

# 2013

## Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers



**Working Well Together**

Training and Technical Assistance Center



Report prepared for CAMHRO-PEERS  
under Working Well Together  
by Inspired at Work  
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## **ACKNOWLEDGEMENTS**

We'd like to specially recognize Karin Lettau for her diligence, hard work and grace in ensuring that all stakeholders felt heard and understood throughout the process.

## **DISCLAIMER**

The views expressed in this publication do not necessarily reflect the views of the Office of Statewide Health Planning and Development.

## Executive Summary

Working Well Together is the only statewide organization dedicated to transforming systems to be client and family-driven by supporting the sustained development of client, family member and parent/caregiver employment within every level of the public mental health workforce. As part of this effort Working Well Together has, for the last three years, engaged in researching and evaluating the feasibility of inclusion of Peer Support into a State Plan Amendment for Specialty Mental Health services. This three year effort has included thorough state-wide and national research and extensive stakeholder involvement and has yielded seventeen recommendations for the development of Peer Support as an integral service within the public mental health system.

The statewide survey conducted to evaluate the current practice of hiring consumers and family members into the mental health workforce revealed that most counties have indeed hired people with lived experience of a mental health challenge or parents/family members of individuals with a mental health issue into the mental health workforce. However the survey also revealed that there remain significant workforce issues that must be addressed. Of the thirty responding counties that hire people with lived experience, none required previous training or education beyond a high school diploma as a qualification for hire. This was found to be true even in counties that have developed excellent training programs for Peer Support. Additional findings revealed that a variety of generalist job titles are used to hire Peer Support Specialists, job duties and descriptions vary widely and may or may not include peer support as a job duty.

The stakeholder process exposed a number of workforce issues that must be addressed to further the professional development of Peer Support as a discipline and Peer Support Specialists as practitioners. Perhaps the most pressing issue is the lack of a definition and/or understanding of Peer Support. While most counties have hired individuals with lived experience as well as parents and family members to provide services, many of these practitioners are providing services that are traditionally considered “case management” and include collateral, targeted case management and rehabilitation services. Another identified trend was the use of peer employees as clerical support, transportation providers and social or recreational activities support. Interestingly, while many of these practitioners are providing billable services within the scope of practice of “Other Qualified Provider”, very few

counties (approximately nine) are billing Medi-Cal for these services. Going forward it is vital that Peer Support is identified as a separate and distinct service from other services provided under the current definitions of Specialty Mental Health services. Additional workforce issues identified by stakeholders necessary to advance the development for and respect of Peer Support include the;

1. Creation of welcoming environments that embrace these practitioners.
2. Development of multi-disciplinary teams that respect this new discipline.
3. Education and training of County Directors and Administration as well as the existing workforce on the value, role and legitimacy of peer support.
4. Training and acceptance of Medi-Caid approved use of recovery/resilience/wellness language in documentation.

While stakeholders strongly support the inclusion of peer support into a State Plan Amendment, they also support flexibility in what services individuals with lived experience can provide within the mental health system. Stakeholders strongly support career ladders that include non-certified peer providers as well as people with lived experience continuing their education and advancing into existing positions traditionally used in mental health settings, including supervision and management as well as the development of career ladders that include advancement opportunities within the practice of peer support. In short, stakeholders support maximum flexibility in what people with lived experience can provide and bill for within the existing State Plan as well as the inclusion of peer support as a new service category.

Stakeholders also emphasize the importance of recognizing that there are a number of services that enhance wellness and recovery/resiliency that peers may provide but that may not be reimbursed by Medi-Caid. It will be vital, when considering adding peer support as a new service, that reimbursement for peer support services not become the primary driving focus when offering/providing these services to clients and their families.

Working Well Together has engaged stakeholders in on-going teleconferences, webinars, work-groups, and five regional stakeholder meetings to provide feedback and recommendations that will support the requirements as laid out by the CMS letter regarding inclusion of peer support as a part of services provided under Specialty Mental Health. This resulted in several recommendations in support of the development of a statewide

Certification for Peer Support Specialists. In May of 2013 a final Statewide Stakeholder Summit was convened to provide further vetting with the goal of finalizing recommendations for the inclusion of peer support into the State Plan Amendment as well as the development of a statewide Certification for Peer Support Specialists. By and large the vast majority of stakeholders support the original recommendations, however, where appropriate, adjustments have been made in alignment with stakeholder feedback. Also where appropriate, additional edits to specific recommendations have been made to provide clarity. The seventeen recommendations are listed below.

DRAFT

## Final Stakeholder Recommendations regarding Certification of Peer Support Specialists

### Recommendation 1

Develop a statewide certification for Peer Support Specialists, to include:

- Adult Peer Support Specialists
- Young Adult Peer Support Specialists
- Older Adult Peer Support Specialists
- Family Peer Support Specialists (Adult Services)
- Parent Peer Support Specialists (Child/Family Services)

- 1.1 Require Peer Support Specialists to practice within the adopted Peer Support Specialist Code of Ethics.
  - 1.1.1 Seek final approval of Peer Support Code of Ethics by the Governing Board of Working Well Together.
- 1.2 Develop or adopt standardized content for a state-wide curriculum for training Peer Support Specialists.
- 1.3 Require a total of 80 hours of training for Peer Support Specialist Certification.
  - 1.3.1 55-hour core curriculum of general peer support education that all peer support specialists will receive as part of the required hours towards certification.
  - 1.3.2 25-hours of specialized curriculum specific to each Peer Support Specialist category.
- 1.4 Require an additional 25 hours of training to become certified in a specialty area such as forensics, co-occurring services, whole health and youth in foster care.
- 1.5 Require six months full-time equivalent experience in providing peer support services.
  - 1.5.1 This experience can be acquired through employment, volunteer work or as part of an internship experience.
- 1.6 Require 15 hours of CEU's per year in subject matter relevant to peer support services to maintain certification.
- 1.7 Require re-certification every three years.
- 1.8 Allow a grandfathering-in process in lieu of training.

- 1.8.1 Require one year of full-time equivalent employment in peer support services.
- 1.8.2 Require three letters of recommendation. One letter must be from a supervisor.  
The other letters may come from co-workers or people served.
- 1.9 Require an exam to demonstrate competency.
  - 1.9.1 Provide test-taking accommodations as needed.
  - 1.9.2 Provide the exam in multiple languages and assure cultural competency of exam.

### **Recommendation 2**

Identify or create a single certifying body that is peer-operated and/or partner with an existing peer-operated entity with capacity for granting certification.

### **Recommendation 3**

Include Peer Support as a service and Peer Support Specialist as a provider type within a new State Plan Amendment.

- 3.1 Seek adoption of the definitions of Peer Support Specialist providers and Peer Support services by the Governing Board of Working Well Together for use within the State Plan Amendment.
- 3.2 Maintain the ability for people with lived experience to provide services as “other qualified provider” within their scope of practice, including but not limited to rehabilitation services, collateral and targeted case management.
- 3.2 Acknowledge that there are important and non-billable services that Peer Support Specialists can and do provide.

### **Recommendation 4**

Include in the State Plan the ability to grant site certification for peer-operated agencies to provide billable peer support services.

- 4.1 Allow for peer-operated agencies to provide other services billable under “other qualified provider” within their scope of practice, including but not limited to rehabilitation services, collateral and targeted case management.

### **Recommendation 5**

Address the concern that current practice of documentation for billing may not be aligned with the values and principles of peer support and a wellness, recovery and resiliency orientation.

- 5.1 Engage with partners such as Department of Health Care Services and the California Mental Health Director’s Association in order to develop an action plan to advocate for the use of CMS-approved recovery/resiliency-oriented language in documentation.

### **Recommendation 6**

Investigate the options for broadening the definition of “service recipient” to include parents and family members of minors receiving services so that peer support services can be accessed more easily.

### **Recommendation 7**

Convene a working group consisting of Working Well Together, the Mental Health Directors, the Office of Statewide Healthcare Planning and Development (OSHPD) and the Department of Health Care Services to develop buy-in and policies that will create consistency of practice regarding peer support services across the state.

### **Recommendation 8**

Develop standards and oversight for the provider/entity that provides training of Peer Support Specialists.

- 8.1 Allow for multiple qualified training entities.
- 8.2 Training organizations must demonstrate infrastructure capacity that will allow for peer trainers.
- 8.3 Training must be provided by either individuals with lived experience or by a team that includes individuals with lived experience.

### **Recommendation 9**

Establish qualifications for who may supervise Peer Support Specialists.

- 9.1 Engage with the Mental Health Directors to develop a policy that outlines key qualifications necessary for the supervision of Peer Support Specialists.
- 9.2 Preferred supervisors are those individuals with lived experience and expertise in peer support.
- 9.3 Due to capacity issues, supervisors may include qualified people who receive specific training on the role, values and philosophy of peer support.
- 9.4 Recognize and define the specific qualities and skills within supervision that are required for the supervision of Peer Support Specialists. These skills should align with the values and philosophy of peer support.

#### **Recommendation 10**

Develop a plan to provide extensive and expansive training on the values, philosophy and efficacy of peer support to mental health administration and staff.

#### **Recommendation 11**

Develop a plan to ensure that welcoming environments are created that embrace the use of multi-disciplinary teams that can incorporate Peer Support Specialists fully onto mental health teams.

#### **Recommendation 12**

Develop a policy statement that recognizes and defines the unique service components of peer support as separate and distinct from other disciplines and services in order to maintain the integrity of peer support services.

#### **Recommendation 13**

Develop a policy statement and plan that supports the professional development of Peer Support Specialists that allows the practitioner to maintain and hone his/her professional values, ethics and principles.

#### **Recommendation 14**

Develop a plan for funding the development of certification.

- 14.1 Work with the Office of Statewide Healthcare Planning and Development to utilize

state-wide monies from the MHSA Workforce, Education and Training fund.

14.2 Investigate other potential funding sources.

14.3 Develop recommendations for funding of components of certification such as financial assistance with training, exam and certification fees.

**Recommendation 15**

Seek representation on committees and workgroups that are addressing civil service barriers to the employment of Peer Support Specialists.

**Recommendation 16**

Work with Mental Health Directors to seek agreement on a desired workforce minimum of Peer Support Specialists within each county to more fully actualize the intent of the MHSA.

**Recommendation 17**

Develop state-wide models that can inform county leadership on the development of career ladders for Peer Support Specialists that begin with non-certified Peer Support Specialists and creates pathways into management and leadership positions.

## Background

With the passage of the Mental Health Services Act in 2004, support for the provision of services to include peer providers identified as consumers, parents and family members has been on the rise. Many California counties have, in some way, included employees with lived experience as consumers and family members into the workforce either through direct hire or through community based organizations (CBOs). As California operates on a county-based system, these efforts have very little consistency across the state with regard to hiring practices, qualifications, necessary skill sets, job duties and supervision. Significantly, there is no statewide standardized statement regarding the value, significance or the role of these peer providers in the mental health system. Specific to services, the Act calls for advancing, “the philosophy, principles and practices of the Recovery Vision”. The Act also calls for increased participation and involvement of consumers and family members. The principles are identified as:

1. Significant increases in the level of participation and involvement of clients and families in all aspects of the public mental health system, including but not limited to, planning, policy development, service delivery and evaluation.
2. Increases in consumer-operated services such as drop-in centers, peer support programs, warm-lines, crisis services, case management programs, self-help groups, family partnerships, parent/family education and consumer-provided training and advocacy services. (CDMH, 2005).

In 2011, the California Network of Mental Health Clients (CNMHC) formed the Peer Support Coalition with the “need to formally legitimize the valued practice of peer support services by developing language to propose certification and Medi-Cal billing of peer support services in a State Plan Amendment” (CNMHC RFP, 2011).

The issue of peer support certification was later taken up by the Working Well Together (WWT) Statewide Technical Assistance Center, a collaborative made up of the California Association of Mental Health Peer Run Organizations (CAMHPRO)/Peers Envisioning and Engaging in Recovery Services (PEERS), the National Alliance on Mentally Illness, California (NAMI), the United Advocates for Children and Families (UACF) and the California Institute for Mental Health (CiMH). *This collaborative expanded the definition of peer provider to include consumers, transition-aged-youth, parents and family members working in the Adult and Children’s Systems of Care. The WWT collaborative has, over the last two years, had as*

*its goal, “to harness the input of various stakeholder groups in identifying certification standards for recommendation on a statewide basis.”* To date, WWT has held monthly teleconferences to seek input from and inform stakeholders, conducted research and developed a report on hiring practices of Peer Support Specialists in California as well as national trends. This culminated in a report entitled, *Certification of Consumer, Youth, Family and Parent Peer Providers: A Review of the Research*. In March and April of 2012, five regional stakeholder meetings were conducted across the state to gather feedback and input regarding state-wide certification standards for Peer Support Specialists working in the public mental health field. Information from the 165 individuals attending these meetings was gathered through a written survey, focus groups and comment sessions and culminated in the development of a report entitled, *Certification of Consumer, Youth, Family and Parent Peer Providers: A Summary of Regional Stakeholder Meeting Findings*. Workgroups were developed and convened to further the work on recommendations based upon the report findings.

In order to develop final recommendations to the state, WWT convened a statewide Stakeholder Summit held on May 17, 2013 in Sacramento. This Summit was attended by more than 200 individuals and was tasked with providing input and comments regarding the recommendations that had been developed for review and final vetting. Prior to the Summit, participants had the opportunity to attend two webinars outlining the two reports and the recommendations. They also received the PDF versions of the reports as well as workgroup documents developed over the months between the regional stakeholder meetings and the Summit. An impressive effort was made to ensure that representation at the Summit was reflective of all stakeholders. This included representation by regional area of the state, peer provider type, county mental health administration and leadership, community based organizations, the Department of Health Care Services and the Office of Statewide Health Planning and Development. In total 223 individuals attended the Summit, 139 surveys were completed and coded for data. Thirty counties were represented at the Summit and total number of attendees by county is listed in the table below.

### Summit Attendees by County

<b>Superior</b>		
Butte	x	2
Colusa		
Del Norte		
Glenn	x	1
Humboldt		
Lake	x	2
Lassen	x	5
Mendocino	x	2
Modoc		
Nevada	x	7
Plumas		
Shasta	x	1
Sierra		
Siskiyou		
Tehama		
Trinity	x	2
<b>Bay Area</b>		
Alameda	x	28
City of Berkeley	x	2
Contra Costa	x	10
Marin	x	5
Monterey	x	7
Napa	x	5
San Benito		
San Francisco	x	14
San Mateo	x	1
Santa Clara		
Santa Cruz	x	5
Solano	x	3
Sonoma	x	3
Unknown		6
National		2
Statewide		9

<b>Central</b>		
Alpine		
Amador		
Calaveras		
El Dorado		
Fresno	x	8
Inyo		
Kings		
Madera		
Mariposa		
Merced		
Mono		
Placer	x	6
Sacramento	x	53
San Joaquin	x	3
Stanislaus	x	2
Sutter/Yuba		
Tulare	x	6
Tuolumne		
Yolo		
<b>Los Angeles</b>		
LA	x	5
Tri-Cities		
<b>Southern</b>		
Imperial		
Kern		
Orange		
Riverside	x	11
San Bernardino	x	2
San Diego	x	3
San Luis Obispo		
Santa Barbara	x	2
Ventura		

In terms of representation by affiliation, perhaps the most interesting statistic is that while 74% of the attendees report representing one group, 26% of attendees present represented more than one stakeholder group. For those individuals who selected a single affiliation, 6% of attendees stated that they were a parent of a child or youth with behavioral health challenges. However, when reviewing all respondents who chose that option as at least one of the groups they represented, the percentage of individuals who represented a child/youth with behavioral health challenges is actually 17.5%. Attendance by affiliation is listed in the table below:

**Summit Attendance by Affiliation**

<b>Lived Experience of Behavioral Health Challenge</b>	<b>27%</b>
<b>State, County or Contracted Agency</b>	<b>18%</b>
<b>Family of Adult with a Behavioral Health Challenge</b>	<b>8%</b>
<b>Parent of Child/Youth with Behavioral Health Challenge</b>	<b>6%</b>
<b>State or County Administrator</b>	<b>5%</b>
<b>Unknown</b>	<b>5%</b>
<b>Prefer not to answer</b>	<b>5%</b>
<b>Lived Experience and State, County or Contract Agency</b>	<b>4%</b>
<b>Lived Experience and Family of Adult and State, County or Contract Agency</b>	<b>4%</b>
<b>Lived Experience and Family of Adult</b>	<b>4%</b>
<b>Family of Adult and Parent of Child</b>	<b>3%</b>
<b>Lived Experience and Family of Adult and Parent of Child and State, County or Contract Agency</b>	<b>3%</b>
<b>Lived Experience and Family of Adult and Parent of Child</b>	<b>3%</b>
<b>Lived Experience and Parent of Child</b>	<b>2%</b>
<b>Lived Experience and State or County Administrator</b>	<b>1%</b>
<b>Lived Experience and Parent of Child and State or County Administrator</b>	<b>.5%</b>
<b>Family of Adult and State, County or Contract Agency</b>	<b>.5%</b>

# Review of Stakeholder Input on the Recommendations

During the Statewide Summit, stakeholders were asked to review the original 18 recommendations and to reflect upon the suggested recommendations and either agree, agree with minor reservations or state that they were unable to agree. For each recommendation, participants were able to write in their comments. During the oral comment periods of the Summit, transcribers recorded statements. To arrive at these final recommendations the original recommendations were reviewed using the regional stakeholder meeting data as well as the written and oral comments from the Summit participants. The following are the finalized recommendations for statewide certification of Peer Support Specialists.

*“To be heard on these teams is a big reason for certification.”*

## **Recommendation 1**

Develop a statewide certification for Peer Support Specialists, to include:

- Adult Peer Support Specialists
- Young Adult Peer Support Specialists
- Older Adult Peer Support Specialists
- Family Peer Support Specialists (Adult Services)
- Parent Peer Support Specialists (Child/Family Services)

The first recommendation received substantial approval from stakeholders, with 79% of stakeholders selecting “agree”, 21% “agree with minor reservations” and 0% choosing “disagree”. While some participants expressed concern about straying from the values and goals of peer support, the majority of stakeholders expressed positive feelings about the movement towards certification.

*“I’ve never met a consumer or family member who was not supportive of the services provided by peers. We need to educate the staff.”*

**Recommendation 1.1**

Require Peer Support Specialists to practice within the adopted Peer Support Specialist Code of Ethics.

- 1.1.1 Seek final approval of Peer Support Code of Ethics by the Governing Board of Working Well Together

This recommendation was originally stated as follows: “Develop a statewide definition and code of ethics for Peer Support Specialists.” The newly revised recommendations split out “definitions” from “code of ethics”. Stakeholders felt strongly that peers should adopt a code of ethics and create definitions that were clear: 86% agreed, 12% agreed with minor reservations and 2% disagreed. At the Summit, a Code of Ethics, developed by the Values and Ethics Workgroup, was distributed for review. (See Appendix 2). Comments about the values and ethics recommendation emphasized the need for training peers supporters on this topic.

**Recommendation 1.2**

Develop or adopt standards for a state-wide curriculum for training Peer Support Specialists.

**Recommendation 1.3**

Require a total of 80 hours of training for Peer Support Specialist Certification.

- 1.3.1 55-hour core curriculum of general peer support education that all peer support specialists will receive as part of the required hours towards certification.
- 1.3.2 25-hours of specialized curriculum specific to each Peer Support Specialist category.

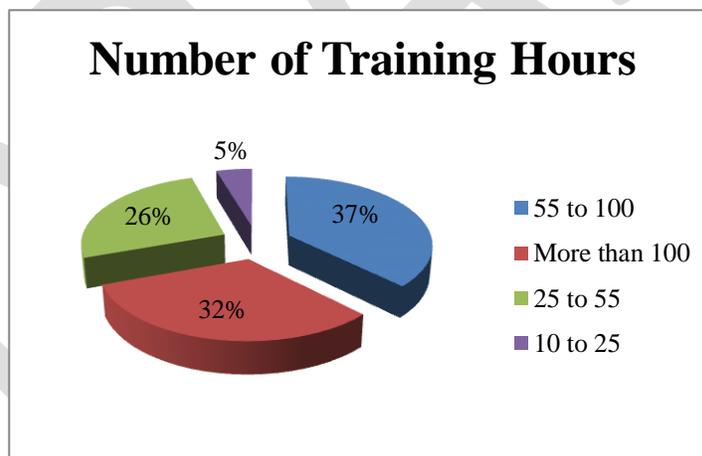
**Recommendation 1.4**

Require an additional 25 hours of training to become certified in a specialty area such as forensics, co-occurring services, foster youth, veterans and whole health.

Stakeholders agreed that a standardized core curriculum, with specialized tracks for each type of peer provider, would be the best approach to training. 73% of stakeholders agreed, 22% agreed with minor reservations and 5% disagreed with this recommendation. Many excellent curricula have been developed across the state. Recommendation 1.2 allows for multiple curricula to be used, providing that they meet the standardized criteria to be set. The content of the core curriculum has not been finalized. The Curriculum Workgroup, established after the five regional stakeholder meetings, produced a crosswalk of multiple peer provider trainings that will be used to determine the core content for this curriculum. (See Appendix 3).

Stakeholders agreed that it made sense to have a core general curriculum that would be a requirement for all types of peer providers, however there are differences of opinion regarding the number of hours of training that should be required. In the regional stakeholder meetings, 37% of participants felt that 55-100 hours of training would be optimal, while 32% felt that more than 100 hours would be appropriate. 26% felt that fewer hours were necessary for training, see the following table.

### Regional Stakeholder Survey on the Number of Hours for the Core Curriculum



At the Summit, 55% of participants agreed that 55 hours of core curriculum was sufficient, 33% agreed with minor reservations and 10% disagreed. Those who made comments in this section generally thought that more than 55 hours were needed. One source of confusion seemed to be a misunderstanding of this item. The intent of the survey was to ask the group to weigh in on core curriculum hours (55) PLUS additional hours for specialization in each of the peer provider types

(adult, youth, older adult, family member and parent partner). Many participants appeared to think that the core curriculum was the only training being suggested for certification. Other issues will need to be addressed going forward regarding the core curriculum:

1. Determine the time-table for completion of these 55 hours of training.
2. Determine what previous training will be accepted as meeting the requirements of Recommendation 1.
3. Determine what timeframe will be used for acceptance of previous training (for example, completion of an approved training program from 2010 or later).

Many stakeholders advocated for specialty areas that would require additional training in order to provide peer support services to specific groups such as those who have co-occurring mental health and substance abuse issues, veterans, youth in foster care and people involved in the criminal justice system.

#### **Recommendation 1.5**

Require six months full-time equivalent experience in providing peer support services.

- 1.5.1 This experience can be acquired through employment, volunteer work or as part of an internship experience.

Another requirement for certification will be a requirement of prior peer support experience in work, volunteer or internship experiences. Stakeholders supported this recommendation, with 67% agree, 27% agree with minor reservations, and 6% who disagreed. Comments by participants suggested that a clear definition of what qualifies as “experience” be developed. While some individuals expressed the desire that all experience be paid, concerns from people in small and rural counties included the issue of lack of employment opportunities and the need for internships and volunteer experience to be included.

#### **Recommendation 1.6**

Require 15 hours of CEU’s per year in subject matter relevant to peer support services to maintain certification.

*“We can have a problem with the need for CEU’s when what’s available is not recovery-oriented, but more clinically focused. We could potentially lose our peeriness.”*

Certification will include the requirement of annual continuing education credits in topics pertaining to peer support work. Stakeholders vetted this recommendation with 65% agreement, 28% agreement with minor reservations and 7% who disagreed. Concerns centered on developing clear parameters about the type of training that will be required and who would be qualified to provide these trainings.

**Recommendation 1.7**

Require re-certification every three years.

The original recommendation developed from the regional stakeholder meetings was that re-certification be required every two years. Stakeholders were in general agreement about the need for re-certification, however, this item had higher degrees of concern expressed: 49% agreed, 29% agreed with minor reservations and 22% disagreed. Written comments expressed concern about the frequency of re-certification and suggested that the re-certification period be extended to three or three-five years. The revised recommendation reflects this input.

**Recommendation 1.8**

Allow a grandfathering-in process in lieu of training.

- 1.8.1 Require one year of full-time equivalent employment in peer support services.
- 1.8.2 Require three letters of recommendation. One letter must be from a supervisor.  
The other two may come from co-workers or people served.

Many peer support providers currently work in counties and agencies across California, as pioneers in wellness, recovery and resiliency-oriented services. Recommendation 1.8 provides a mechanism for recognizing the valuable work that these individuals have done and creates a process by which these individuals can utilize their experience in lieu of additional

training. Stakeholders supported this recommendation: 56% agreed, 34% agreed with minor reservations and 10% disagreed. For those who had minor reservations, the following issues emerged:

1. Define clearly the work experience required
2. Define who the letters of recommendation may come from

These concerns have been addressed in the revised recommendation.

*“It’s a difficult job that takes effort and intention to do it right, as well as lived experience....I believe that as much training as possible is a good thing.”*

### **Recommendation 1.9**

Require an exam to demonstrate competency.

- 1.9.1 Provide test-taking accommodations as needed.
- 1.9.2 Provide the exam in multiple languages and assure cultural competency of the exam.

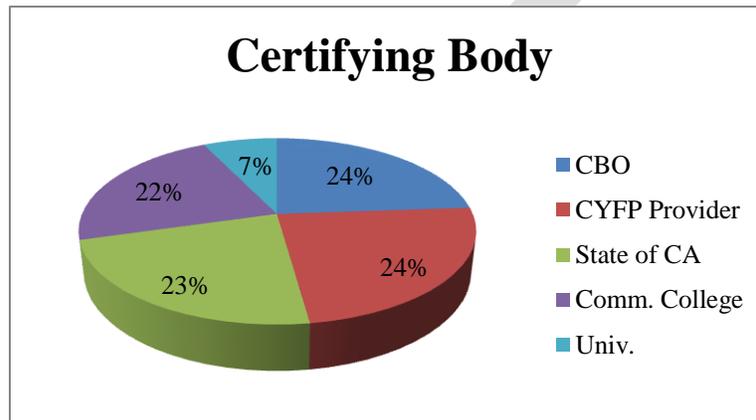
Peer Support Specialist Certification will require passing an exam. Stakeholders expressed agreement with this requirement, with 72% agreed, 25% agree with minor reservations and 3% disagree. Stakeholders advised that the exam be made available in multiple languages and that it meet cultural competence requirements. Suggestions were made to offer the exam in both an oral and written format, and to offer test-taking accommodations when needed for individuals who qualify.

### **Recommendation 2**

Identify or create a single certifying body that is peer-operated and/or partner with an existing peer-operated entity with capacity for granting and managing certification.

A single certifying body creates consistency and promotes the development of Peer Support Specialist as a distinct profession. In the regional stakeholder meetings, participants were fairly evenly divided about who the certifying body should be, with Community-Based Organizations (CBO's), Peer-Run Organizations, the State of California and Community Colleges each receiving approximately 25% of the stakeholder votes. (See table below).

### Regional Stakeholder Meeting Responses regarding the Certifying Body



Stakeholders at the Summit felt strongly that a peer-run organization should be the entity for certification, or at minimum, that peers should play a major role in the granting and managing of certification. When asked to respond to the original recommendation, 53% agreed, 39% agreed with minor reservations and 8% disagreed with the original recommendation. The largest category of written comments on this item was the support of peer-run agencies being the certifying body. The new recommendation reflects this input.

*“We need to be well-informed of the intended and unintended consequences of changing the State Plan to include Peer Support Services.”*

### **Recommendation 3**

Include Peer Support as a service and Peer Support Specialist as a provider type within a new State Plan Amendment

- 3.1 Seek adoption of the definitions of Peer Support Specialist providers and Peer Support services by the Governing Board of Working Well Together for use within the State Plan Amendment.
- 3.2 Maintain the ability for people with lived experience to provide services as “other qualified provider” within their scope of practice, including but not limited to rehabilitation services, collateral and targeted case management.
- 3.2 Acknowledge that there are important and non-billable services that Peer Support Specialists can and do provide.

Stakeholders were strongly in favor of adding Peer Support Specialist as a provider type within a new State Plan Amendment: 71% agreed, 22% agreed with minor reservations and 7% disagreed. Stakeholders cautioned that the ability to bill for services should not over-ride the importance of providing vital but non-billable services. Stakeholders also desired maximum flexibility in providing a full range of services within their scope of practice.

### **Recommendation 4**

Include in the State Plan the ability to grant certification for peer-operated agencies to provide billable peer support services.

- 4.1 Allow for peer-operated agencies to provide other services billable under “other qualified provider” within their scope of practice, including but not limited to rehabilitation services, collateral and targeted case management.

*“I would like to see peer specialists as a provider type and a peer-run organization to be able to get paid.”*

Peer-operated agencies provide many services that could be billable if included in a new State Plan Amendment. Stakeholders were in support of this option, with 71% agreement, 18% agree with minor reservations and 11 % who disagreed. As in Recommendation 3, stakeholders recommended that peer-operated agencies be allowed maximum flexibility to provide other mental health services that are billable (within scope of practice requirements) and to recognize that non-billable services are an important part of service provision as well.

### **Recommendation 5**

Address the concern that current practice of documentation for billing may not be aligned with the values and principles of peer support and a wellness, recovery and resiliency orientation.

- 5.1 Engage with partners such as Department of Health Care Services and the California Mental Health Director’s Association in order to develop an action plan to advocate for the use of CMS-approved recovery/resiliency-oriented language in documentation.

*“We need to educate...in how to bill in a person-centered manner.”*

Stakeholders expressed understandable concern about current practice in documentation and a perceived disconnect with peer values. Documentation is all too often exclusively focused on medical necessity. Many counties, concerned with audit exceptions, are restrictive and overly emphasize a medical-model orientation in documentation and treatment planning practices.

Stakeholders strongly supported development of a process to change documentation practices to align more closely with peer values and principles, such as strengths, empowerment and shared decision-making: 72% agree, 20% agreed with minor reservations and 8% disagreed.

### **Recommendation 6**

Investigate the options for broadening the definition of “service recipient” to include parents and family members of minors receiving services so that peer support services can be accessed more easily.

Parent Partners working in the Child/Family System of Care currently provide services to the family when these services are seen to be of benefit to the child, who is the actual service recipient. These services are often billed as “Collateral” services. This recommendation requests that there be an inquiry into the possibility of billing those types of services directly, creating more access to Parent Partner support services. Stakeholders were largely in agreement with this idea: 63% agreed, 25% agreed with minor reservations and 12% disagreed. Some confusion arose regarding this recommendation, largely due to a lack of clarity in the original wording of the recommendation. This recommendation is directed at peer providers in the Child/Family system only.

**Recommendation 7**

Convene a working group consisting of Working Well Together, the Mental Health Directors and the Department of Health Care Services to develop buy-in and policies that will create consistency of practice regarding peer support services across the state.

One concern among stakeholders is that the availability and delivery of peer support services varies widely across the state. This recommendation seeks to develop buy-in and agreement to create a set of policies and practices that will strengthen the development of peer support as a profession and assure access to these services no matter where in California an individual resides. While a few stakeholders expressed the desire for county control, most thought that creating buy-in across county lines would “allow portability” and “really help legitimize the work”. Stakeholders were in agreement, with survey results of 63% agree, 32% agree with minor reservations and 5% disagreed.

*“We need to foster the process of becoming a peer by experiencing the process through groups and owning our own journey and being able to model it.”*

### **Recommendation 8**

Develop standards and oversight for the provider/entity that provides training of Peer Support Specialists.

- 8.1 Allow for multiple qualified training entities.
- 8.2 Training organizations must demonstrate infrastructure capacity that will allow for peer trainers.
- 8.3 Training must be provided by either individuals with lived experience or by a team that includes individuals with lived experience.

Stakeholders were strongly in favor of creating standards and oversight for organizations as well as individual trainers providing Peer Support Specialist training: 82% agreed, 15% agreed with minor reservations and 3% disagreed. Many peer-run organizations currently provide Peer Support Specialist training. Additionally, there are many other state-wide and county organizations, community colleges and other groups that provide training for peer specialists. This recommendation endorses the development of multiple venues that will provide the training required for certification and creates standards to assure that each individual receives comparable training. This also creates assurance of competency for employers as well as service recipients. Stakeholders strongly suggested that training be provided by peers or in teams that include peers, while acknowledging that some training provided by non-peers is also welcomed and needed at times.

*“Make all trainings and services multi-lingual.”*

### **Recommendation 9**

Establish qualifications for who may supervise Peer Support Specialists.

- 9.1 Engage with the Mental Health Directors to develop a policy that outlines key qualifications necessary for the supervision of Peer Support Specialists.
- 9.2 Preferred supervisors are those individuals with lived experience and expertise in peer support.

- 9.3 Due to capacity issues, supervisors may include qualified people who receive specific training on the role, values and philosophy of peer support.
- 9.4 Recognize and define the specific qualities and skills within supervision that are required for the supervision of Peer Support Specialists. These skills should align with the values and philosophy of peer support.

Supervision is a vital component of developing and growing as a professional and equally true for Peer Support Specialists. Stakeholders concurred that clear policies should be put in place regarding the qualifications, skills and training needs of those who supervise these staff. The Summit survey indicated that 59% agreed, 33% agreed with minor reservations and 8% disagreed with the recommendation. Comments from stakeholders overwhelmingly supported having supervision provided by people with lived experience. If there is not someone with enough peer experience to be a supervisor, it was recommended that supervisors of peer support receive specific training on providing this supervision. The training would emphasize the values and practices of peer support, with a focus on the relationship and communication qualities that are the hallmark of peer support: mutuality, shared leadership and circular feedback and evaluation.

*“It is very important to have a peer supervisor – someone who knows the services provided by peers.”*

#### **Recommendation 10**

Develop a plan to provide extensive and expansive training on the values, philosophy and efficacy of peer support to mental health administration and staff.

Despite the fact that the Mental Health Services Act was passed in 2004 and that peer support services have been provided for many years before that time, many providers in California remain unaware of the benefits and value of peer support. This recommendation addresses the need for widespread training on what peer support is and is not, a strong orientation to the values and philosophy of peer support and a thorough introduction to the full

*“The hardest part of my job as a family member supervisor is the attitude of other staff.”*

range of peer support services. The Summit stakeholders gave very strong support for this recommendation: 87% of stakeholders agreed, 11% agreed with minor reservations and 2% disagreed.

### **Recommendation 11**

Develop a plan to ensure that welcoming environments are created that embrace the use of multi-disciplinary teams that can incorporate Peer Support Specialists fully onto mental health teams.

Recommendation 11 speaks to the need for continuing to prepare the mental health workforce for the inclusion of peer providers. Of all the recommendations, this one garnered the most whole-hearted support: 89% of stakeholders agreed, 10% agreed with minor reservations and 1% disagreed.

### **Recommendation 12**

Develop a policy statement that recognizes and defines the unique service components of peer support as separate and distinct from other disciplines and services in order to maintain the integrity of peer support services.

For many, the importance of certification lies in the explicit identification of the unique services, values, philosophy and practice that define peer support as a distinct profession. Stakeholders were very clear about not becoming co-opted by business as usual on mental health teams, but rather, being a value-added service, utilizing lived experience and the specific contributions that this experience can bring to helping people in their wellness, recovery and resiliency journeys. The distinct aspects of peer support are easily lost in a system that is ill-informed or simply inclined to continue doing what it has always done. A question arose as to the possible use of the Certified Psychosocial Rehabilitation Practitioner (CPRP) certification for peer support, rather than creating a separate certification. The CPRP is an example of a more general certification which relates to the provision of psychiatric rehabilitation services, some of

which many Peer Support Specialists may provide. However, the CPRP has a different set of values and principles, compatible with peer support, but clearly not the same. Maintaining the integrity of peer support requires distinguishing its key components and differentiating it from other services and disciplines.

Development of a policy that outlines these distinctive characteristics will help create a better understanding of the role of Peer Support Specialists and guard against the dangers of co-optation. Stakeholders supported this recommendation strongly: 85% agreed, 13% agreed with minor reservations and 2% disagreed.

*“I’ve heard a lot of concern about high standards and big expectations. People with lived experience have been through harder. I fought for years to have people expect something from me. Lived experience means lived experience of doing really hard things. We have wonderful accomplishments. Fight for high expectations.”*

### **Recommendation 13**

Develop a policy statement and plan that supports the professional development of Peer Support Specialists that allows the practitioner to maintain and hone his/her professional values, ethics and principles.

For Peer Support Specialists to grow as professionals, the stakeholders agreed that a plan and policy was required to provide guidance on ways to provide training and development opportunities. This recommendation received 74% agreement, 21% agreement with minor reservations and 5% disagreement. A variety of options may be considered under this recommendation. One option is networking, defined as providing opportunities for peers to meet with other peers for consultation and support. This may be done through specific groups during work time or may happen through conferences and trainings where peers are gathered. More information needs to be developed on alternative strategies for aiding in the professional development of Peer Support Specialists.

*“We need to remember who we are.”*

**Recommendation 14**

Develop a plan for funding the development of certification.

- 14.1 Work with the Office of Statewide Healthcare Planning and Development to utilize state-wide monies from the MHSA Workforce, Education and Training fund.
- 14.2 Investigate other potential funding sources.
- 14.3 Develop recommendations for funding of components of certification such as financial assistance with training, exam and certification fees.

State-wide Workforce Education and Training (WET) funds are currently being used to support the training of traditional mental health providers including psychiatrists, social workers and Marriage and Family Therapists about recovery and resiliency-oriented services. Stakeholders felt that some of the state-wide WET funds could be utilized for the Peer Support Specialist Certification project. Results of the Summit survey indicated that 82% of stakeholders agreed with the recommendation, 15% agreed with minor reservations and 3% disagreed. Many stakeholders suggested an investigation into alternative funding sources, such as Substance Abuse and Mental Health Services Administration (SAMHSA) or other Federal grant money.

**Recommendation 15**

Seek representation on committees and workgroups that are addressing civil service barriers to the employment of Peer Support Specialists.

Throughout California, counties run into barriers to peer employment due to civil service rules and regulations, or interpretation of those rules. While some counties have found ways to navigate these issues, others are using community-based agencies to hire peers until the problem can be resolved. Stakeholders felt that it was important to join forces with other interested

parties in creating a blueprint for resolution of these issues. Stakeholders were in agreement on this recommendation: 73% agreed, 20% agreed with minor reservations and 7% disagreed. Reservations centered on concern that the issue could only be resolved locally, a need for more information on the subject, a need for professional assistance to tackle the issue and some concern that it was not relevant to the topic of certification.

### **Recommendation 16**

Work with Mental Health Directors to seek agreement on a desired workforce minimum of Peer Support Specialists within each county to more fully actualize the intent of the MHSA.

*“How many counties are using existing codes? This is dangerous because peers get bumped out of jobs.”*

The Mental Health Services Act clearly promotes the hiring of people with lived experience on all mental health teams. Yet, there are many places in California where peer support services are minimal or non-existent. This recommendation seeks to engage the Mental Health Directors in a conversation that grapples with the issue of a minimum standard of Peer Support Specialists in the mental health workforce.

Stakeholders surveyed at the Summit were 74% in agreement with this recommendation, 14% agreed with minor reservations, and 12% disagreed.

*“Whoever works on this issue needs to be skillful and inclusive of people with forensic backgrounds. For example, we might suggest that the employer not look back more than three years.”*

**Recommendation 17**

Develop state-wide models that can inform county leadership on the development of career ladders for Peer Support Specialists that begin with non-certified Peer Support Specialists and creates pathways into management and leadership positions.

*“Achieve, aspire, climb!”*

Many stakeholders expressed concern that there are peers currently providing peer support services, some of whom were pioneers in this area and have been doing this important work for many years, who may not be able to meet all the requirements for certification. This recommendation honors the service of those individuals and includes them as a part of the career ladder for Peer Support Specialists. In addition, this recommendation recognizes the need to develop clear pathways into management and leadership positions for Peer Support Specialists as well. By looking for and then distributing models of career ladder development, more opportunities for advancement and salary increases can become available. 84% of stakeholders were in agreement with this recommendation, 14% agreed with minor reservations and 2% disagreed.

## Conclusion

Current Peer Support efforts in the adult mental health system were initiated more than thirty-five years as an alternative to mental health services that were as viewed as disempowering and overly focused on pathology. Similarly, the parent and family movements grew in response to a system that often viewed families as the cause of distress in children and dismissed them as an integral part of the wellness and resiliency of their children.

The passage of the Mental Health Services Act provided great hope for the opportunity to transform the systems of care from a maintenance and stability focus to a recovery and resiliency focus. Indeed, it provided the hope that evidence-based practices that serve to assist individuals to gain or regain a healthy meaningful life would be implemented in a more systemic manner. While mental health care in California has evolved to recognize the importance of developing opportunities for recovery and resiliency, services remain focused on stability and maintenance of symptoms and behaviors. Among the numerous evidence-based practices including, Assertive Community Treatment, Illness Management and Recovery, Family Psycho-education, Wrap-Around Services, Supported Employment, Psycho-social Rehabilitation services, WRAP, Co-occurring Services, Trauma Informed Care, Peer Support and Consumer Operated Agencies, only Assertive Community Treatment, in the form of Full Service Partnerships, has been systemically implemented in California.

The promise of transformation has not fully materialized, in part, because the workforce has not substantially changed. Education and training did not, in large part, focus on or support practice transformation. The existing workforce remains largely entrenched in a medical model tradition that views psychiatric symptoms and emotional distress as a life long illness that is best managed through treatment that seeks to create stability. The empirical data, however, is clear that for adults, the majority of individuals diagnosed with a serious mental illness do in fact recover and that services designed to support recovery are more effective than traditional medical model services. According to Drake, et.al, “Despite extensive evidence and agreement on effective mental health practices for persons with severe mental illness, research shows that routine mental health programs do not provide evidence-based practices to the great majority of their clients with these illnesses” (2001).

Studies on Peer Support include early research of drop-in centers and found that participants experienced an increased quality of life as well as enhanced social support and

problem solving (Mowbray and Tan, 1993). Mental health self-help groups have been shown to decrease symptoms, increase coping skills, and increase life satisfaction (Davidson et al., 1999; Chamberlin et al., 1996, Humphreys, 1997; Raiff, 1984). Peer specialists have been proven successful in engaging people who have serious mental illness into treatment (Sells et al., 2006; Solomon, 2004). One-to-one peer support with people who have co-occurring disorders of mental illness and substance use was found to result in fewer hospitalizations, improved social functioning, reduced substance use and improved quality of life among participants (Klein, Cnaan, and Whitecraft, 1998). Research has also shown that peer support plays a part in reducing the overall need for mental health services over time (Chinman et al, 2001; Klein, Cnaan, and Whitecraft, 1998; Simpson and House, 2002).

While most counties have included family members and people who have been diagnosed with a serious mental illness into the workforce, the peer community is replete with anecdotal evidence of trauma created when the hiring of peers has not been managed in a manner consistent with typical good hiring and training practices. It simply is not enough to hire someone because they are a parent or a “consumer”. Clear job duties and roles must be present, the existing staff must be educated, environments must be welcoming and appropriate supervision must be present. Additionally, skills beyond the experience of being a parent, family member or consumer are necessary to ensure the highest quality of service is provided. Not only does the peer community recognize the damage that has been done when poor employment practices are used, the existing workforce has also been traumatized when the employment of “peers” has not gone well. Unfortunately, these negative experiences have only served to increase the stigma that exists within the mental health workforce.

The Certification of Peer Support Specialists is essential to develop the respect and legitimacy necessary to fully incorporate these practitioners into mental health systems of care. Inclusion of Peer Support into the State Plan Amendment will ensure that peer support, as an evidence-based practice, is provided as a separate and distinct service with the goal of increasing recovery and resiliency opportunities for adults diagnosed with a mental health challenge and children and their families coping with severe emotional distress.

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## Appendix 1: Draft Proposed Values & Ethics of Peer Specialists for CA Certification

Values	Ethics
<b>Hope</b>	<ul style="list-style-type: none"> <li>▪ Hope is defined as a desire with the expectation of fulfillment.</li> <li>▪ Peer Specialists inspire hope in those they serve by                             <ul style="list-style-type: none"> <li>○ Living a life of Recovery and/or Resiliency</li> <li>○ Responsibly utilizing hope as a catalyst for Recovery and/or Resiliency</li> </ul> </li> </ul>
<p><b>Person-Driven (Adult)</b></p> <p><b>Child/Youth-Centered, Family-Driven (Children)</b></p>	<ul style="list-style-type: none"> <li>▪ Person-Driven (Adult System) and Child/Youth Centered and Family Driven (Children’s System) is defined as supporting individuals, families, parents and caregivers they serve to achieve <i>their</i> goals, based upon <i>their</i> needs and wants. Peer support is                             <ul style="list-style-type: none"> <li>○ Voluntary. Being forced or pressured is against the nature of genuine peer support. The voluntary nature of peer support makes it easier to build trust and connections with one another.</li> <li>○ Respects self-determination. Peer Specialists inform others about options, provide information about choices, and then respect peers’ decisions. Peer Specialists encourage people to look at the options, take risks, learn from mistakes, and grow from dependence on the system toward healthy interdependence with others.</li> <li>○ Upholds the principle of non-coercion as essential to Recovery/Resiliency and encourage those served to make their own decisions, even when the person served is under forced treatment.</li> </ul> </li> <li>▪ Peer Specialists will                             <ul style="list-style-type: none"> <li>○ When helpful, assist those they serve to access additional resources.</li> <li>○ Disclose personal stories of Recovery/Resiliency in a way that maintains the focus on and is beneficial to the person served.</li> <li>○ Support the recovery/resiliency process for the persons served, allowing the person to direct their own process.</li> <li>○ Not force any values or beliefs into an individual’s process of recovery/resiliency.</li> <li>○ Recognize that there are many pathways to recovery/resiliency, often very different than the Peer Specialists’ own journey.</li> </ul> </li> </ul>
<b>Holistic Wellness</b>	<ul style="list-style-type: none"> <li>▪ Holistic Wellness is defined as practicing in a manner that considers and addresses the whole health of</li> </ul>

	<p>those served.</p> <ul style="list-style-type: none"> <li>▪ Peer Specialists will <ul style="list-style-type: none"> <li>○ Recognize the impact of co-occurring challenges (Substance Use, Intellectual and Physical Challenges) in individual’s Recovery/Resiliency journey, and provide support sensitive to those needs.</li> <li>○ Honor the right to choose alternative treatments and practices including: Culturally specific traditional methods (herbs, etc.); Healing Arts (e.g. acupuncture, meditation); Spiritual Practices or Secular Beliefs; Harm Reduction Practices</li> </ul> </li> </ul>
<b>Authenticity</b>	<ul style="list-style-type: none"> <li>▪ Authenticity is defined as the practice of honest and direct communication, saying what is on one’s mind in a respectful way.</li> <li>▪ Peer Specialists will <ul style="list-style-type: none"> <li>○ Address difficult issues with those who are directly involved. Direct communication moves beyond the fear of conflict or hurting other people to the ability to work together to resolve issues with caring and compassion.</li> <li>○ Practice healthy disclosure about their own experience focused on providing hope and direction toward Recovery and/or Resiliency.</li> <li>○ Work within their scope of practice as defined by this Code of Ethics and the employing Agency.</li> <li>○ Remain aware of their skills and limitations and not provide services or represent themselves as an expert in areas for which they do not have sufficient knowledge or expertise.</li> <li>○ Avoid providing services mimicking clinical treatment.</li> <li>○ Know that maintaining the authenticity and integrity of their role is critical to the effectiveness of Peer Support. Therefore, Peer Specialists shall seek Supervision, Peer Support, and/or other contact with Peer Colleagues or Peers to maintain “Peerness”.</li> </ul> </li> </ul>
<b>Culture</b>	<ul style="list-style-type: none"> <li>▪ Valuing culture is defined as striving to provide culturally competent and relevant services to those they serve.</li> <li>▪ Peer Specialists will <ul style="list-style-type: none"> <li>○ Not discriminate against others on the basis of gender, race, ethnicity, sexual orientation or gender identity, age, religion, national origin, marital status, political belief, mental or physical challenge</li> <li>○ Not discriminate against others on the basis of any other preference, personal characteristic, condition, state or cultural factor protected under Federal, State or local law.</li> <li>○ Seek further information, education and training in issues related to cultural relevance as</li> </ul> </li> </ul>

	<p>necessary to assist those they serve.</p> <ul style="list-style-type: none"> <li>○ Adopt an attitude of “cultural humility”, understanding that culture is broad and complex.</li> </ul>
<b>Trauma-Informed</b>	<ul style="list-style-type: none"> <li>▪ Trauma-informed is defined as being knowledgeable about trauma, including prevalence, and actual and potential effects on mental and physical health.</li> <li>▪ Peer Specialists will <ul style="list-style-type: none"> <li>○ Practice in a trauma-informed manner.</li> <li>○ Provide trauma-informed care.</li> </ul> </li> </ul>
<b>Respect</b>	<ul style="list-style-type: none"> <li>▪ Respect is defined through the following behaviors. Peer Specialists will <ul style="list-style-type: none"> <li>○ Provide non-judgmental support demonstrated by the ability to honor people who have experiences, beliefs, or ways of living their lives that may be different from our own, despite the things we have in common. Being non-judgmental means approaching each person with openness, genuine interest, appreciation, and acceptance of the person as a unique individual.</li> <li>○ Be empathic. Make a genuine effort to imagine how the other person feels, what might have led to those feelings, and how we would want someone to respond to us in that situation.</li> <li>○ View everyone as having something important and unique to contribute.</li> <li>○ Value and treat each other with kindness, warmth, and dignity.</li> <li>○ Accept each other and be open to sharing with people from many ethnicities and cultures, educational levels, and religions.</li> <li>○ Honor and make room for everyone’s opinions and see each other as equally capable of contributing.</li> <li>○ Demonstrate respect toward those served, colleagues (including other Mental Health Professionals), and the community.</li> <li>○ Use language that is respectful and “person-first” to, and with, those served, and colleagues and the community.</li> <li>○ Never use language that could be construed as or is derogatory, insulting or demeaning in written, electronic or verbal communications.</li> <li>○ Be competent in communicating with co-workers and colleagues in ways that promote conflict resolution</li> </ul> </li> </ul>
<b>Integrity</b>	<ul style="list-style-type: none"> <li>▪ Integrity is defined as the commitment to avoid relationships or commitments that conflict with the interests of individuals served, impair professional judgment, imply a conflict of interest, or create risk of harm to those served.</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Peer Specialists will <ul style="list-style-type: none"> <li>○ Refrain from accepting gifts of significant value from individuals they serve and will seek supervisory support to make judgments about what constitutes “significant” value and understand cultural differences in gift giving.</li> <li>○ Refrain from lending, giving or receiving money or payment for any services to, or from, individuals they serve.</li> <li>○ Demonstrate accountability to fulfill commitments to those they serve.</li> <li>○ When dual relationships are unavoidable, will be responsible for conducting themselves in a way that does not jeopardize the integrity of the Peer Support relationship.</li> <li>○ Maintain good self-awareness and opt out of providing services if he/she is unable to be in a supportive, helpful relationship with any individual.</li> <li>○ Not abuse substances that will impair judgment or the ability to perform the job.</li> </ul> </li> </ul>
<b>Advocacy</b>	<ul style="list-style-type: none"> <li>▪ Advocacy is defined as the ability to support and defend the basic rights and freedoms that all people are entitled to regardless of nationality, sex, national or ethnic origin, race, religion or spiritual persuasion, language, disability, sexual identity, or socio-economic status. Human rights include civil and political rights, such as the right to life, liberty and freedom of expression; and social, cultural and economic rights including the right to participate in culture, the right to food, and the right to work and receive an education.</li> <li>▪ Peer Specialists will <ul style="list-style-type: none"> <li>○ Advocate for inclusion of those served in all aspects of services.</li> <li>○ Advocate for the full involvement of those served into the communities of their choice and promote the value of these individuals, parents, family members and caregivers to those communities.</li> <li>○ Be directed by the knowledge that all individuals have the right to live in a safe and least restrictive environment.</li> <li>○ Consciously reduce the effects of stigma and discrimination, i.e., race, creed, age, sexual preference, handicap, physical/mental functioning, history of prior treatment, or relation/association with an individual who may experience discrimination.</li> </ul> </li> </ul>
<b>Safety &amp; Protection</b>	<ul style="list-style-type: none"> <li>▪ Safety and Protection is defined as respecting the rights, dignity, privacy and confidentiality of those served at all times.</li> <li>▪ Peer Specialists will</li> </ul>

	<ul style="list-style-type: none"> <li>○ Never engage in romantic or sexual/intimate activities with the individuals served. Peer Specialists will not provide services to individuals with whom they have had a prior romantic or sexual relationship.</li> <li>○ Not engage in exploitive relationships with coworkers or those they serve.</li> <li>○ Respect the right to privacy of those served and should not solicit private information from those served unless it is essential. Once private information is shared, standards of confidentiality apply.</li> <li>○ Respect confidential information shared by colleagues in the course of their professional relationships and interactions, unless such information relates to an unethical or illegal activity</li> <li>○ Follow applicable Federal, State and Local laws in the prevention of harm as identified in Statute. Peer Specialists are “Mandated Reporters”.</li> <li>○ Will inform appropriate persons when disclosure is necessary to prevent serious, foreseeable, and imminent harm to an individual they are serving or other identifiable person. In all instances, Peer Specialists should disclose the least amount of confidential information necessary to achieve the desired purpose.</li> <li>○ Never intimidate, threaten, harass, use undue influence, physical force or verbal abuse, or make unwarranted promises of benefits to individuals served.</li> <li>○ Recognize the unique nature of the Peer Support relationship, and seek supervision and/or Peer Support, as necessary, to maintain appropriate boundaries with individuals served.</li> </ul>
<b>Education</b>	<ul style="list-style-type: none"> <li>▪ Education is defined as remaining current regarding new developments in Recovery/Resiliency theories, methods and approaches and providing information to clients being served.</li> <li>▪ Peer Specialists will <ul style="list-style-type: none"> <li>○ Remain current regarding new developments in theories, methods and approaches of related disciplines/systems with whom those who are served interface.</li> <li>○ Be aware of a diverse array of helpful resources and share information about those resources with those they serve.</li> <li>○ Educate those served as to available resources, managing conditions and options for supporting a life in Recovery and/or in development.</li> <li>○ Accept responsibility for continuing education and professional development as part of their commitment to provide quality services.</li> </ul> </li> </ul>
<b>Mutuality</b>	<ul style="list-style-type: none"> <li>▪ Mutuality is defined as each Peer Specialist taking responsibility for voicing his/her own needs and feelings. Each of us needs to understand that we are not there to take care of the other, but that each</li> </ul>

	<p>person is responsible for making sure that everyone is heard.</p> <ul style="list-style-type: none"> <li>▪ Peer Specialists will <ul style="list-style-type: none"> <li>○ Share power. This means that everyone is equally responsible for the success of the peer support relationships. Abuse of power is avoided when peer support is a true collaboration. Those who have been in service systems for a long time may have gotten used to being told what to do. Sometimes when people gain the freedom to make decisions, they act like the people who used to make decisions for them; do to others what was done to them. This is against the nature of genuine peer support. In peer support, power is shared, people give and take the lead in discussions, everyone is offered a chance to speak, and decisions are made in collaboration with each other.</li> <li>○ Demonstrate reciprocity. Every person in the peer support relationship both gives and receives in a fluid, constantly changing dynamic. This is very different from what most people are used to in treatment programs, where people are seen as needing help and staff are the ones giving help. In peer support relationships, we are aware that each of us has things to teach and things to learn. This is true whether you are a paid peer supporter, someone with a volunteer role, or someone who drops in to help out once in a while.</li> <li>○ Believe that in Peer Support relationships there is no hierarchy; no one is more qualified, advanced, or better than anyone else.</li> </ul> </li> </ul>
<b>Self-Help</b>	<ul style="list-style-type: none"> <li>▪ Self-help is based on helping oneself and others at the same time. Self-help is a mutual process without a dichotomy between the helper and the person being helped.</li> <li>▪ Peer Specialists will <ul style="list-style-type: none"> <li>○ Provide self-help groups that include people with a common bond who voluntarily come together to share, reach out and learn from each other in a trusting, supportive and open environment.</li> </ul> </li> </ul>
<b>Strengths-based</b>	<ul style="list-style-type: none"> <li>▪ Strengths-based is defined as the belief that every person has skills, gifts and talents that they can use to better their lives.</li> <li>▪ Peer specialists will <ul style="list-style-type: none"> <li>○ Focus on what's strong, not what is wrong, in a person's life</li> <li>○ Help others identify these strengths and explore how they can be used for the benefit of the client.</li> </ul> </li> </ul>
<b>Recovery and/or Resiliency</b>	<ul style="list-style-type: none"> <li>▪ Recovery and/or Resiliency express the belief that each individual has the ability to recover and the capacity to draw on personal resiliency to have a full and meaningful life of their choice.</li> </ul>

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|  | <ul style="list-style-type: none"><li>▪ Peer Specialists will<ul style="list-style-type: none"><li>○ Communicate and behave in ways that promote recovery and/or resiliency.</li><li>○ Understand the importance of being a role-model of Recovery and/or Resiliency as one of the most powerful ways of inspiring others in their own Recovery/Resiliency journey</li><li>○ Engage in regular self-care activities.</li><li>○ Learn and use language that is respectful and reflects Recovery and/or Resiliency principles.</li><li>○ Understand the importance of self-sufficiency in Recovery/Resiliency journeys and be familiar with local resources to obtain self-sufficiency, including benefits and employment opportunities as well as supportive resources for families, parents and caregivers.</li><li>○ Not impose limitations on an individual's possibilities of Recovery/Resiliency</li><li>○ Recognize the importance of relationships and community in recovery and encourage individuals to identify and develop such natural supports.</li></ul></li></ul> |
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## Appendix 2: Curriculum Crosswalk Matrix Curriculum Workgroup

Source	Law, Ethics Boundaries	Inter Personal Skills	Indiv. Peer Support	Group Facilitation	Culture	History Of C/F Movement Stigma Discrimination	Self Awareness & Self Care	Defined Practices WRAP Wrap around	Recovery & Resiliency	Role Of Peer to young adult ≥18 and adult, older adult, parent/caregiver Model	Role of Peer to youth <18, child as Mentor, to parent guardian
Research	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	
Survey		yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
NFFCMH	yes	yes	yes	yes	yes	yes	yes	Yes	yes	yes	
Alaskan CC	yes	yes	yes	yes	yes		yes	yes	yes	yes	
RI Parent	yes	yes	yes		yes	yes	yes	yes	yes	yes	
NAPS	yes	yes			yes		yes		yes	yes	
Youth Core Comp	yes		yes	yes	yes		yes	yes	yes	yes	yes
NAMI F2F		yes	yes	yes		yes	yes	yes	yes	yes	
NAMI P2P		yes	yes	yes		yes	yes	yes	yes	yes	
UACF PP101	yes	yes	yes	yes	yes	yes	yes	yes wrap@	yes	yes parent & caregiver model	yes

Source	Care Coord. Planning, Documentation	Knowledge of BH Dx & Tx	Child, Youth, Adult, Older Adult Systems Of Care, Justice, education, Foster, DV	Safety, Crisis Planning	Co-occurring MH & SU	Spirituality	Trauma Informed	Holistic Wellness including Alternative tx	Education/Advocacy/leadership for system change	Local Resources & Natural Supports	Study, Test Skills, Employment & supports, from benefits to work
Research	yes	yes	yes	yes	yes	yes	yes				yes
Survey	yes	yes	yes	yes			yes	Yes	yes		yes
NFFCMH	yes	yes	yes	yes	yes	yes	yes	Yes	yes	yes	yes
Alaskan CC	yes	yes	yes	yes	yes	yes	yes	Yes	yes	yes	
RI Parent					yes	yes	yes	Yes			yes
NAPS					yes		yes	Yes	yes	yes	
Youth CC	yes	yes	yes	yes	yes	yes	yes		yes	yes	yes
NAMI F2F		Yes		Yes			Yes	Yes	Yes	Yes	
NAMI P2P		yes		yes			yes	Yes	yes	yes	
UACF PP101		yes	yes	yes	yes				yes	yes	yes

Additional Curriculum Content Areas from the National Association of Peer Specialists Curriculum

- WWT CYFP Research Crosswalk (p. 21-22) of 8 curricula: Recovery Innovations PET, The Transformation Center (Massachusetts), Alameda

NAPS Peer Specialist Service Principles: Person-Driven (adults/older adults), Youth Driven (TAY), Family Driven and Child Guided.							
Source	Share Lived Experience	Empower, Voluntary, Non-coercive (for ≥18)	Based on Mutuality, Learning from one another	Professional Development Personal growth	Inclusion & Collaboration Community Based	Respect, Person-first Non-clinical language	No Judgment, Recovery/resiliency possible for all
Research	yes	yes	yes	yes	yes	Yes	yes
Survey	yes	yes	yes	yes	yes		
NFFCMH	yes	yes	yes	yes	yes		
Alaskan CC	yes	yes	yes	yes	yes		
RI Parent	yes	yes	yes		yes	Yes	yes
NAPS	yes	yes	yes	yes	yes	Yes	yes
Youth CC	yes	yes	yes		yes	Yes	yes
NAMI F2F	yes	Yes	Yes	Yes	Yes	Yes	Yes
NAMI P2P	Yes	Yes	Yes	Yes	Yes	Yes	Yes
UACF PP101	Yes			Yes	Yes	Yes	Yes

Best Now, Family and Youth Roundtable (FYRT), Family Education and Resource Center (FYRC), San Francisco City College, SPIRIT, Working Well Together.

- Survey completed by stakeholder participants at WWT CYFP Regional Forums in spring, 2012 in Summary document p. 17-18.
- National Federation of Families for Children’s Mental Health, National Parent Support Provider Certification Core Competencies
- Alaskan Core Competencies with Behavioral Descriptors
- Recovery Innovations Parent Partner Training
- National Association of Peer Specialists national standards draft September, 2012:  
[http://na4ps.files.wordpress.com/2012/09/peer\\_support\\_providers\\_values\\_and\\_standards\\_harrington\\_draft1.pdf](http://na4ps.files.wordpress.com/2012/09/peer_support_providers_values_and_standards_harrington_draft1.pdf)
- Pathways Transition Training Collaborative Draft Direct Service Core Competencies for Youth/Young Adults  
<http://www.pathwaysrtc.pdx.edu/pdf/projPTTC-Compiled-Core-Competencies.pdf> &
- A Curriculum for Family to Family Peer Services Based on System of Care Values:  
[http://gucchdtacenter.georgetown.edu/Activities/TrainingInstitutes/2012/Resources/Inst\\_25\\_PPT.pdf](http://gucchdtacenter.georgetown.edu/Activities/TrainingInstitutes/2012/Resources/Inst_25_PPT.pdf)
- NAMI National: Family to Family Education link: <http://www.nami.org/>; Peer to Peer Education link: <http://www.nami.org/>
- United Advocates for Children and Families (UACF) developed the PP101: Parent Partner Basic Training Curriculum, designed specifically for newly hired Parent/Family Advocates employed or volunteer with the public mental health system. <http://www.uacf4hope.org/>

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## Appendix 3: WWT CYFP Key Definitions Draft

**Practice standards:** Rules or principles that are used as a basis for judgment established by an authoritative entity. Standards are based on values, ethics, principles, and competencies. Having a core set of standards is one way to legitimize a profession.

(~ Wilma Townsend, Presentation at Pillars of Peer Support 2012)

**Behavioral Health Challenges:** Mental health or emotional challenges that may include the following co-occurring issues: substance use, intellectual challenges, dementia or trauma.

**Consumer:** A person who is eligible for, or who has received behavioral health services. For a child or youth whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians. (From Washington State)

**Family Member to Adult:** An adult, or older adult with lived experience of having or caring for an adult or older adult relative with behavioral health challenges.

**Parent/Caregiver:** A person who is parenting or has parented a child, youth, or young adult with behavioral health challenges. This person may be a birth parent, adoptive parent, family member standing in for an absent parent or a person chosen by the family or youth to function in the role of a parent. (Adapted from FFCMH)

**Peer:** A person of similar lived experience

**Peer Specialist:** Someone who, first and foremost, has experiential knowledge themselves or in a loved one, of the healing process of recovery/building resiliency and can offer genuine compassion for the struggles, and hope that it is possible to come through those struggles stronger, with respect for each individual's personal journey. (IAPS survey From the Focus Group at WRAP Around the World 2013).

It is important that certified peer support specialists have common experiences with the people they work with. Certified peer support specialists whose experience is as a parent, family member, or caregiver should work with other parents, family members, caregivers as they share similar experiences. (Based on WA)

**Peer Specialists value the principles of wellness, mutuality, recovery and resiliency as defined:**

**Wellness:** Wellness is the conscious and deliberate process of creating and adapting patterns of behavior that lead to improved health in the following wellness dimensions: Emotional, Financial, Social, Spiritual, Educational/Occupational, Physical, Intellectual, Environmental. (Adapted from Peggy Swarbrick and SAMHSA's Eight Dimensions of Wellness)

**Mutuality:** Mutuality is defined as each Peer Specialist taking responsibility for voicing his/her own needs and feelings. Each of us needs to understand that we are not there to take care of the other, but that each person is responsible for making sure that everyone is heard.

**Recovery:** Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Each individual may define recovery differently. (Adapted from SAMSHA’s 2012 working definition of recovery)

**Resiliency:** Resiliency is an inner capacity that when nurtured, facilitated, and supported by others– empowers individuals and communities to successfully meet life’s challenges with a sense of self-determination, mastery and hope. (Adapted from Ohio Resiliency Consensus Statement, 2010)

**Peer Support Groups:** Peer support groups are groups that include people with a common bond who voluntarily come together to share, reach out and learn from each other in a trusting, supportive and open environment. Membership is a self-selection process. Self-help groups grow from the bottom up, or at the grassroots. Decision-making rests solely in the hands of the people within the group. (Edward Knight, Ph.D., CPRP)

**Peer Support Services:** Based upon the fundamental principles of recovery and resiliency, Peer Support services are therapeutic interactions conducted by self-identified current or former consumers of behavioral health services, family members/caregivers to adults with behavioral health challenges, or parents/caregivers to children, youth or young adults with behavioral health challenges and delivered to a person of similar experience to that of the person they are serving. Peer Specialists are trained and may become certified to offer support to others in their recovery and/or resiliency process and in their community integration process. Peer support is intended to inspire hope in individuals, parents, family members and caregivers that recovery and/or resiliency is not only possible, but also probable. Peer support services are designed to promote empowerment, self-determination, understanding, wellness skills, and resiliency through mentoring and service coordination supports that allow individuals with behavioral health challenges to achieve personal wellness, or to their family members, parents, or caregivers, to support building resilience to stressors and barriers encountered. (Based on PA)

Peer Support Services facilitate the development of recovery and/or resiliency skills, are multi-faceted and include, but are not limited to, individual advocacy, crisis management support, asset building, and skills training. Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another’s situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others whom they feel are “like” them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to “be” with each other without the constraints of traditional (expert/patient) relationships. Further, as trust in the relationship builds, both people are able to respectfully challenge each other when they find themselves re-enacting old roles. This allows members of the peer community to try out new behaviors with one another and move beyond previously held self-limiting beliefs and concepts built on disability, diagnosis, and a trauma worldview. (Based on PA)

**Certified Peer Specialist:** a person with lived experience who is trained in core content areas, passed the certification exam, is able to articulate their lived experience to support a peer of similar lived experience in a variety of settings, AND who

- as a consumer with lived experience of behavioral health challenges, is actively pursuing their own wellness, recovery, and/or resiliency (Peer Support Specialist)  
or
- as a youth/young adult with lived experience of behavioral health challenges, is actively pursuing their own wellness and development (Youth Peer Support Specialist),  
or
- as a family member of an adult/older adult with behavioral health challenges, supports a family member in their recovery (Family Member Peer Support Specialist),  
or
- as a parent/caregiver of a child/youth involved in multiple systems including behavioral health, has supported and advocated for the child/youth in building resiliency (Parent Partner Peer Support Specialist, Family Support Partner).

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