer on-call telephone Peer Support services;
 - iii. Be available to members, participants, and others who want or need assistance with crises;
 - iv. Have staff trained to provide warm line services; and
 - v. Be provided in the hours during which the PSA is closed; and
 - e. Transportation.
- 3. A PSA shall conduct community education activities, including the provision of education and consultation to members of the community at large, with the goal of increasing the acceptance of persons recovering from mental illness. Activities shall include working with the media, public speaking and information dissemination.
- 4. A PSA shall collaborate with other local human service providers that serve consumers in order to:
 - a. Facilitate referrals; and
 - b. Share information about services and other local resources.
- 5. A PSA shall offer training and technical assistance to help consumers advocate on their own behalf regarding health care.
- 6. A PSA shall ensure that consumers are informed and involved in local and system-wide service planning, program evaluation, and education and training activities.
- 7. Guests may be invited to participate in Peer Support activities.

He-M 402.07 Executive Director Selection and Evaluation:

- 1. Each PSA shall employ an Executive Director who has, at a minimum:
 - a. The following qualifications:
 - i. Demonstrated knowledge of the values and philosophy of Peer Support as determined by the board of directors of the PSA;
 - ii. One year of supervisory or management experience; and
 - iii. An associate's degree or higher in administration, business management, education, health, or human services; or
 - b. Each year of experience in the peer support field may be substituted for one year of academic experience.

2. An executive director of a PSA shall be appointed and evaluated as follows: (additional information is available)

He-M 402.08 Quality Improvement.

1. The department of health and human services shall conduct announced or unannounced quality assurance reviews of PSAs to assure that such services and programs are operated in accordance with the department's rules and contract provisions.
2. A PSA shall perform active monitoring and comprehensive quality assurance activities including, at a minimum:
 - a. Participation in quality improvement reviews conducted by the bureau of behavioral health;
 - b. Member satisfaction surveys;
 - c. Reviews of personnel files for completeness; and
 - d. Reviews of the complaint process.

Hawaii

From the Adult Mental Health Division, Policy and Procedures Manual, Number 60.646

This pertains to the Code of Ethical Conduct for Hawaii Certified Peer Specialists in their various roles, relationships and levels of responsibility in which they function professionally.

Definitions:

1. Hawaii Certified Peer Specialist – A person in recovery from mental illness and possibly with co-occurring substance abuse who has taken the Hawaii Certified Peer Specialist Training and successfully passed the written and oral examinations, and who has been awarded a Certification Diploma.
2. Self-Determination – An essential part of recovery in which a mental health consumer/survivor/ex-patient has the lead and choice in the recovery process and in any recovery-based activities.
3. Recovery – A process by which people with mental illnesses regain mental health and/or sobriety. Elements of recovery include self-determination, mutual support, hope, acceptance, and responsibility. Recovery includes the belief of personal growth, living a satisfying, hopeful and contributing life, and developing new meaning and purpose in life, even with the presence of severe mental illness and co-occurring substance abuse.
4. Dual Relationship – An inherent conflict of interest, such as a Hawaii Certified Peer Specialist receiving additional and separate income from serving consumers in a program from which they already receive compensation.
5. HCPS – Abbreviation for Hawaii Certified Peer Specialist.
6. c/s/x – Abbreviation for consumer/survivor/ex-patient or person.

Procedures:

1. The primary responsibility of Hawaii Certified Peer Specialists (HCPS) is to help individuals achieve their own needs, wants, and goals. HCPSs will be guided by the principle of self-determination for all.
2. HCPSs will maintain high standards of personal conduct. HCPSs will also conduct themselves in a manner that fosters their own recovery.
3. HCPSs will openly share with c/s/xs and colleagues their recovery stories, and will likewise be able to identify and describe supports that promote their own recovery.
4. HCPSs will at all times respect the rights and dignity of those they serve. HCPSs will never intimidate, threaten, harass, use undue influence, physical force or verbal abuse, or make unwarranted promises of benefits to the individuals they serve.
5. HCPSs will not practice, condone, facilitate or collaborate in any form of discrimination on the basis of ethnicity, race, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, or any other preference or personal characteristic, condition, or state.
6. HCPSs will advocate for those they serve that they will make their own decisions in all matters when dealing with other professionals.
7. HCPSs will respect the privacy and confidentiality of those they serve.

8. HCPSs will advocate for the full integration of individuals into communities of their choice, and will promote the inherent value of those individuals to those communities. HCPSs will be directed by the knowledge that all individuals have the right to live in the least restrictive and least intrusive environment.
9. HCPSs will not enter into dual relationships or commitments that conflict with the interests of those they serve.
10. HCPSs will never engage in sexual/intimate activities with the people they serve.
11. HCPSs will not abuse substances under any circumstance.
12. HCPSs will keep current with emerging knowledge relevant to recovery, and openly share this knowledge with their colleagues and people they serve.
13. HCPSs will not accept gifts of significant value from those they serve.

Oregon

Current Options to provide Medicaid funding for peer delivered services in Oregon include:

1. Twenty (20) Hour Personal Care Services - An individual who is eligible for Medicaid and needs assistance with an activity of daily living (e.g., medication management, nutrition, basic personal hygiene) may select and employ a personal care assistant of their choosing, including a peer. The eligible individual must be living independently (e.g., not in foster care or a residential treatment home or facility).
2. Mental Health Organizations (MHOs) provide Prevention, Education and Outreach. MHOs can support peer services through PE&O activities, which include services such as parent/family education, life skills development, prevention support activities, and services integration. Prevention, Education and Outreach (PE&O) activities are provided on an individual or broad basis. These services do not result in encounterable clinical services covered by the Oregon Health Plan's mental health benefit package. The PE&O activities are reported in a lump sum by the MHOs.
3. MHOs may provide reimbursement for clinical interventions or services by peers who are employed by an agency certified by Addictions and Mental Health (AMH) Division. These peer delivered services must be part of a treatment plan which meets the Oregon Administrative Rules for Adult Outpatient services. These services are reported with encounter codes to document the services provided by the MHO.
4. Peer run organizations may apply for AMH certification and Medicaid credentialing requirements and, with approval of the Community Mental Health Program, provide the full range of Adult Outpatient services. The full range of adult outpatient services includes training requirements, clinical services, clinical supervision, etc. These services are reported with encounter codes to document the services provided by the MHO.

The procedure code for "Self-help/Peer Services" (H0038) is an "encounter" code used by Mental Health Organizations to document and report to DHS the provision of services. There is no state specified payment amount assigned to H0038, but some MHOs provide payment for this service. MHOs negotiate payment rates for the services provided. This is particularly true for encounter-only codes such as H0038 that are not included in the fee-for-service payment system, and are used to provide data to establish future rates.