Peer Support Certification Workgroup Recommendations
September, 2018

The Certification Workgroup was formed in January, 2018 as one of 3 workgroups from the larger Peer Support Stakeholder group which met in November, 2017. Invitation to join any of the workgroups was extended to all participants of the large Stakeholder meeting. The group was essentially open to anyone who wanted to participate, in-person or telephonically. The Certification workgroup had 40 members, with average attendance of 12-15, and included significant representation from peers (both from the mental health and substance use treatment communities), agency providers, re-entry coalition staff, and other advocates from a variety of locations around the state. The group met approximately every 2 weeks between January and September. Co-leaders for the workgroup were Jim McLaughlin, DBH and Alan Green, Choices. The group reviewed peer support certification programs from eleven states and some national programs and then worked through the 12 categories below and made recommendations around each.

I. Scope of the Certification

We had a series of discussions on whether the Certification should apply exclusively to behavioral health peer support or instead apply to a broad range of types of peer support workers. The discussion included an observation that we had already frequently referred to it as being a BH peer certification, that the stakeholders we assembled last Fall were those from MH and SUD backgrounds, that the primary interest of the Division of Behavioral Health is related to the provision of BH services, and that the core competencies we adopted were the SAMHSA Core Competencies. The certification programs we reviewed from other states also were either focused on the mental health population or both the mental health and substance use recovery populations. Expanding the range of types of peer support could also complicate recommendations for training, for work experience sites and for supervision. The group acknowledged the importance of the varieties of peer support that are developing including with other disability groups and in other areas of healthcare such as asthma and diabetes support and a host of other areas. Also, although BH peers could provide forensic peer support (to the reentry population), it was pointed out that re-entry peers without a behavioral health history would not be eligible for this certification. The workgroup ultimately recommended to develop it as a BH peer certification but urges that the certification body chosen for this project would work to create additional areas of certification to address other groups in addition to behavioral health.

Recommendation #1: The focus of the certification should be on peers with lived experience with behavioral health issues. The group also recommends that the certification body look at developing certifications for other types of peers using the same or similar core competencies.

II. Determine Core Competencies

The SAMHSA Core Competencies were developed in 2015 by a broad group of stakeholders in the mental health and substance use disorder recovery communities. The 12 competencies are:

1. *Engaging peers in collaborative and caring relationships*: Relates to the quality of interactions with peers and the skills that are needed, e.g. listening skills.

2. *Provide support*: The ability to convey hope and to provide concrete assistance to folks.
3. *Shares lived experience of recovery*: This is fundamental and a central piece that peers offer.
4. *Personalizes peer support*: This includes cultural competencies among other items.
5. *Supports recovery planning*: Helping people set goals
6. *Links to resources services and supports*: Includes some of the basics related to access needed supports in the community.
7. *Provides information about skills related to health, wellness, and recovery*: Includes learning about WRAP and other types of wholeness and wellness knowledge and skills.
8. *Helps peers to manage crisis*:
9. *Values communications*: Includes listening skills, communicating with colleagues and documentation, and issues confidentiality and privacy.
10. *Supports collaboration and teamwork*: To be able to work within an interdisciplinary team.
11. *Promotes leadership and advocacy*: How to advocate for people being served and populations in general.
12. *Promotes growth and development*: How to practice self-care, knowing when there is a need for supervision or mentorship, and being able to utilize supervision.

The group reviewed and discussed the Alaska Core Competencies for Direct Service Providers. An enormous amount of work went into developing these competencies and there is a robust training program already in existence with a capacity for distance delivery. They align quite well with many of the SAMHSA Core Competencies but since the Alaska Competencies were not developed specifically with Peer Support Workers in mind there are some areas not adequately covered. Also reviewed were Core Competencies in Criminal Justice Settings and the Veterans Administration Core Competencies for Peer Providers.

The group also discussed the value of the SAMHSA Core Competencies being applicable for both the mental health and substance use recovery communities.

Recommendation #2: Use SAMHSA Core Competencies as the foundation for this process.

III. Framework for Certification

This is the set of issues around whether the certification and training would be a general certification or whether it would be broken out to more specific "sub-specialties" such as training specifically related to family/caregivers of youth, families of individuals with psychiatric disabilities, transitional-age youth, or the re-entry population.

We discussed the difficulty of creating more than one certification program as well as the pros and cons of creating specialized "endorsements" to recognize someone's basic training in a particular specialty. It was mentioned that nationally, managed care companies were looking for peer support workers to be certified but weren't particularly interested in any sub-specialties or endorsements.

We discussed the importance of having continuing education coursework for "re-certification" to include sub-specialty topics. The point was also made that it likely makes best sense to begin with a

basic, general certification to launch the certification program and, over time, if we see the need and value, to then build in sub-specialty endorsements.

Recommendation #3: Have a single, general BH peer certification as opposed to creating a variety of different certifications or sub-specialties. This could be utilized by peers with lived experience with a BH challenge, including peers with a re-entry focus, youth peers, and families of individuals with a BH challenge.

IV. Levels of Certification

This step in the process considered whether we would recommend just one level of certification or possibly multiple levels to acknowledge differing levels of experience and training.

From our survey of states, it was noted that most states do not break it down into levels but it was also noted that the states that did not develop the levels of certification are having problems with peers not moving up the career ladder and some are going back to attempt to change their original structure.

We discussed the potential value of having a "Provisional Certification" to allow new peer support workers to work in an agency after their classroom training while they were gaining required hours of experience. We also discussed for peers not having training prior to hire to allow a timeframe of 90 days within which to complete it post-hire. We would need to establish a fixed time limit to complete the hours of experience, for example 2 years, so peers don't stay in the provisional certification indefinitely but also allows for sufficient time in cases where people are working only part-time.

In addition to a "Peer Support Worker I" level which would have the standard requirements we develop, the group felt there was merit in having a "Peer Support Worker II" level which would require some additional hours/years of experience and additional training.

And we also discussed a "mentor" level which would be another level of experience and training where someone would be recognized as having the ability to provide guidance to peers from a peer perspective. Having experienced peer workers providing guidance to other peers in agencies will be extremely important as many agency supervisors will likely not have experience of working with peers or have the perspective of someone with a lived experience. Discussion here included some concern that in establishing such a certification level that we might create obstacles to potential peer mentors who didn't meet whatever experience and training levels we established.

Recommendation #4: Utilize multiple Certification levels including Provisional (for those accumulating their work experience), Peer Support I, and Peer Support II (additional training/experience), and consider a Peer Mentor/Supervisor level.
* Some concerns were raised about the need for this Peer Mentor/Supervisor level and clarification of how these terms are used.

V. Minimum Requirements

Age

Most states have a minimum age of 18 y.o. for their Peer Certification, a few have 21 y.o. and at least one (Rhode Island) doesn't include age at all as a required qualification. Some workgroup members, particularly from the SUD perspective, raised concerns that someone 18 y.o. would likely not have the life experience and maturity to be a peer support worker but others described bringing individuals onto their staff as young as 17 who had exceptional ability to connect with peers in that age group. They advised against adopting criteria that unnecessarily narrowed the potential pool of peer support workers. It was noted that regulatory criteria for Clinical Associates do not have a minimum age criteria. There were concerns expressed about potential liability for a certification board in certifying individuals under 18 years old. In practice, hiring agencies may have their own policies that would impact this issue.

The group reached a consensus to support not including age as a criteria for certification.

Education

Virtually all states listed having a high school diploma or GED as a requirement. The group then discussed this and brought up similar issues to the ones around age. In fact, adhering to a minimum education requirement would, in almost all cases, mean that peers would need to be at least 18 y.o. The group felt that there well could be individuals without a HS diploma/GED who could potentially be excellent peer support workers, including younger peers or peers with the re-entry population. This also was not a specific requirement in the current regulations for Clinical Associates or SUD counselors.

Concerns were mentioned about the ability of individuals without a HS diploma/GED to be able to document services adequately or some basic assurance that they can communicate orally and in writing. Workgroup members didn't feel like having a HS diploma/GED gave any assurance of those abilities necessarily. We discussed whether or not requiring a HS diploma/GED would have negative impact on how providers viewed the integrity of the certification. As with age, agencies might have their own agency-specific education requirements that would impact this. The group, though, did not want to preclude someone without a GED from becoming certified.

The group ultimately supported not including an education level as a requirement for certification.

Lived Experience and Engagement in Recovery

The group reviewed criteria from different states used to address "lived experience" and "engagement in recovery". Some states ask for a BH diagnosis or some documentation of their diagnosis. Some states ask whether the individual is currently hospitalized or a certain length of time (a year, two years) that they've been in recovery. Some Alaska SUD treatment agencies have adopted a required 2 year timeframe of recovery for their hires with lived experience but it was acknowledged there was considerable difficulty in how to measure this in a clear-cut manner. The workgroup had previously discussed the difficulty with an arbitrary length of time for recovery – recovery is a personal perspective that's difficult to pinpoint an exact "start" and often interspersed with relapses. The group was generally not supportive of specific requirements around diagnosis or length of time in recovery.

There was consensus to not recommend a specific diagnosis or length of time in recovery as a minimum qualification.

Recommendation #5: Minimum Requirements should not include age, educational level, diagnosis or an arbitrary number of years in recovery.

VI. Training Requirements

For this section, we began to do a comparison between the SAMHSA Core Competencies and the content of local trainings that currently exist.

Information about the Alaska Core Competencies and how that training is being delivered was provided by the Alaska Training Cooperative staff. In collaboration with agencies, the Alaska Training Cooperative can arrange face-to-face trainings. Additionally, they provide distance-delivery via "Zoom" live audio/visual technology which allows them to reach the whole state. They do the Zoom training on a Quarterly basis (the next series will happen over 2 weeks in August in 4 hour blocks daily). They have reduced the total time required to complete from 32 to 24 hours. The Learning Management System tracks registrations, and student progress through the modules.

Staff from the Alaska Peer Support Consortium presented their curriculum and the work around its development. The training is designed as a 40 hour training with a series of follow-up workshops. It's important that this training is provided by peers vs. clinical staff or non-peers. Elements of training include reviewing what peer support is, the importance of the quality of engagement with peers, and that it has an experiential (or role playing) component. Ethics are reviewed and a big piece is helping peers learn to tell their own story.

Staff from Ionia described the Natural Path training which they have developed. They have collaborated with Kenai Peninsula College to offer the training there and to have college credit available for it. The training in total (all three segments) is 80 hours and runs for 4-5 hours a week over a 3 month period. Scholarships are available. They focus on an introduction to peer culture and developing student ability to teach wellness skills. The WRAP training is embedded.

Workgroup members listed three important criteria for a training program including for it to address the SAMHSA Competencies, that there be access for peers in rural areas, and that there be some experiential (or role playing) component to the training.

There was a desire expressed for the training to be offered in multiple areas of the state with trainers who come from the particular local area. Also there was discussion about possible sources of funding for the cost of training such as DVR, DOL, and the University (especially with Jeff Jesse being over at the Health Sciences department).

We had additional discussion about how many peers would potentially want this training and some guessed less than a hundred, and certainly less than 50 in the first year. Some suggested that given the costs involved (especially if students traveled to a central location) that we might consider prioritizing people that were likely to go to work as peers but others raised concerns about restricting it in that way.

There was also discussion about not requiring peers who were already working in the field to go through a training.

Ultimately, there was consensus that it might be better for the group to simply recommend what the training should cover and leave any selection to a process that would happen separately. This also generated some discussion of the potential role of a certifying body in making determinations on an ongoing basis whether particular trainings met the standards required.

Recommendation #6:

- Training should cover the 12 SAMHSA Core Competencies, plus the History of Peer Support and the Peer Specialist Role.
- Emphasis should be on experiential learning and the development of skills. Therefore, training is encouraged to be face-to-face but if delivered remotely should be via real-time distance delivery to allow for "virtual" audio-visual interaction.
- Multiple training vendors could be approved to provide training provided they were "approved". Determination of "Approved Trainings" would be done by the certifying body and based on content specified above.
- A network of trainings should be developed to ensure statewide availability and access but individual training vendors could serve any size area. *This would also allow for agencies to provide their own in-house trainings if their curriculum was approved*.
- Training should be delivered by at least one individual with a lived experience/"peer". A non-peer could be a second trainer but a peer trainer should be required.
- Training should be made affordable for individuals/agencies and it is recommended that DBH and the Alaska Mental Health Trust work to identify funding for this such as the utilization of Trust mini-grants for this purpose.
- If training is not completed before hire, an individual should have up 90 days to complete it once hired. A provision for a waiver to the 90 days could be made by the certifying body if extenuating circumstances exist (e.g. training not available).
- Trainers should have some type of evaluation which indicated whether an individual satisfactorily completed the curriculum and how that was determined.

VII. Work Experience/Supervised Experience

Type of Work Settings

The group discussed that Community Behavioral Health agencies would be one type of work setting for peers to gain their work experience but we also felt it would be important for there to be other options such as peer-run organizations. We discussed how best to describe these types of organizations and landed with organizations whose mission was to serve clients with behavioral health issues. The group also discussed organizations other than Community Behavioral Health agencies being "pre-approved" by the certifying body.

Number of Hours of Work Experience Required

This issue was discussed at three separate meetings. Other states with Peer Certifications had a wide range of "required work hours" to achieve certification. A number had 500 hours, some had 1000, New York had 2,000. Some had zero. We discussed the balance between having sufficient integrity with the certification requirements and minimizing the barriers to certification.

Originally we were recommending that 500 work hours should be required for Full Certification. Then there was reconsideration and discussion that a new peer worker may not be fully prepared after as little as 3 months of work and that 1000 hours (minimum 6 months) may be more appropriate. In regard to the 500 hours vs 1000 hour question, it was mentioned that it could vary by agency as to what amount of hours fully prepared someone. One member indicated his agency used 1000 hours as guideline before they have peer staff work solo, always working with a more experienced partner initially. Others indicated their support for 1000 hours. The group ultimately recommended requiring 1000 hours.

Supervision – There had been a few different recommendations made around who should provide the supervised hours for the certification. The group is aware that for purposes of agencies that bill Medicaid, a mental health professional is required to provide supervision. The workgroup, however, felt strongly that an experienced peer worker is in the best position to guide the development of a new peer worker through the certification process and beyond. For agencies that bill Medicaid, the recommendation would be for an experienced peer to provide the supervised hours for certification working together with a mental health professional. For a situation where an experienced peer is not available the recommendation is that the mental health professional be required to have developed, through training and/or experience, a "level of expertise in peer support". The "level of expertise" will need to be more precisely defined by the certifying body.

Number of hours of face-to-face supervision

Although the group had previously recommended requiring 25 hours of direct contact with supervisor, with the increase of recommended work hours to 1000, the group agreed that 40 hours of direct contact with a supervisor would be more appropriate. There was some concern expressed about the possible difficulty of peers keeping track of the supervisor hour documentation particularly in situations of turnover in supervisors.

Recommendation #7:

- Acknowledging the importance of including other organizations besides traditional behavioral health organizations, eligible settings for "work experience" should include both Community Behavioral Health organizations and other organizations who serve behavioral health clients. These other organizations should be "pre-approved" by the certifying body.
- Work Requirements should include 1000 hours of work experience
- Forty (40) hours of direct supervision should be required
- Eligible supervisors should have an established level of expertise in peer support.

VIII. Code of Ethics

The group reviewed a variety of sample Codes from different states including the Code which the Alaska Peer Support Consortium had previously developed approximately 6 years ago with input from the Peer Support Implementation Work Group. Our Certification workgroup was in agreement that we should recommend using the Code developed by the Consortium with the caveats that there be an opportunity to update it and that the entity selected as a Certification Body would have the final decision on its adoption.

Recommendation #8

- Utilize the Code of Ethics previously developed by the Alaska Peer Support Consortium
- Allow for a review and potential update to this Code by a group with a majority representation of peers.
- The Certification Body will have final decision on the adoption of a Code of Ethics

IX. Exam

This topic had been briefly discussed early on in the workgroup and there was little support for an exam at that point. There were concerns about the cost and administration of an exam and the validity of such a test in determining capability. Although there was some support expressed for having an exam there was more support for not doing so. The alternative suggested was having both an evaluation of successful completion of the training as well as a supervisor's assessment of core competencies during the course of the required work experience.

Recommendation #9

- The group does not recommend a formal final exam for certification
- The group does recommend an evaluation of whether an individual has satisfactorily completed training
- The group recommends that the successful development of core competencies be evaluated by the supervisor of the work experience

X. Certification Body

The Division's likely intent would be to issue some type of solicitation for the Certification Body – either RFP or contract.

The group discussed the importance of peer representation with the certification body. It's not clear at this point what type of organization would become the certification body and the particular make-up and structure of the organization (peer-run/not peer-run) would likely require a different approach to peer representation but the group was clear substantial peer involvement in decision making about the certification was critical and in keeping with the peer motto, "Nothing about us, without us". This could

take the form of a majority of peers on the board of the organization or a special advisory group in an established organization.

There was discussion about the possible make-up of that peer representation. It was suggested there be a representative from each organization with peer workers. Others were concerned that would be too large a group and too difficult to maintain. Others recommended representatives from each region of the state. There was caution expressed about being too prescriptive with such a requirement. A point was made about the importance of having representation from rural and frontier areas as well as urban.

Recommendation #10 Decisions related to peer certification should be made by a group with majority representation of peers from urban, rural, and frontier areas.

XI. Grandfathering

The issue relates to the certification of peers workers who have already been working in the field, particularly in regard to training and work hour requirements. One of the key issues to address would be the amount of work time which would be required for grandfathering.

It was suggested that given how significant this recommendation would be for the numbers of individuals already in the field that a smaller group focused solely on this issue be convened to make recommendations.

Recommendation #11 Recognizing the importance of providing special access to individuals who have already been working in the field as peer support workers, a group should be convened to do more focused work and produce recommendations for the grandfathering process along with related issues of training and reciprocity.

XII. Background Checks

We had a discussion about criminal background checks and if (and how) this should be part of the certification process. Clearly the issue of peers working with a potentially vulnerable population and the need to assure safety is of considerable importance but we discussed the logistics and practicality of doing this as part of the certification application. There was also the understandable concern that many potential peer workers have had involvement with the justice system and that shouldn't constitute an automatic barrier.

In all behavioral health agencies that have any type of State oversight, a criminal background check is a requirement for employment. When a check shows an existing barrier crime, the agency has the option of applying for an exception (or variance) to this barrier. Although there are many ongoing concerns about problems with this process, the vast majority of individuals who apply for a variance are granted one.

It would be difficult, if not impossible, for a certification body to duplicate this process. Only state-affiliated employers can use the State's Background Check system and the certification body would likely not be eligible to. There was discussion about having a disclosure statement on the application about previous offenses. Concerns were raised that asking a question about criminal background on the certification application could raise complications with a positive response – how would the body obtain the best information about the offense (only in-state records would be accessible) and how would the body make decisions about granting a certification in light of the information that was available.

To obtain certification, each individual will have to work in an agency to gain their work hours. In virtually all situations this would require a criminal background check. The certification body could ask the individual for proof of the outcome of that process.

Recommendation #12 The workgroup recommends that any criminal background checks be conducted through the State Background Check Unit in the course of hiring and not be conducted by the Certification Body.