Working Well Together

Training and Technical Assistance Center

Certification of Consumer, Youth, Family and Parent Providers

A Review of the Research

2012

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Purpose

Certification of consumer, youth, family, and parent peer support providers grants legitimacy to the important work that these employees do to foster recovery and build resiliency in those who seek mental health services and their families. It assures consumer, youth, family members, and parents that the persons providing services have a certain level of skills in addition to their valued lived experience. This measure of competency also gives mental health employers baseline information about the qualifications of peer providers that are hired within the system of care. Peer support services enhance the recovery of individuals who receive services through the public mental health system and provide hope to family members and parents who are seeking services for their family member. Studies highlight the benefits of peer-provided services. For example:

> Studies have shown that consumer delivered case management is as effective as non-consumer-delivered case management, and crisis teams involving consumers are as effective as those with non-consumers (Chinman et al, 2000; Solomon & Draine, 1995).
>
> Studies of drop-in centers have shown that they are associated with high satisfaction and increased quality of life, enhanced social support and problem-solving (Mowbray & Tan, 1993).
>
> One study found that case management services plus a peer specialist counselor were associated with enhanced quality of life, fewer major life problems, and greater gains in social support for those receiving such services than for those receiving case management services without a peer (Felton et al., 1995).
>
> A study of a one-to-one peer support program for persons with co-occurring mental health and substance abuse problems found that program participants had fewer crisis events and hospitalizations, improved social functioning, greater reduction in substance use, and improvements in quality of life compared to a non-matched comparison group (Klein, Cnaan, & Whitecraft, 1998).

Researchers are beginning to focus on family and parent peer-to-peer effectiveness as well. Positive outcomes were reported by the San Diego System of Care, which found improved youth functioning and lower parental stress with family supports (Becker and Kennedy, 2003). Despite these known benefits, children and adults with mental health challenges and families do not always have access to this type of service. Certification at the state level can incentivize county and contract mental health employers to increase the number and availability of peer provider and peer-driven services.

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 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). This paper builds on the work of this group and reviews the information related to certification for both purposes: as a standardization of practice and as a method to bill Medi-Cal for the services provided.

The issue of certification has been taken up by the Working Well Together (WWT) Statewide Technical Assistance Center, a collaborative project of CNMHC, NAMI California, United Advocates for Children and Families (UACF) and the California Institute for Mental Health (CiMH) and has 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. Additionally, the goal of the project is now inclusive of harnessing the input of various stakeholder groups in identifying certification standards for recommendation on a statewide basis."

This report is intended to provide stakeholders with background information on efforts in other states to include peer services into their systems of care. Additionally, the report will review existing hiring and training practices of peer providers in California. The report will also identify varying mechanisms and types of certification and discuss special considerations such as health care reform and the needs of small and/or rural counties. The report will conclude with recommendations and next steps toward certification. It is the intention of WWT that the report will precede and inform five regional stakeholder meetings in 2011-2012 to allow stakeholders the opportunity to utilize the information in the report to make recommendations to the state.

Scope of the Research

For the purposes of this paper the term peer support providers includes those individuals with lived experience as consumers/survivors, transition-aged youth (TAY) consumers, family

members and parents working in both the Adult and Children's Systems of Care. Across the nation and in California, peer support providers have a vast variety of titles including civil service classifications that may or may not include "peerness" as a qualification.

Each county in the state as well as the City of Berkeley and Tri-Cities was contacted to participate in a survey of county practices regarding the hiring and training of peer support providers (Appendix 1). An initial contact was made through the Workforce Education and Training Coordinator for each county. Follow-up contacts were then made where necessary. Forty (40) surveys were completed representing thirty-two (32) counties out of a total of fifty-nine (59) counties/entities. Representation of the county either came from information gathered about a county system of care, a county contracted community based organization or a Community College. In addition, the survey was distributed to individuals participating in the Working Well Together Peer Certification monthly teleconferences. Several members of this group made contacts in order to complete the survey. The number of surveys completed per region is listed below:

Superior	**Central**	**Bay Area**	**LA**	**Southern**
5	12	16	2	5

For information regarding Medi-Cal billing in California, a thorough review of the California State Plan for Specialty Mental Health Services was conducted. Additionally, the California Mental Health Directors Association (CMHDA) was contacted for specific information. Further information was gathered from the Centers for Medi-Caid and Medi-Cal websites both at the national and state level.

The national data was collected from a variety of sources. A primary source was the *Pillars of Peer Support: Transforming Mental Health Systems of Care through Peer Support Services* (2009). The raw data supporting the report was obtained from the National Association of State Mental Health Program Directors and used to draw further conclusions. Information regarding specific states was gathered from websites and telephone interviews.

Definitions of Peer Support

There are a number of definitions for the services that peers provide. Following are examples of definitions used for consumer/survivor, parent and family member, and TAY peer support.

Consumer/Survivor Peer Support in the Adult System of Care

Sherry Mead
"*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-concepts built on disability, diagnosis, and trauma worldview. The Stone Center refers to this as "mutual empowerment" (Stiver & Miller, 1998).

Davidson et al
"*Peer support* occurs when people share common concerns or problems and provides emotional support and coping strategies to manage problems and promote personal growth (Davidson, et al, 1999).

State of Tennessee Department of Mental Health
Certified Peer Specialist has self-identified as a person with a mental illness or co-occurring disorder and has successfully navigated the service system to access treatment and resources necessary to build personal recovery and success with his or her life goals. This individual undergoes training recognized by the department on how to assist other persons with mental illness in fostering their own wellness, based on the principles of self-directed recovery. (TDMH, 2011)

Parent Provider in the Child/Youth System of Care

United Advocates for Children and Families
Peer support "Provides encouragement and support to families receiving mental health services. Through our personal experiences and professional training, we help families to navigate the various child-serving systems in the county which can include, Juvenile Justice, Child Welfare, as well as Special Education services. We also provide support by educating families and the community about mental health and help in reducing mental health stigma". (UACF, 2012)

Peer Providers are "A parent or primary caregiver who is raising (or has raised) a child/youth who has emotional and/or behavioral challenges and has experience in advocating for his/her child in multiple settings or systems". (UACF, 2012)

State of Tennessee Department of Mental Health
Family support is defined as "direct caregiver-to-caregiver support services to families of children and youth with emotional, behavioral, or co-occurring disorders. Because of their life experience in caring for children with these disorders and navigating child-serving systems, Certified Family Support Specialists (CFSSs) are able to use their unique experience to inspire hope and provide support to others who are facing similar challenges". (TDMH, 2011)

"A Certified Family Support Specialist (CFSS) is a person who has self-identified as the caregiver of a child or youth with an emotional, behavioral or co-occurring disorder and who has successfully navigated the child-serving systems to access treatment and resources necessary to build resiliency and foster success in the home, school, and community. This individual has successfully completed training recognized by TDMH on how to assist other caregivers in fostering resiliency in their child, based on the principles of resiliency and recovery". (TDMH, 2011)

Family Advocate in Adult Mental Health Services

Transitions – Mental Health Association, San Luis Obispo and Santa Barbara Counties
"Family Services staff assists families in navigating the mental health system of care in both the public and private sector. They offer direct, support, information, and education with the goal of providing recovery and hope." (T-MHA, 2012)

Transition-Age Youth (TAY) Peer Mentors

Cindy Ross, Program Coordinator, Transition-Age Youth Center, Glenn County
"Youth Peer Mentors provide youth relevant, youth-friendly and youth-generated supports and services to young adults receiving mental health services. They provide the youth voice to the community and act as consultants on the youth culture to the larger system of care."

National Data

The research conducted indicates that there are anywhere from twenty-three (23) to thirty-five (35) states currently providing certification for Peer Support Specialists and four or five states providing Family Support Specialist certification. Raw data from the *Pillars of Peer Support Summit Report* (2009) indicate that twenty-three (23) states are currently providing certification. As this data was collected from attendees at the conference, it is limited to the number of states represented at the Summit. Data from an OptumHealth report draft entitled, *State Handbook for Peer and Family Support Services* (2010) reports data for thirty (30) states that are providing certification. When these two reports are combined there is a great degree of overlap, however there are five states that have data that appear in one data set but not the other.

Federal Guidelines for the Development of Peer Support Specialist

In addition to the lack of clarity regarding the number of states providing certification for peer support is the great diversity in how states implement peer support services for the purpose of billing Medi-Caid. In 2007, the Centers for Medi-Care and Medi-Caid Services (CMS) disseminated a set of guidelines by which states could develop Peer Support Providers and Peer Support Services (Appendix 2). This letter encouraged the development of such services and providers and recognized the service as a best practice. The guidelines set forth by CMS state that at a minimum there should be a plan developed to:

- Train and certify/credential Peer Providers
- Address the supervision of Peer Providers
- Ensure care coordination in the context of a comprehensive and individualized plan of care.

These guidelines are meant to allow states flexibility, with the result being that these standards have been developed specifically for each state and do not follow a predictable pattern. For some basic information on how Medi-Caid works, please see Appendix 3.

Medi-Caid Billing Mechanism

In terms of Medi-Caid billing for these services, states by and large have chosen to include these services within their State Plans. The majority of states utilize the Rehabilitation Option for service delivery. The Medi-Caid code for this option is (1905)(a)(13). A minority of states have used waivers as a mechanism to incorporate these services into their system. These waivers include:

1915(b)	Managed Care Waiver
1915(c)	Home and Community Based Waiver
1115	Research and Demonstration Projects

State Implementation of Peer Support Services

It is important to note that CMS allows for states to use a variety of methods to achieve the same outcome - the inclusion of peer support into mental health service delivery systems. Because of this flexibility, a number of different implementation strategies have been used. These strategies can be grouped into the following categories:

Creation of a distinct provider type	Services billed by this provider must have a rate established.
Creation of a distinct service	This service would be called peer support and would have its own rate of reimbursement.
Utilization of existing service types	Peer providers bill for services already existing in the State Plan. For example, a peer provider providing a rehabilitation service would simply bill to this code.

Development of Peer Support Agencies	Services are provided in a peer-operated setting. The setting must be certified according to CMS standards to bill for services.
Peer services provided as part of a capitated rate within managed care entities	Peer services are incorporated into the capitated rate and do not require a separate billing code.

This variety of implementation strategies and billing practices shows that examples from other states can be informative but cannot be used as boilerplates for California certification of peer support specialists. Additionally, stakeholders will need to consider carefully the purpose and best use of Peer Support Certification to maximize buy-in and reduce potential conflicts of interests with existing State Plan services and billing mechanisms.

Authorized Certification Bodies

In most states the authorized certification body is the state itself. However there are alternatives that have been used. In some cases the state delegates certification to either training organizations, CBOs or Universities. Following is a list compiled by OptumHealth (2010) of states recognizing a certification and their certifying entities. In some cases the certifying body is also the training provider. The states, through the legislature, the Department of Mental Health or other department within the state, determine the requirements of a certifying body when the certifying body is not the state itself.

Certification Entities	
Alabama	DMH and CBO
Arizona	State and CBO
Connecticut	Advocacy Unlimited
Florida	FL Certification Board
Georgia	GA Certified Peer Specialist (CPS) Project
Hawaii	State DMH
Idaho	Office of Consumer and Family Affairs
Illinois	DHS Division of Mental Health
Indiana	Affiliated Service Providers for IN
Kansas	Wichita State University
Kentucky	Dept. for Behavioral Health and Developmental Disabilities
Massachusetts	Transformation Center
Michigan	MI Department of Community Health; Lansing College
Minnesota	MN DMH
Mississippi	State
Missouri	DMH
New Hampshire	Intentional Peer Support
New Mexico	NM Credentialing Board for Behavioral Health Professionals
North Carolina	DMH University of North Carolina School of Social Work
North Dakota	Department of Human Services Division of Mental Health

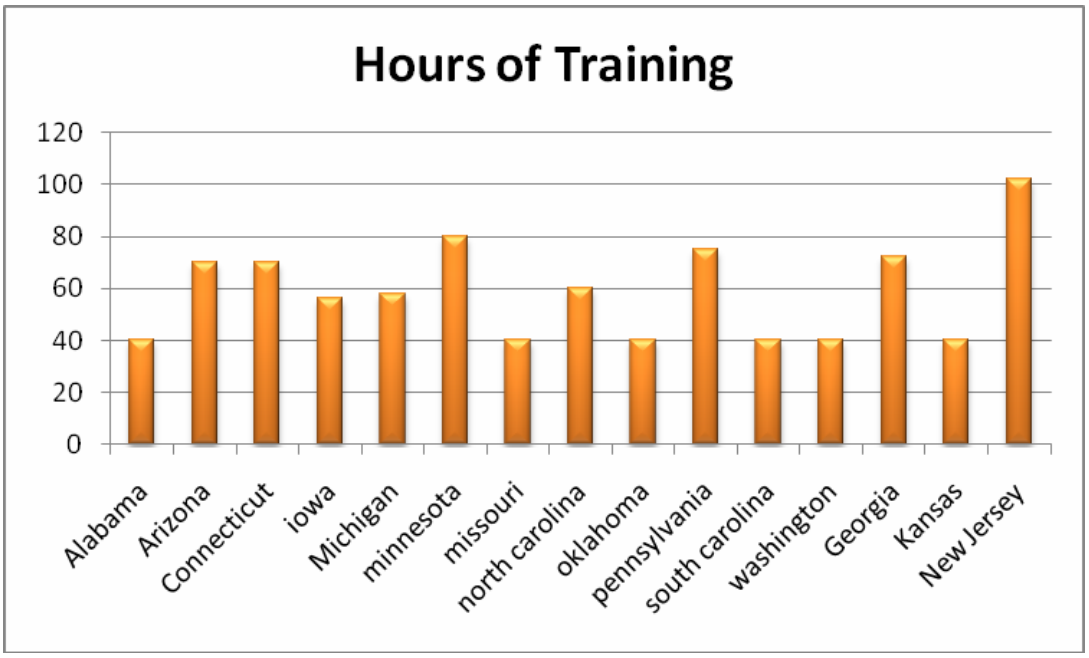
	and Substance Abuse
Oklahoma	Department of Mental Health and Substance Abuse
Oregon	Addictions and Mental Health Division certify training programs and local systems credential employees
Pennsylvania	Two approved private training vendors
South Carolina	DMH
Tennessee	TN Certified Peer Specialist Certification Program
Washington	Department of Behavioral Health and Recovery
West Virginia	Recovery Education Center
Wisconsin	State
Wyoming	Mental Health Services Division

Certification Standards

As noted earlier, states have developed certification standards individually and there exists a wide range of training required. In addition to training, many states require continuing education to maintain certification. Almost all of the certification programs require passing an exam. Examples are provided below:

	Hours of training	**CEU's**	**Exam**
Minnesota	**80**	**30 hours every two years**	**Yes**
Georgia	**40**	**12 hours annually**	**Yes**
Illinois	**30**	**0**	**Yes**
Michigan	**64**	**0**	**Yes**

Data from the *Pillars of Peer Support Summit* (2009) shows that the range of training hours among the states surveyed was from forty (40) to one-hundred (100) hours.



(Table taken from the Pillars of Peer Support Report 2010)

In addition to training requirements and exams, other requirements for certification include:

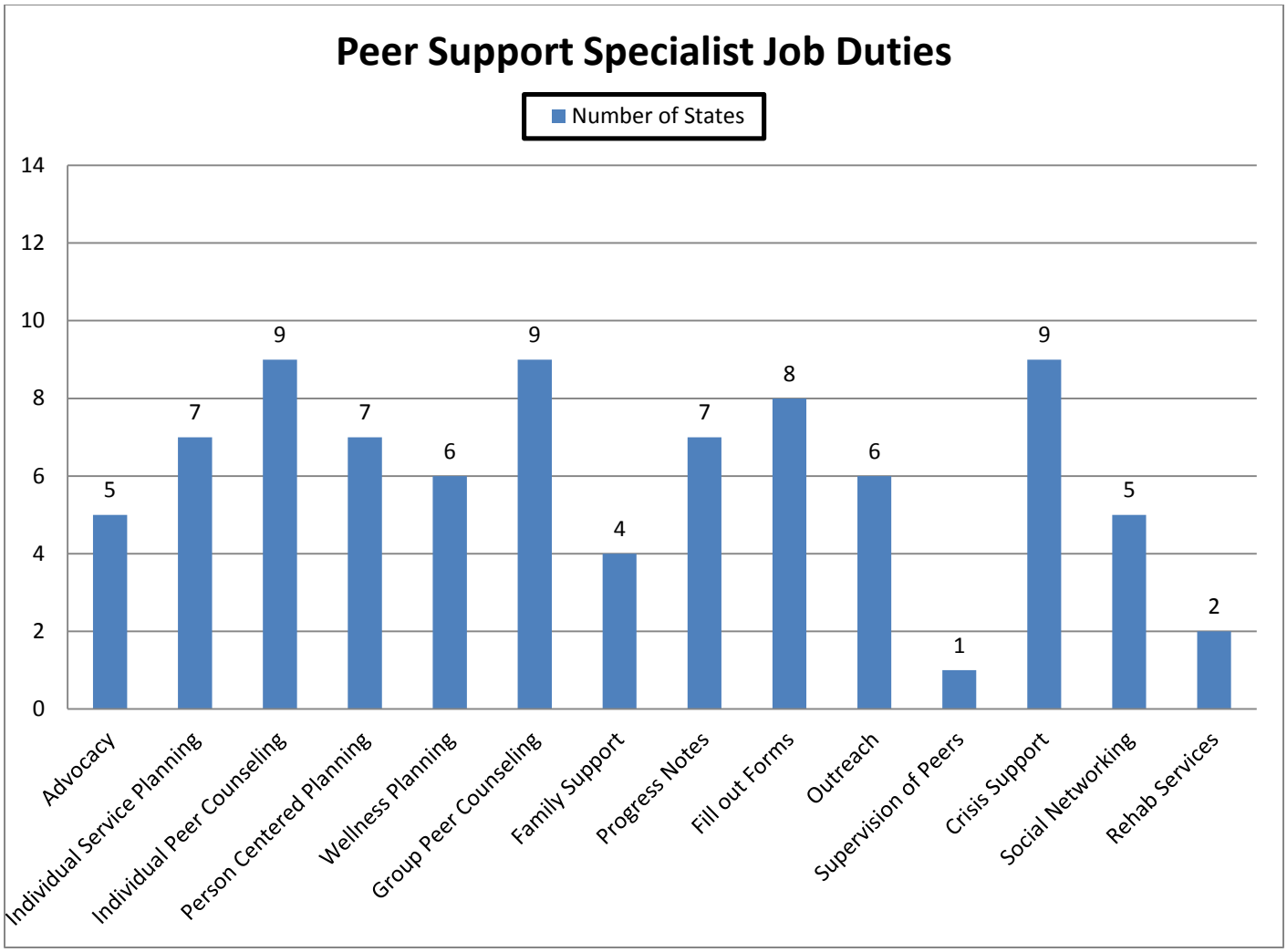
- Being 18 years of age
- Holding a valid driver's license
- Being a current or past recipient of mental health care
- Being willing to disclose and use personal story
- A specified amount of time in recovery

Supervision

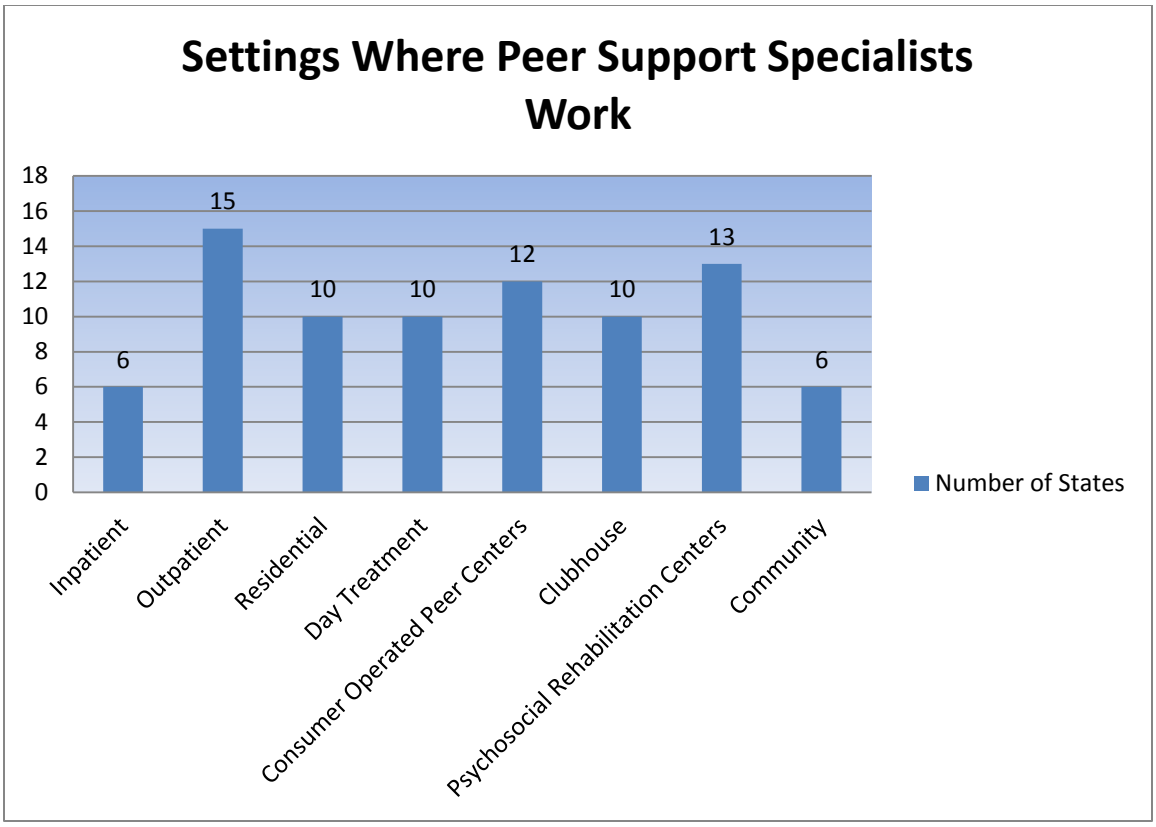
According to the CMS letter, peer support specialists must be supervised by a qualified mental health professional as defined by the state. Many states have required supervisors of peer support specialists to attend the same certification training that the peers receive.

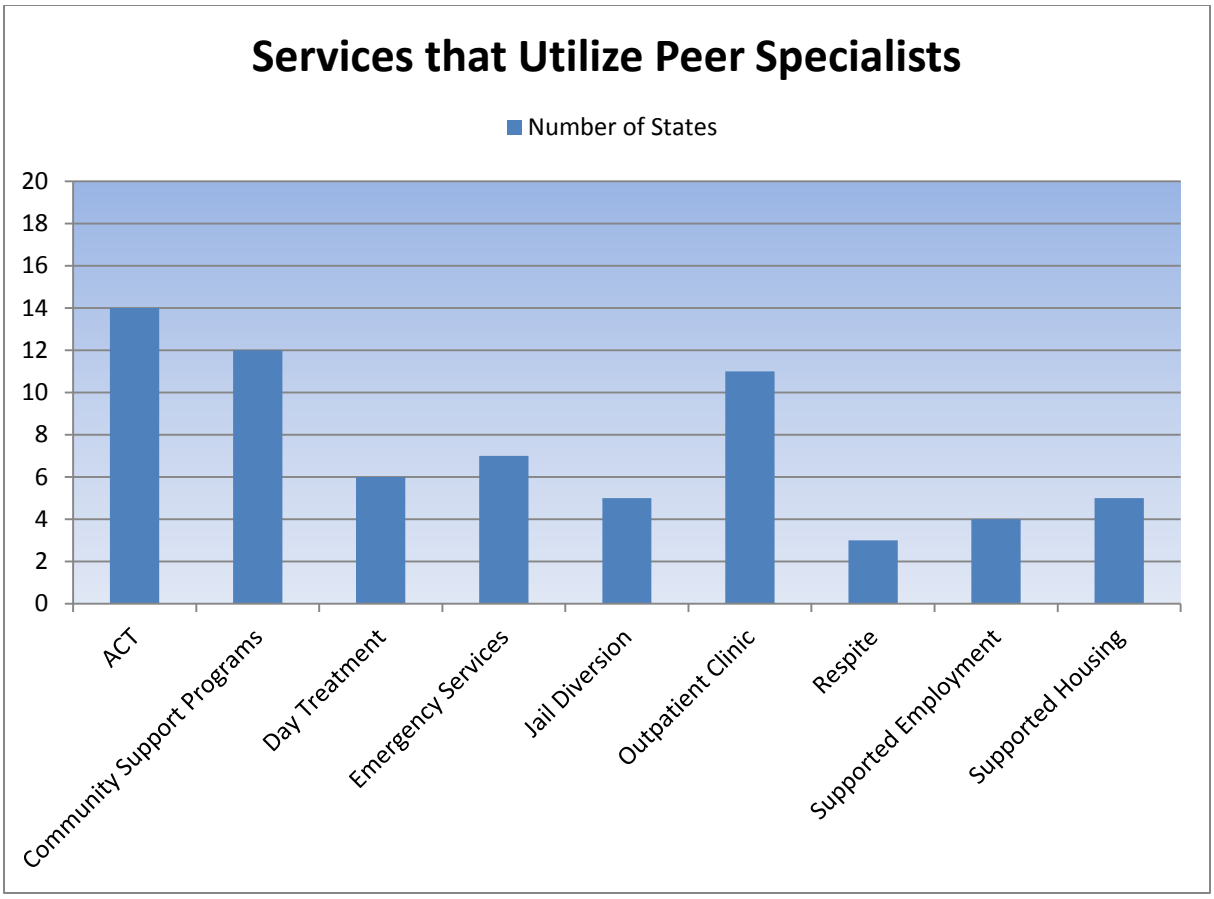
Job Duties

Information gathered from the *Pillars of Peer Support* data (2010) provides a representative view of the types of job duties performed by peer specialists. Of the fourteen (14) respondents, at least nine listed individual peer counseling, group peer counseling and crisis support as job duties. All job functions listed in the report are found in the graph below.



In addition to job duties, the report provided information on job settings and types of services that utilize peer support specialists.


Settings Where Peer Support Specialists Work
18
16
14
12
10
8
6
4
2
0
6
15
10
10
12
10
13
6
Inpatient
Outpatient
Residential
Day Treatment
Consumer Operated Peer Centers
Clubhouse
Psychosocial Rehabilitation Centers
Community
Number of States



California and Billing for Services

It is important for the purposes of this paper to identify the qualifications of the service provider entitled "Other Qualified Provider". The state plan lists the qualifications as "An individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service." It is under the category of "Other Qualified Provider" that people with lived experience who meet the qualifications may provide and bill for services.

In California the state plan utilizes the Rehabilitation Option for the provision of Specialty Mental Health Services and broadly defines Rehabilitative Mental Health Services (Appendix 4). In the state plan, a number of services are defined as billable to Medi-Caid, or Medi-Cal in California. The state plan also defines who may provide which service. It is important to note that California also has a waiver that allows for the provision of Targeted Case Management.

The following table identifies the services that can be provided and who is able to provide them within their scope of practice (California State Plan Amendment 2011). Not all providers are able to provide all service components within a category. For example, under Mental Health Services the service component "therapy" is provided by psychiatrists, psychologists, Marriage Family Therapists (MFT) and Licensed Clinical Social Workers (LCSW). Rehabilitation may be provided by a wider range of professionals, including "other qualified providers."

	Service Component	**Provider-Within Scope of Practice**
Mental Health Services	Assessment Plan Development Therapy Rehabilitation Collateral	Physician, a Psychologist, a Licensed Clinical Social Worker, a Marriage and Family Therapist, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and ***Other Qualified Provider***.
Medication Support Services	Evaluation of the need for medication Evaluation of clinical effectiveness and side effects The obtaining of informed consent Medication education including instruction in the use, risks and benefits of and alternatives for medication Collateral Plan Development	Physician, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Physician Assistant, a Nurse Practitioner, and a Pharmacist
Day Treatment Intensive	Assessment Plan development Therapy Rehabilitation Collateral	Physician, a Psychologist, a Licensed Clinical Social Worker, a Marriage and Family Therapist, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and ***Other Qualified Provider***.
Day Rehabilitation	Assessment Plan development Therapy Rehabilitation Collateral	Physician, a Psychologist, a Licensed Clinical Social Worker, a Marriage and Family Therapist, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a

		Pharmacist, an Occupational Therapist, and ***Other Qualified Provider***.
Crisis Intervention	Assessment Collateral Therapy Referral	Physician, a Psychologist, a Licensed Clinical Social Worker, a Marriage and Family Therapist, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and ***Other Qualified Provider***.
Crisis Stabilization	Assessment Collateral Therapy Crisis Intervention Medication Support Services Referral	A physician must be on call at all times for the provision of crisis stabilization services that must be provided by a physician, there shall be a minimum of one registered nurse, psychiatric technician, or licensed vocational nurse on site at all times beneficiaries are present, at a minimum there shall be a ratio of at least one licensed mental health or waivered/registered professional on site for each four beneficiaries or other clients receiving crisis stabilization services at the same time. If a beneficiary is evaluated as needing service activities that may only be provided by a specific type of licensed professional, such a person must be available. Other persons may be utilized by the program according to need.
Adult Residential Treatment	Assessment Plan development Therapy Rehabilitation Collateral	Physician, a Psychologist, a Licensed Clinical Social Worker, a Marriage and Family Therapist, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and ***Other Qualified Provider***.
Crisis Residential Treatment	Assessment Plan Development Therapy Rehabilitation Collateral Crisis Intervention	Physician, a Psychologist, a Licensed Clinical Social Worker, a Marriage and Family Therapist, a Registered Nurse, a Certified Nurse Specialist, a Licensed Vocational Nurse, a Psychiatric Technician, a Mental Health Rehabilitation Specialist, a Physician Assistant, a Nurse Practitioner, a Pharmacist, an Occupational Therapist, and ***Other Qualified Provider***.

Psychiatric Health Facility Services	Assessment Plan development Therapy Rehabilitation Collateral Crisis intervention	Psychologist, a Licensed Clinical Social Worker, a Marriage and Family Therapist, a Psychiatric Technician, a Registered Nurse, a Licensed Vocational Nurse, a psychiatrist, a Physician with training and/or experience in psychiatry, a Pharmacist or ***Other Qualified Provider.***

State Plan Amendment Stakeholder Process

During the most recent State Plan Amendment process, stakeholder questions and suggestions were reported by the Department of Mental Health. ***In the responses to questions regarding peer providers it is made clear that the expansiveness of the Other Qualified Provider is intended to include consumer and family member employees.*** Excerpts from Mental Health State Plan Amendment Questions/Comment and Response Summary (2011) are provided below. The complete version of this document can be found at http://www.dmh.ca.gov/services_and_programs/medi_cal/docs/meetings/2010/october/spaqasummary.pdf

Area of Concern/Comment	Response from DMH
Several stakeholders had concerns over the proposed definition of 'Other Qualified Provider' and requested clarification on what types of individuals could be considered as other qualified providers.	DMH has made changes to this definition based on stakeholder input and direction from CMS to clarify this definition. The revised draft definition of "other qualified provider" is intentionally broad in order to not limit what is currently allowed while providing some basic, minimum qualifications. The definition is intended to include peer support, parent partners, and paraprofessionals who meet the minimum requirements. Other qualified provider will be added to the Targeted Case Management State Plan Amendment documents as it was originally omitted in error.
Several stakeholders requested that the State add Medi-Cal reimbursable Peer Support services and providers to the current State Plan Amendment.	The State is open to stakeholder input regarding peer support services and will consider making that service available in the future. The purpose of the current SPAs is to update the service definitions and provider qualifications to be consistent with current practice. Peer support and parent partner providers may be specifically included in the future and will be considered in

	conjunction with the addition of peer support services. Peer support providers and parent partners are currently covered in the draft State Plan Amendment language under the very broad definition of "other qualified provider." Other qualified providers may provide some existing services under the direction of a licensed mental professional that can direct services.

An Overview of California Practices Regarding Certification and Employment of Peers in the Mental Health System

The beauty and the beast of California is the independent nature of its fifty-nine (59) counties/entities. Data here represents information gathered from thirty-two (32) counties (Appendix 7), through a mix of county representatives, community-based organizations and colleges. There is great diversity in terms of how peer providers are trained for the important work that they do in the system. In this sample, thirty-one (31) out of thirty-two (32) counties currently employ peer providers, either in civil service positions or contracted through community-based organizations.

Certification in California

Certification for a profession serves several purposes. It provides legitimacy to the certificate holder as well as the profession in general. In California, efforts by peer providers to promote the legitimacy of peer support services have focused on:

1. Development of standards for certification
2. Linking peer support services to Medi-Cal billing
3. Development of mechanisms for maintaining "peerness" while working in the existing systems of care
4. Promoting autonomy for peer support services through the development of Peer Provider sites

Peer providers coming into the mental health system as employees are valued for their lived experience – the lessons learned from a recovery journey either from direct experience or from the viewpoint of a family member. For some counties, this lived experience is the sole qualification for the job. Other counties opt to provide on-the-job training for these new employees. Some counties develop the curriculum for this training in-house or utilize a standardized curriculum offered throughout the state by private/non-profit training organizations or educational institutions.

California does not have a statewide certification for peer providers. It is the private/non-profit entities and educational institutions that offer certification. This lack of statewide standardization of criteria creates great diversity in what training is available for peer providers.

Process for Developing Certification – Becoming a Certified Body

Some private organizations offer certification and have developed processes for granting certification as well as standards for becoming an authorized trainer. In general, this process involves the following components:

- Development of standards of practice and competencies
- Curriculum vetting by a wide group of stakeholders
- Measurement of successful completion of the curriculum

Groups that develop the capacity to grant certification have long-term, well-established reputations in the area of expertise. Potential candidates for certification must apply, and in some cases pay fees to be certified through the organization. Some training organizations offer a train-the-trainer opportunity in order to develop standardization among instructors of the prescribed curriculum. Other training organizations will only offer certification based on receiving training directly from the certifying body.

Listed below are a few examples of certification programs for peer providers and the elements of the certification program. These programs do not require employment or volunteer experience though other types of certification programs do have this requirement.

Certification Criteria for Peer Provider Training Programs

Name of Program	Provider	Training hours	CEU's	Supervision	Fee	Train-the-Trainer
Peer Support Certification – Children's Services	Family Youth Roundtable (Alliant University)	90 hours core training + 16 hours Advanced	24 hours of Advanced trainings annually	18 hours peer-to-peer supervision to be certified and 24 hours group consultation meetings to maintain certification.		Yes $1250 in-person or $1790 online plus coaching and consultation costs
Peer Employment Training	Recovery Innovations	75 hours core training	No	No	Can be contracted through Training Hub or as part of county contract	
Parent Partner 101 Certification	United Advocates for Children and Families	18 hours	No	No	$450	No
Educate, Equip and Support Train the Trainer	United Advocates for Children and Families		No	No		18 hours, + exam $350

Educational Institutions Offering Certification

Educational institutions such as the community college, state schools and universities, have processes in place to develop certification programs and a number of these apply to the training of peer providers. For example, Human Services Certificates provide generalist knowledge and skills for a variety of entry-level jobs in mental health and social services. The Psychosocial Rehabilitation Certificate, developed by California Association of Social Rehabilitation Agencies (CASRA) is another example of a certificate program that focuses on training individuals for work in the public mental health system, including peer providers. This curriculum can be offered in a variety of ways, including certification programs at community colleges. Some community colleges also have certificates explicitly for Peer Support Services. The Community Mental Health Certificate program at City College in San Francisco and the Peer Counseling Certificate program in San Mateo County at the College of San Mateo are two examples. The SPIRIT program in Contra Costa County, which started as a consumer-operated training program offered through county mental health services, is now offered through Contra Costa Community College.

Certification Requirements through Community Colleges

Name of program	Community College	Course Units Required	Internship
Community Mental Health Worker Certificate	San Francisco City College	16	Yes
SPIRIT Community Mental Health Worker Certificate	Contra Costa College	9	Yes
Peer Mentoring Certificate	College of San Mateo	12	Yes

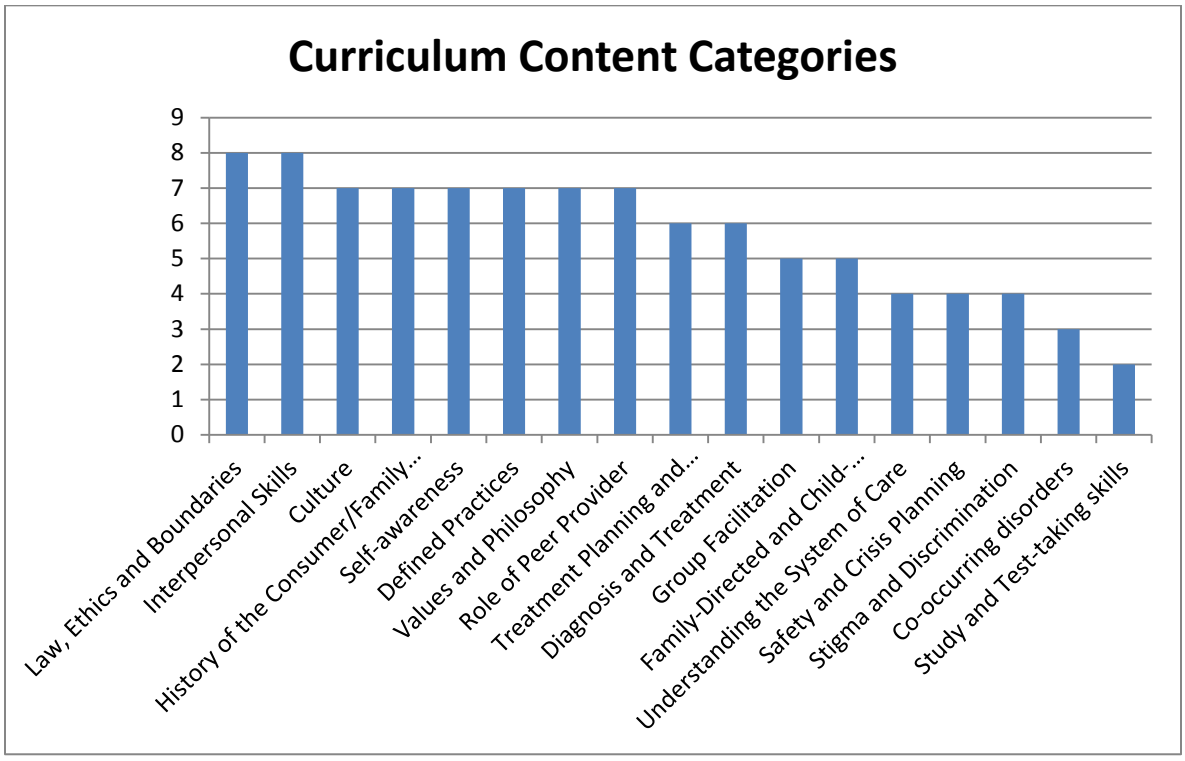
Training Programs for Peer Providers

In addition to the peer provider certification programs listed above, counties also use peer provider training programs with specific trainings developed exclusively for peer providers. Some of these training programs are developed at the county level. Los Angeles is currently in development of a peer specialist training program due to be released soon. Other counties pick among the trainings available for all staff. Working Well Together at the state level provides a training series entitled, ***Training Individuals Who Identify as Consumers and Family Members for Employment in Public Mental Health,*** for peer providers that is posted online at http://www.workingwelltogether.org

Curriculum Content

The number of hours required for training or certification programs of all types reviewed in this research, ranged from twelve (12) hours to four-hundred-eighty (480) hours. The amount of time invested in training determines the extent of material that can be covered.

A crosswalk of eight curricula was done, reviewing curricula content areas across two community colleges, three consumer-provider organizations, two family-provider organizations and one statewide training curriculum. Sixty-two discreet topic areas, found in Appendix 5, were condensed into seventeen broader categories by grouping similar content areas (Appendix 6). This crosswalk suggests that core curriculum content across consumer and family providers is very similar. Over 70% of content areas occur in at least half of the curricula reviewed. The categories of practices reflect a wide array of service delivery options that include best practices and strategies for working in the adult and/or children's system, as well as for transition-age youth. This category would be one in which specialization material might be developed, i.e., topics of interest to family and/or parent partners only, TAY-specific or focused on best practices for people with lived experience as consumers in the adult system.



California Employment Data

As mentioned above, of the thirty-two counties represented, thirty-one hire consumers and/or family members either as direct hires or through CBO's. Twenty-one counties directly hire consumers into civil service positions. Requirements for employment have one thing in common: lived experience is identified as a direct qualification requested or "desired" in 32 out of 33 responses. Some counties use supplemental questions on their application to elicit this information.

Requirements for employment vary considerably outside of the necessity of lived experience. ***Only five counties require completion of any training program before hire, even when training programs exist within their area.*** The requirement for job experience ranges from six months to

four years. Driver's licenses were mentioned in three instances and only one respondent mentioned utilizing a background check.

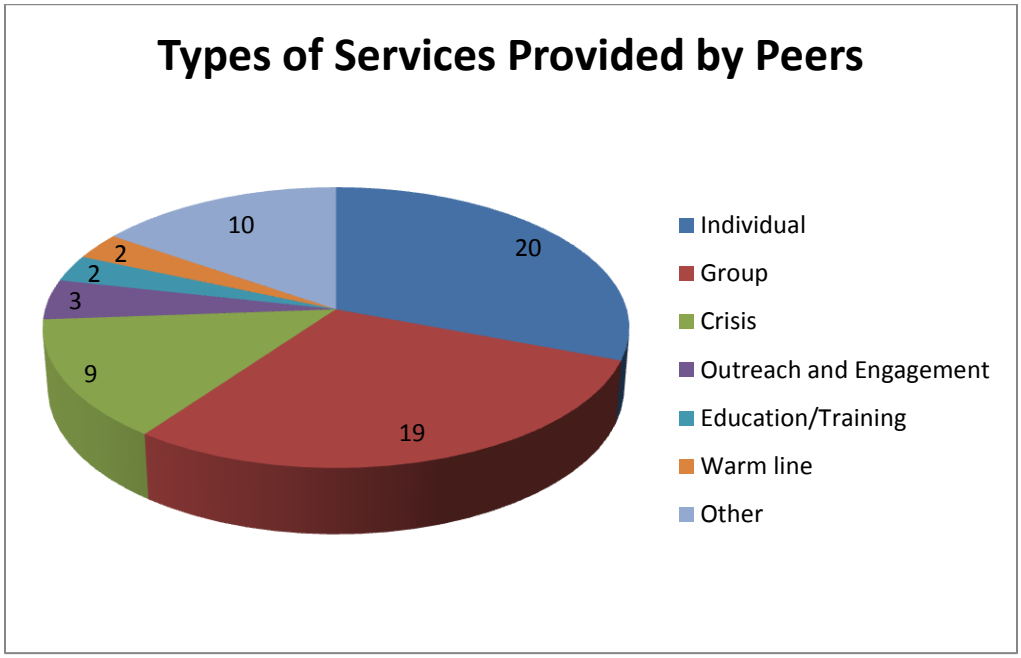
Job Requirements of Peer Providers

Lived Experience/Lived Experience Strongly Preferred	13
Lived Experience plus completion of a recognized training program	5
Lived Experience plus two years of mental health work/volunteering	3
Lived Experience plus meet County Qualifications per county positions	2
Lived Experience plus Recovery	1
Mental health diagnosis plus driver's license	1
Lived Experience plus Driver's License	1
Lived Experience plus 6 months of Peer Support work	1
Lived Experience plus 12 hours of a specific training or 6 months working with consumers	1
Lived Experience plus one year mental health work	1
Lived Experience plus 2-3 years working in Peer/Mental Health Services plus Peer Support Training plus WRAP facilitator training	1
Lived Experience plus 2 years' experience in mental health work. College courses may be substituted on a year for year basis	1
Lived Experience plus 4 years' experience in mental health work plus driver's License	1
Lived Experience plus Leadership Training plus background check	1

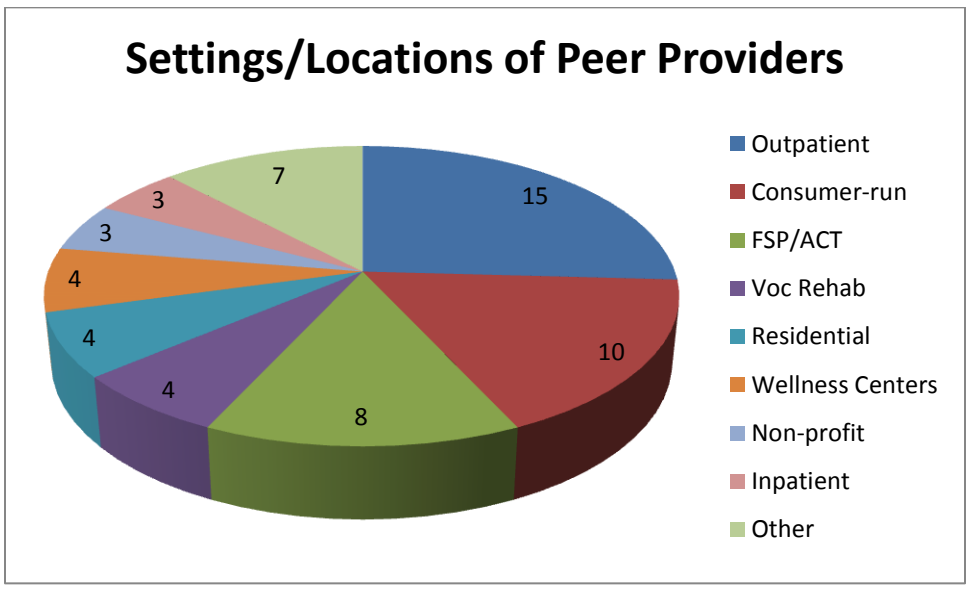
Scope of practice

Scope of practice here refers to the defined range of responsibility and practice guidelines that determine the boundaries within which a professional practices. The survey asked about three general types of services that may be provided by peers: crisis support, individual peer support and group support. Peer providers are offering individual and group services in a majority of instances. Peers also provide support in crisis situations, outreach and engagement, provide education and training and work on warm lines. Respondents mentioned other services that peers provide within the system including career development, leadership, arts and crafts, as a

meeting participant, employment assistance, welcoming, transportation, peer bridging and case management.



Peers work in a variety of settings, most often in outpatient clinics, consumer-operated programs and Full Service Partnership/Assertive Community Treatment (FSP/ACT) programs. Single responses (labeled as "Other" in the chart below) for the location of peer providers included the jail, long-term locked facilities, board and care homes, mobile outreach, psychiatric emergency facility, on teams and in administration.



County Classifications for Peer Providers

A multitude of classifications are used when Peer Providers are working in civil service positions, with very little commonality across the state.

County Classifications	
Mental Health Specialist I	2
Mental Health Specialist II	1
Mental Health Specialist III	1
Senior Mental Health Specialist	1
Community Workers	2
Family Partner	1
Family Advocate	2
Community Services Liaison	1
Mental Health Aide	1
Mental Health Worker I	3
Mental Health Worker II	1
Mental Health Rehabilitation Technician	1
Mental Health Peer Advocate	1
TAY Peer Mentor	1
Community Development Partners	1
Consumer Assistant Workers	1
Rehabilitation Specialist	1
Occupational Trainee	1
Client Services Assistant	1
Public Service Aide	1
Mental Health Peer Support Worker	1
Mental Health Client Aide	1
Peer Mentor	2
Parent Partner	2
Behavioral Health Advocate	1
Consumer Job Intern	1
Community Mental Health Support Worker II	1

Examples of Certification Programs

CPRP and CDAC

Two examples of certification programs that set a high standard are 1) the United States Psychiatric Rehabilitation Association (USPRA) which offers the Certified Psychiatric Rehabilitation Practitioner (CPRP), and 2) the California Certification Board of Alcohol and Drug Counselors (CCBADC), which offers the Certificate for Alcohol and Drug Counseling

(CADC). In order for these organizations to offer certifications, a number of functions must be performed including, but not limited to:

1. Create a guild that maintains their influence in educational and employment settings
2. Develop practice standards/competencies
3. Develop ethical standards
4. Create a process for handling ethical violations/revoking certification
5. Determine and vet curriculum
6. Determine eligibility for sitting for the exam
7. Develop exam questions, initial and ongoing
8. Administer the exam
9. Provide oversight and management of fees
10. Review applications
11. Review CEU requirements
12. Audit CEU's

The following is a brief overview of both certificate program requirements. For a full description of these certifications, you can go to:
Certified Psychiatric Rehabilitation Practitioner (CPRP)
https://netforum.avectra.com/eWeb/DynamicPage.aspx?Site=USPRA&WebCode=cprp
Certified Drug and Alcohol Counselor (CDAC)
http://www.caadac.org/pages/certification.php

Comparison of CPRP and CADC Certification Programs

Certifying Body	Fees	Process for Approved Providers of Training	Work/Volunteer Experience	Training	Test	Code of Ethics
California Certification Board of Alcohol and Drug Counselors (CCBADC)	For members: $145 for portfolio submission $164 for test	Yes	2 years (40 hrs. per week)	270 hours + 45 hours internship/practicum or 4000 hours of supervised practicum	Yes – per course	Yes
United States Psychiatric Rehabilitation Services Association (USPRA)	For members: $365	Yes	2 years (40 hrs. per week)	48 hours (or specific certification/degrees in psychiatric rehabilitation)	Yes	Yes

Special Note regarding Billing in Alcohol and Other Drug (AOD) Services

Medi-Cal billing in the alcohol and drug system of care focuses on certifying sites that provide these services. In addition however, regulations require that "at least 30 percent of the staff providing counseling service in any AOD program (including any Drug Medi-Cal (DMC) program) must either be licensed or be certified by an organization approved by the California Department of Alcohol and Drug Programs (ADP) to register and certify AOD counselors, and any staff members that are neither licensed nor certified must be registered for certification within six months of their date of hire", Drug Medi-Cal Billing Manual (2002).

This example may be something for peer provider agencies to look at when considering a mechanism for billing Medi-Cal services.

The Forensic Peer Specialist

The Forensic Peer Specialist certificate is another example of a certification program for a specific type of services. It is offered through a peer-run organization in New York City. The Howie the Harp Peer Advocacy Center started STARR (Steps to a Renewed Reality) program, a Forensic Peer Specialist Training Program, which was the nation's first program to train mental health consumers with histories of incarceration to work in human services.

"The STARR program consists of four core components: classroom training, supervised internship, placement and post placement supports and continuing education. The classroom training lasts for approximately 6 months and prepares trainees for entry level positions in human services. Training modules include: "Confronting Your Criminal Justice History," "Case Management and Service Coordination," "Understanding the Criminal Justice System," "Peer Counseling" and "Conflict Resolution and Mediation." Classes are taught by trainers who are not only subject matter experts but who are also committed to successfully integrating peer staff in the workplace, and share our values of resiliency and recovery. Trainees also receive job readiness training to ensure that they are fully prepared for the demands of the workplace." (Miller, 2012).

The Howie the Harp Peer Advocacy Center offers technical assistance on the development of a Forensic Peer Specialist program in local areas. They have demonstrated positive outcomes on their work to date, including that 60 percent of the graduates of this program have maintained employment for at least one year.

Critical Decisions for Implementation Planning

There are a number of critical decisions for stakeholders to make when developing an implementation plan and recommendations to the state for certification of Peer Support Specialists.

Statewide Certification of Peer Support Specialists

Authorizing Body

There are two options that the State has in selecting a certifying body to grant a Peer Support Specialist certification. The State itself can utilize already existing entities to include Peer

Support Specialist Certification, such as the Department of Health Care Services (DHCS) or the Board of Behavioral Sciences (BBS). The other option is for the State to delegate authority to another agency/training organization.

Infrastructure Needs
Decision-makers will need to determine who will provide oversight and management of the certification process. This entity will require significant infrastructure and funding to adequately administer all the components of certification. These include such areas as:

- The provision of CEU audits
- Management of ethical accusations and violations
- Determining the process regarding revocation of certification
- Determining the process for certification renewal

Training
A set of criteria to authorize training entities will need to be established. This must include qualifications of the training entity as well as trainers themselves, such as whether trainers must have lived experience.

Curriculum
A number of curriculum issues must be discussed and agreed upon, such as whether or not there will be a single curriculum adopted or whether multiple curricula may qualify using a defined core set of standards regarding content. If multiple curricula are used, there will need to be a group that reviews and vets these curricula. In addition to core curricula, specialization curricula must be determined for peer provider type as well as specialized content areas including forensics, health care and potentially other types of specialty areas requiring very specific types of knowledge and expertise.

Core competencies
Upfront it will be important to develop a set of core competencies for Peer Support Specialists. Decisions will need to be made regarding who will conduct this process as well as what type of process will be used. Along with core competencies, a Code of Ethics must be established. There are codes of ethics that exist currently which may be adopted, such as the National Association of Peer Specialists Code of Ethics, or a new one could be developed for California.

Measurement
If an examination is used to measure completion of the certificate program, this exam will need to be created, administered and periodically reviewed and changed. Reasonable accommodations for test-taking must be built into the process.

Continuing education units
Continuing education is commonplace in any credentialing program. Decisions must be made regarding the number of CEU's required per year. In addition, specific topic areas could be required or standards applied to coursework that will be accepted for CEU's.

Meeting Federal CMS Guidelines for Peer Support Specialists and Billing
Stakeholders must also decide on how to address the issues surrounding Medi-Cal billing. Using the Federal CMS guidelines on certification of peer providers, these additional criteria must be determined:

- How peer support services will be coordinated within the client care plan.
- Minimum supervision requirements for peer providers.

Medi-Caid Billing Options

In order for peer providers to bill Medi-Cal through certification, the Department of Health Care Services (DHCS) must negotiate with the Center for Medicare and Medicaid Services to include Peer Specialist Certification either into the state plan or into a waiver. This could take the form of:

- Creating a distinct provider type
- Creating a distinct service type (peer support services) and negotiating a fee for these services, which would likely be paid at a lower rate than current rehabilitation services
- Create a certified peer provider agency that utilizes peer support specialists
    - This does have a potential advantage for peer provider organizations who wish to provide a specific array of services and have a mechanism for billing Medi-Cal.

Funding and Sustainability

Underlying all of these issues is the question of funding. Developing core competencies is done one time (with periodic checks/updates), but vetting curricula, administering tests, maintaining a database of certified providers and receiving/auditing CEU information for ongoing certification requires a sizable infrastructure. Any certification process of providers will require funds to administer and manage the certification program. Additionally, funds for required training and on-going continuing education will be necessary.

This leads to the question of fees – what should the cost of certification be and who should fund it? One option would be to request funds that have been set aside through the Mental Health Services Act for statewide Workforce and Education Training (WET).

Another consideration is whether peer-operated organizations will seek to become certified sites for the provision of Medi-Caid (Medi-Cal in California) services. In some states, start-up costs for the certification of peer-operated agencies to meet Medi-Caid requirements have been included in the billing structure.

Currently, few counties report that they bill Medi-Cal for Rehabilitation or Targeted Case Management services provided by peer support employees. There are many more counties that currently employ or contract with agencies that provide services through peers that could be billed under the current State Plan. Perhaps an expansion of this practice could free up monies to go toward funding certification.

Partnering with State Entities

It will be vital to create a working partnership with key state entities to move certification through to completion. Examples of important partnerships to establish are the California Mental Health Directors Association (CMHDA) and the Mental Health Services Oversight and

Accountability Commission (MHSOAC). These associations will offer access to expert information as well as providing a sounding board to create a cohesive and acceptable plan for all stakeholders. CMHDA has staff resources that focus on policy, programs, legislation and much more. The MHSOAC oversees the Mental Health Services Act and reviews county mental health expenditures regarding Prevention and Early Intervention and Innovation monies. They also have review and comment responsibilities regarding the Community Services and Supports, Capital Facilities, Technological Needs and Workforce Education and Training plans/programs. This committee will play an important role in policy development and advocacy regarding statewide peer certification.

Additionally, the Department of Health Care Services (DHCS) and the State Centers for Medi-Case Services (CMS) will need to be brought into the discussion early on. Input from these two bodies will help tremendously in the state plan amendment process and the establishment of a statewide infrastructure to support certification.

Employability

Statewide action to deal with the civil service issues is integral to the ultimate success of certification. Becoming employed is the goal of completing a Peer Support Certification program. Mental health services in California are provided by individual counties. Each county has a set of civil service positions. Most employees working within a civil service system are represented by unions. These two factors have created a situation whereby, mental health systems seeking to hire peer support providers have found it difficult to create new civil service codes within their counties. This is why many peer providers are hired into positions using existing county civil service codes and job titles. It is a difficult struggle for mental health systems to implement transformation through peer providers and services when they are restricted by civil service rules and regulations.

This consideration should be part of the planning process for the certification of peer providers. Certification of peer providers in and of itself will not have a direct effect on whether county systems will be able to hire peer support specialists.

Career Ladder Opportunities

The issue of a career ladder for peer support specialists must again take into consideration the county civil service system. Every county will have specific opportunities and barriers for developing positions and advancement opportunities. Career advancement opportunities may be more readily available in peer-operated agencies that become certified to bill Medi-Caid. These agencies would be in a unique position to create a number of different jobs that would include increasing responsibilities and pay.

Some states have created certifications that build in a career ladder, for example, Peer Support Specialist I, II and III. (See list of classifications on page 25). As you move from one level to the next new requirements must be met to qualify for advancement. Other states encourage career advancement through meeting the criteria of another job category. For example, a peer support specialist may take coursework to become a social worker. These examples can assist decision-makers in creating the right options for California.

Portability

Portability refers to whether a certificate will be recognized across county lines. A statewide certification will still need to be recognized by the different county mental health systems. It is crucial that stakeholders involve county Mental Health Directors in the recommendation process to ensure buy-in and acceptance.

Rural and Small County Issues

Certification poses some particular challenges for rural and small counties. One key issue is access to training. Individual small/rural counties may not have a large pool of Peer Specialist employees or candidates to efficiently provide training services. Currently there are only a few online opportunities for training that provide instruction as well as testing. Transportation to trainings can also be a large obstacle.

Decision-makers will need to take into consideration a number of strategies that can help in reducing these types of barriers. Some of these strategies are listed below:

- Promote the development of agencies operated by individuals with experience at consumers, parents, and family members. These agencies could provide direct services where existing service capacity is limited. Getting these employees certified is an upfront investment to increase and localize services, creating benefits for the whole system.
- Utilize curricula available on the web, such as the WWT series on Employment of Consumers and Family Members in Public Mental Health. These trainings address hiring, training, retention and support of employees, as well as preparing the existing workforce to be welcoming.
- Create regional partnerships to share resources and trainers.

Health Care Reform

Key decisions need to take into consideration the impact of Health Care Reform. Health Care Reform makes a number of significant changes to coverage as well as services. The main points to keep in mind while developing the certification program are:

1. Expansion of Medi-Caid coverage will include people living at or below 133% of the federal poverty level. This will expand coverage to millions of Americans.
2. States will be required to establish State Insurance Exchanges as a method of enrollment of newly covered persons.
3. Mental health and addiction services will be mandated services in the new health care exchanges.
4. Integration of primary care and mental health and addiction services will occur. It is thought that primary care will become the "health home".
5. Patient-centered care is emphasized.
6. The use of best practices is required.
7. Monies will become available for the education of primary care providers about the integration of mental health and physical health.
8. Education is also required for integration of special populations; including chronic disease management, treating vulnerable populations including those with mental health or substance use issues.

Integration and expansion of care will create a number of opportunities for peer support specialists. Initially, peer support will be needed to assist individuals and families to access care, thus bridging activities will be necessary to assist people to maneuver within the new system. Peers can also be integral in the education of primary care providers about mental health and substance use issues. Significantly, peers can play a powerful role in implementing wellness strategies and prevention through peer support.

The magnitude of healthcare reform suggests that stakeholders consider putting health care content into the core curriculum for peer specialist providers. There are curricula that have been developed in this area that could potentially be integrated into the Peer Specialist Certification.

Best Practices in Peer Provider Certification

When making decisions about certification, stakeholders can utilize information from the Pillars of Peer Support Summit, which has identified a group of twenty-five best practice standards in the summit report (2010). State representatives from across the country developed a consensus statement of those items that will strengthen a Peer Specialist Certificate Program. WWT supports the application of similar supports for all peer providers including those who are parents, family members and transition-age youth. According to the Pillars of Peer Support, a program is strengthened when:

1. There are **Clear Job and Service Descriptions** that define specific duties that allow Certified Peer Specialists to use their recovery and wellness experience to help others recover.
2. There are **Job-Related Competencies** that relate directly to the job description and include knowledge about the prevalence and impact of trauma in the lives of service recipients as well as trauma's demonstrated link to overall health in later life.
3. There is a **Skills-Based Recovery and Whole Health Training Program** which articulates the values, philosophies, and standards of peer support services and provides the competencies, including cultural competencies and Trauma Informed Care, for peer specialist duties.
4. There is a **Competencies-Based Testing Process** that accurately measures the degree to which participants have mastered the competencies outlined in the job description.
5. There is **Employment-Related Certification** that is recognized by the key state mental health system stakeholders, and certification leads directly to employment opportunities that are open only to people who have the certification.
6. There is **Ongoing Continuing Education,** including specialty certifications that expose the peer specialists to the most recent research and innovations in mental health, Trauma Informed Care and whole health wellness, while expanding their skills and providing opportunities to share successes mentor and learn from each other.
7. There are **Professional Advancement Opportunities** that enable Certified Peer Specialists to move beyond part-time and entry level positions to livable wage salaries with benefits.
8. There are **Expanded Employment Opportunities** that enable certified peer specialists to be employed in a variety of positions that take into account their own strengths and desires.

9. There is a **Strong Consumer Movement** that also provides state-level support, training, networking and advocacy that transcends the local employment opportunities and keeps Certified Peer Specialists related to grassroots consumer issues.
10. There are **Unifying Symbols and Celebrations** that give Certified Peer Specialists a sense of identity, significance and belonging to an emerging profession or network of workers.
11. There are ongoing mechanisms for **Networking and Information Exchange** so that Certified Peer Specialists stay connected to each other, share their concerns, learn from one another's experiences, and stay informed about upcoming events and activities.
12. There is **Media and Technology Access** that connects Certified Peer Specialists with the basic and innovative information technology methods needed to do their work effectively and efficiently.
13. There is a **Program Support Team** that oversees and assists with state training, testing certification, continuing education, research, and evaluation.
14. There is a **Research and Evaluation Component** that continuously measures the program's effectiveness, strengths and weaknesses and makes recommendations on how to improve the overall program.
15. There are opportunities for **Peer Workforce Development** that help identify and prepare candidates for participation in the training and certification process.
16. There is a **Comprehensive Stakeholders Training Program** that communicates the role and responsibilities of Certified Peer Specialists and the concepts of recovery and whole health wellness to traditional, non-peer staff (peer specialist supervisors, administration, management and direct care staff) with whom the Certified Peer Specialists are working.
17. There are **Consumer-Run Organizations** that operate alongside government and not-for-profit mental health centers that intricately involve consumers in all aspects of service development and delivery and provide value-added support to the peer workforce.
18. There are regularly-scheduled **Multiple Training Sessions** that demonstrates the state's long-range commitment to training and hiring Certified Peer Specialists to work in the system.
19. There is a **Train-the-Trainer Program** for Certified Peer Specialists that demonstrates the State's commitment to developing its in-state faculty for the on-going training.
20. There is **Sustainable Funding** that demonstrates the State's commitment to the long term success and growth of the program.
21. There is **Multi-Level Support** across all levels of the government, with champions at all levels that demonstrates the State's commitment to the program and continually promotes the valuable role of Certified Peer Specialists in the system.
22. There is a **Peer Specialist Code of Ethics/Code of Conduct** that guides peer support service delivery.
23. There is a **Culturally Diverse Peer Workforce** that reflects and honors the cultures of the communities served.
24. There is **Competency-Based Training for Supervisors** of Certified Peer Specialists which reinforces fidelity to the principles of peer support and emphasizes the role of peer specialists in building culturally competent and trauma informed systems of care that take into account the overall health and wellbeing of persons served.
25. There is opportunity for Certified Peer Specialists to receive training in and deliver **Peer Support Whole Health Services** to promote consumer recovery and resiliency.

Summary and Conclusions

In summary, certification of peer providers has value and benefit in and of itself. It provides a mechanism for ensuring that the services delivered by peer providers meet a core standard of practice and include a particular knowledge and skill base. This benefits the peer providers, their employers and the consumers that they serve.

While the MHSA makes it clear that peer support and peer-operated services are a pathway to system transformation, California has faced many barriers in implementing this due to the individualized county system of delivering mental health services. While most counties in California have hired peer support specialists there is no common definition, training or role described for these providers.

A majority of the states in the country have developed peer certification programs. Many of these states have some mechanism to bill Medi-Caid for peer support services. Although the State Plan and the CMHDA are clear that peers may provide and bill for rehabilitation services and targeted case management, most California counties have not utilized this mechanism.

To develop a well-thought out, creative and innovative plan for certification, stakeholders must:

1.	Work closely with the California Mental Health Directors Association CMHDA, Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC)
2.	Work with CMHDA to create a recommendations that resolves the current barriers to employment created by civil service systems
3.	Utilize the lessons learned from the three Pillars of Peer Support Summits by • Following their best practice recommendations • Expanding the role of peer support services • Developing the role of peer support services in health care reform
4.	Work collaboratively to develop a single, cohesive plan that embraces consumers, youth, parent, family member peer provider roles.
5.	Encourage and embrace the certification of peer-operated agencies in order to bill Medi-Cal
6.	Recommend a structure for the ongoing work required to: • Develop a certification process • Develop competencies for peer providers • Develop or adopt a code of ethics • Finalize curriculum content that bridges the needs of consumers, youth, parent and family member peer providers • Create working relationships with key influential groups, inclusive of state agencies with authority to adopt or recommend • Develop a plan for funding this effort

There is an emerging base of research that peer-provided services improve quality of life outcomes for consumers and their families. As California moves towards implementing evidence-based practices, peer support services must be included in these efforts. In order to fully achieve the transformation of the mental health system, California must find ways to increase the employment of peer providers, legitimize their important role and create a mechanism to ensure the quality of services provided by peers. Two mechanisms for doing this are 1) to create a state-wide certification for peer providers and 2) to embrace the certification of peer-operated services.

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Appendices

Appendix 1: WWT CYFP Certification Standards Questionnaire for Counties and CBO's

Information gathered by: Deb	Phone/Email	
County/CBO contacted	Name of contact person	Phone/Email

	General Information	
1.	Do you hire consumers/family members in direct service positions? (yes/no)	
2.	Do you have specific qualifications that you require for hiring? (completion of training program, lived experience preferred, etc.)	
3.	***(counties only)*** What are the county classifications used for each position above?	
4.	How many people do you have in each consumer/family position?	
5.	Do people in those positions bill Medicaid/medical? If yes, what codes are used?	
6.	Where are these employees located?	Consumer-run services __ Outpatient Clinic __ FSP's/ACT ___ Vocational Rehabilitation _____ Residential_____Inpatient ___ Other programs/services _____
7.	What service type do they provide?	Crisis Support____ Group Peer Counseling ___ Individual Peer Counseling_ __ Other _____

8.	Are there advancement opportunities? If yes, list additional training/requirements.	
	Supervision	
9.	How much supervision is given in each category?	Individual Group
10.	Are supervisors given additional specific training for the supervision of consumers/family member employees? If yes, please list topic areas of specialization.	Topic Areas
	Training Program Information	
11.	Do you use a specific training program for CYFP staff? (Yes/No)	
12.	Title of the training program	
13.	Provider of the training program	
14.	Total number of people trained through this program	
15.	Do you provide a certificate of completion? (Yes/No)	
16.	Number of training hours required	
17.	Number of work/volunteer hours required	
18.	Testing/Proficiency exam? If yes, please list name of exam/type of exam (midterm, final, etc.)	
19.	Required subject areas for the curriculum used (list course titles or attach curriculum/syllabus)	(use complete titles, not acronyms, and terms that would be generally understandable, please)

20.	Prerequisites for entering the training program/process to apply to the training program (HS Diploma/GED, lived experience, recommendations, work experience, etc.)	
21.	Other required qualifications, if any	
22.	Is continuing education required? If yes, how many hours?	
	Other information	
23.	Any additional information you think we should know about?	

Appendix 2: Letter from Center for Medicaid and State Operations

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #07-011

August 15, 2007

Dear State Medicaid Director:
The purpose of this letter is to provide guidance to States interested in peer support services under the Medicaid program. The Centers for Medicare & Medicaid Services (CMS) recognizes that the mental health field has seen a big shift in the paradigm of care over the last few years. Now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses when persons have access in their communities to treatment and supports that are tailored to their needs. Recovery refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

Background on Policy Issue
States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services. The following policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers.
As States develop behavioral health models of care under the Medicaid program, they have the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system. When electing to provide peer support services for Medicaid beneficiaries, State Medicaid agencies may choose to collaborate with State Mental Health Departments. We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service.

States may choose to deliver peer support services through several Medicaid funding authorities in the Social Security Act. The following current authorities have been used by States to date:

- Section 1905(a)(13)
- 1915(b) Waiver Authority
- 1915(c) Waiver Authority

Delivery of Peer Support Services

Consistent with all services billed under the Medicaid program, States utilizing peer support services must comply with all Federal Medicaid regulations and policy. In order to be considered for Federal reimbursement, States must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. States must describe utilization review and reimbursement methodologies. Medicaid reimburses for peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders. Additionally, reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States must provide an assurance that there are mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods.

Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services. The following are the minimum requirements that should be addressed for supervision, care coordination and training when electing to provide peer support services.

1) Supervision

Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.

2) Care-Coordination

As with many Medicaid funded services, peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

3) Training and Credentialing

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

Please feel free to contact Gale Arden, Director, Disabled and Elderly Health Programs Group, at 410-786-6810, if you have any questions.

Sincerely,
/s/
Dennis G. Smith, Director

cc:
CMS Regional Administrators
CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Debra Miller
Director for Health Policy
Council of State Governments

Appendix 3: General Overview of Medi-Caid and Medi-Cal

Redacted from
A Report to the Governing Board of Working Well Together
Clarification of Medi-Cal Billing Rules and Regulations in California
Inspired at Work 2012

General Overview of Medi-Caid

Medi-Caid is a federally funded insurance program for qualifying recipients. Federally, the program is administered by the U.S. Department of Health and Human Services, under the direction of the Center for Medicare and Medi-Caid Services (CMS). Each state has a state level Center for Medicare and Medi-Caid Services. The Federal CMS authorizes and delegates authority to the state CMS to implement the Medi-Caid program.

Each state must write a State Plan to show how they will follow the regulations and intent of Medi-Caid for the provision of the whole array of services provided to Medi-Caid recipients. Included in the State Plan are services designed for people who meet the criteria of having a serious mental illness and are eligible to receive "Specialty Mental Health Services". Generally, the State Plan is a negotiation between the state Department of Mental Health and the state CMS. In the State Plan, the state is allowed to interpret the Federal guidelines in a manner consistent with the principles, but with the flexibility required for each state to best implement the plan. The plan gets updated as needed through a process called a State Plan Amendment or by requesting a waiver. Waivers create exceptions or new agreements as necessary. For example, billing for "Targeted Case Management" is done through a state plan waiver.

States are given the flexibility through their State Plan to determine how they will provide Specialty Mental Health Services. Many states have elected to provide services under the federally defined category called the "Rehabilitation Option". Under the Rehabilitation Option, states can bill for defined Rehabilitative Mental Health Services such as rehabilitation, therapy, medication services, and other types of services related to specialty mental health treatment.

California, Medi-Cal and Specialty Mental Health Services

In California, our Medi-Caid program is called Medi-Cal and there are several unique issues that stakeholders need to be aware of:

1. California utilizes a county system to implement authorized services under specialty mental health services as well as all other Medi-Cal services.
2. The California State Plan is negotiated between the CMS and the Department of Health Care Services with input from the former Department of Mental Health and the California Mental Health Directors Association.
3. Once a State Plan and Amendments and Waivers are determined, each county contracts with the former Department of Mental Health and now the Department of Health Care Services to implement the Rehabilitation Option services and billing.
4. A very important provision of the California State Plan is that it delegates authority and responsibility to the County Mental Health Director for compliance with all regulations. The County Mental Health Director is responsible and liable for the billing of every service provided by County Mental Health Staff.

5. In recent years County Mental Health Departments that contract with community based agencies have assigned the responsibility for appropriate and legal billing to the Executive Directors of the agencies providing services. Therefore the Executive Director or CEO is responsible and liable for the billing of every service provided by its employees.

Flexibility

Flexibility in interpretation and practice is intentional as not every circumstance could be covered adequately in a federally authorized program. This, however, can lead to some confusion and uncertainty as to the exact rules and regulations. This uncertainty prompts administrators to do their best to mitigate unnecessary risks of audit exceptions which are often mistakes/errors in billing. Audit exceptions require that the county or community based agency pay back monies received for inappropriately documented services. Administrators have a responsibility to mitigate this risk and since each Mental Health Director has been delegated this authority it, in large part, accounts for differing rules among the counties regarding billing policies and procedures.

Appendix 4: Rehabilitative Mental Health Services Definition

"Rehabilitative Mental Health Services are services recommended by a physician or other licensed mental health professional within the scope of his or her practice under State law, for the maximum reduction of mental or emotional disability, and restoration, improvement, and/or preservation of a beneficiary's functional level. Rehabilitative Mental Health Services allow beneficiaries to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention. Rehabilitative Mental Health Services include services to enable a child to achieve age-appropriate growth and development. It is not necessary that a child actually achieved the developmental level in the past. Rehabilitative Mental Health Services are provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency. Services are provided based on medical necessity criteria, in accordance with an individualized Client Plan, and approved and authorized according to State of California requirements."

State Plan Amendment 2011

Appendix 5: Individual Content Titles across Eight Curricula

1. History of the Consumer/Family/Survivor Movement
2. Introduction to systems of care
3. Medical Model/DSM Medications
4. Advocacy
5. Patient's Rights
6. Advance Directives
7. Self-Care
8. Engagement
9. Case Management
10. Targeted Case Management
11. Awareness of community resources
12. Assessment
13. Documentation and treatment planning
14. Working with Families/Parents
15. Importance of Peer Support
16. Self-awareness and using your recovery journey as a role model
17. Strengths-based practice
18. Self-Disclosure
19. Transitioning from service recipient to peer provider
20. Role and Competencies of the Peer Provider
21. Boundaries
22. Code of EthicsConfidentiality
23. Telling Your Recovery Story/Family Story
24. Defining Recovery and Recovery Values
25. Language
26. Recovery and other models of care
27. Learning and Test-Taking Skills
28. Co-Occurring Disorders and Chemical Dependency
29. Being with people in challenging situations
30. How to work in program environments
31. Listening Skills and Facilitative Questions
32. Learning Style and Study Plan
33. Trauma informed careCultural awareness
34. Using your recovery story well
35. Test Prep Class
36. Tools for helping people who are stuck
37. Combatting negative self-talk
38. Study plan for exam
39. Psych Rehab
40. WRAP® and other Self-help tools
41. Practice oral exam
42. Managing conflict at work
43. Peer Specialists as change agents
44. Group Facilitation

45. Facilitating recovery dialogue groups
46. Maintaining peerness
47. Purpose of Family Peer Support
48. Wrap-around
49. Life Domain Planning
50. Mandated Reporting
51. Safety and crisis planning
52. Working with your supervisor
53. Leadership skills
54. Working as part of the team
55. Best Practices
56. The Family Experience
57. Psychoeducation
58. Decision-making and living arrangements
59. Health Education
60. Internship/Job Prep
61. Stigma and Discrimination
62. Holistic Health and Alternative Strategies
63. Spirituality

Appendix 6: Curriculum Crosswalk Categories

History	Self-Awareness	Law, Ethics and Boundaries	Practices	Practices, continued	Treatment Planning and Documentation	Working with Special Populations	Recovery Values and Philosophy	Family-Directed and Child-Centered Care	Diagnosis and Treatment	Role of Peer Providers	Interpersonal Skills	Culture	Group Facilitation	Stigma and Discrimination	Study Skills and Test Taking	Safety and Crisis Planning	Understanding systems of care
Consumer/Family movement	Self-Care	Confidentiality	Engagement	Self-help tools	Life Domain Planning	Co-occurring disorders	Importance of peer support	Wrap-around	Medication	Maintaining peerness	Listening			Language	study plan for exam		
Models of care: Medical Model, PSR, Recovery and Family-Directed/Child-Centered	Combatting negative self-talk	Mandated reporting	Case Management	Best Practices		Transition age youth	Recovery and other models of care	Working with families in the adult system		Transitioning from service recipient or family member to service provider	Communication			Within the mental health system	practice oral exam		
An overview of self-help organizations and their characteristics	Telling your recovery story		Strengths-based practice	Psychoeducation		Seniors		Purpose of Family Peer Support		Peers as change agents	Conflict resolution				test prep		
Understanding peer recovery programs			Support	Holistic Health and Alternative Strategies		Medically Fragile		Decision making and living arrangements for adult children		Working with the team	Being with people in challenging situations				learning styles and study plan		
			Advocacy/Leadership	Suicide Prevention						Collaboration	Working with your supervisor				Learning and Test Taking Skills		
			Advance Directives	Resources													
			WRAP	Public assistance and benefits													
			Spirituality	Trauma informed care													
				Motivational Interviewing													

Appendix 7: Counties Responding to CYFP Survey

1.	Alameda	17.	Plumas
2.	Alpine	18.	Riverside
3.	Butte	19.	Sacramento
4.	Calaveras	20.	San Bernardino
5.	Contra Costa	21.	San Diego
6.	El Dorado	22.	San Francisco
7.	Glenn	23.	San Mateo
8.	Imperial	24.	Santa Clara
9.	Lassen	25.	Santa Cruz
10.	Los Angeles	26.	Sierra
11.	Madera	27.	Solano
12.	Marin	28.	Stanislaus
13.	Merced	29.	Sutter-Yuba
14.	Mono	30	Trinity
15.	Napa	31.	Tri-Cities
16.	Placer	32.	Yolo