States' Alignment with SAMHSA Model Standards for Peer Support Certification

Current Progress & Future Directions

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Executive Summary

Over the past 30 years and more, individuals with lived experience of recovery from mental health and substance use disorders (SUDs) have played a growing role in supporting the delivery of a continuum of behavioral health and social services. The work of peer recovery support staff was enhanced in 2023, when the Substance Abuse and Mental Health Services Administration (SAMHSA) brought together "federal, state, tribal, territorial, and local partners — including peer specialists — to develop the *National Model Standards for Peer Support Certification*."[1] These standards are intended to give guidance to "accelerate universal adoption, recognition, and integration of the peer workforce, and strengthen the foundation set by the peer workforce, reinforced by the Core Competencies."[2]

On behalf of the University of Missouri – Kansas City Peer Recovery Center of Excellence (UMKC PR CoE), a team from the Technical Assistance Collaborative, Inc. (TAC) prepared the present report on state alignment with the SAMHSA National Standards. The authors of this report reviewed existing data and conducted semi-structured interviews with states and their certifying body counterparts to identify alignment with the Model Standards, potential barriers to certification, and opportunities for reciprocity. This report also includes data gathered from regional, SAMHSA-led state discussions on certification.

There is significant investment in, and commitment to, a strong peer workforce across all states. Many states are actively engaged in examining requirements and engaging in new partnerships to support certification. In all our discussions with states and certification bodies, we heard a strong emphasis on engaging the voice of lived experience throughout the certification process, as is emphasized in the National Model Standards. However, there is also wide diversity in states' alignment with the Model Standards, and in how states organize and interact with certifying bodies. Particularly significant is variation in training content, delivery, and oversight, with many states reporting more confidence in their own standards than in those of other states, hampering considerations of reciprocity. Finally, there is an overall need for data-based evidence that supports specific standards and avoids instances where 'exceptional' standards, assumed to be 'higher,' become instead, barriers to certification.

This report offers several considerations for achieving alignment and reciprocity in peer certification:

- Conducting multistate comparative analyses of state standards
- Completing of a crosswalk for alignment with National Model Standards
- Facilitating regional convenings
- Exploring existing models for reciprocity in related fields

[1] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

[2] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

SAMHSA's guidance, in the form of the National Model Standards for Peer Support Certification, has been a great resource to engage states' authorities, certification boards, and recovery support staff in meaningful conversations. Implementation and ongoing development of the National Model Standards can be facilitated by periodic review, assessment, and modification; the development of empirical data; and greater alignment of peer recovery support skills and roles, curriculum content, training approaches, and testing content and mechanisms. An entity like the PR CoE will clearly have a role to play in supporting regional and national state meetings to promote practices that reinforce quality, facilitate reciprocity, and reduce dysfunctional variation and duplication in certification standards and processes. And most specifically, states need leaders to promote peer certification training standards that foster unity in approach, allow reciprocity, and assure safety and effectiveness for those served by peer recovery workers.

Introduction

For over 30 years, individuals with lived experience of recovery from mental health and SUDs have helped create a strong continuum of behavioral health and social services by increasing the capacity of several delivery systems, including crisis services, health care, criminal justice, and child welfare. Peer support services are nonclinical enhancements based on shared understanding, mutual respect, compassion, and empowerment. The primary responsibilities of a peer support worker are 1) to help individuals living with mental health conditions and SUDs to identify and achieve their own needs and goals and make their own decisions in all matters related to professional services, and 2) to advocate for the full inclusion of these individuals in the communities of their choice.

A strong peer workforce is the cornerstone of a recovery-oriented system of care, which represents a change from the traditional, deficit-based medical model to a strengths- and community-based approach to behavioral health. From the recognition that peer support services can strengthen various systems has emerged a commensurate determination to clarify and develop standards of experience, training, and skills for providers of these services.

SAMHSA's Model Standards

In 2023, SAMHSA brought together "federal, state, tribal, territorial, and local partners — including peer specialists — to develop the *National Model Standards for Peer Support Certification*, inclusive of substance use, mental health, and family peer certifications."[3] The standards were intended to give states, territories, and other jurisdictions guidance to "accelerate universal adoption, recognition, and integration of the peer workforce, and strengthen the foundation set by the peer workforce, reinforced by the Core Competencies."[4]

SAMHSA's Office of Recovery was charged with the development of the National Model Standards. This office convened a technical expert panel (TEP) to create standards based on the needs of the peer workforce as well as the needs of the people served by the peer workforce. The steps to defining and developing each standard were clear:[5]

1. **Identify a Domain** that is critical to the peer workforce and common across mental health, substance use, and family peer support certifications.
2. **Develop a Model Standard**, i.e., a set of criteria for each domain based on existing certification requirements and identified as being widely accepted, effective, and adaptable across state peer support certifications.

[3] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

[4] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

[5] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

The Office of Recovery, along with the TEP, defined how adoption of the National Model Standards for Peer Support Certification, or alignment of existing certification programs with the National Model Standards, can benefit states:[6]

- **Increase reciprocity** and partnership between state certification entities.
- **Promote quality** of peer services being delivered across the country.
- **Protect the authenticity** of peers through promotion of and emphasis on lived and living experience.
- **Support state certification entities** in the development and/or revision of certification requirements that align with the needs of the peer workforce and the people they serve.
- **Cultivate the peer workforce** by elevating the profession and bringing national attention to the critical services they provide.
- **Reinforce the scope** of the peer role through distinct certification criteria.
- **Strengthen diversity, equity, inclusion and accessibility** efforts in the peer workforce.
- **Expand career pathways** for certified peer workers and peer supervisors.

The Technical Assistance Collaborative was subcontracted through the UMKC PR CoE to produce a report that examines and assesses degrees of state alignment with SAMHSA's National Model Standards for Peer Support Certification, specifically for certifications for SUDs or integrated models inclusive of peers with SUDs and mental health conditions. In efforts to assess states' alignment with the National Model Standards, the project team gathered data through a variety of methods. First, the team compared key elements of the Model Standards against the raw dataset from the Peer Recovery Center of Excellence's *Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States*. Through this process, the team confirmed that alignment could not be determined through the data alone, and therefore gathered additional information through key informant interviews, attendance at regional meetings, and a review of information about certification processes and curricula available on state websites. For full methodology please see Appendix B. This report provides observations on the current state of alignment, including both successes and challenges, and offers recommendations for advancement at the federal and state levels.

The Diverse and Changing Landscape of Peer Support Standards

The past 30 years have seen an evolution of the peer workforce across the country. What began with individuals living with mental illness and SUDs gathering to support each other soon grew into a principled movement that viewed lived recovery experience as valuable and integral to like-minded people living meaningful lives in communities. Peer recovery support services grew more formalized, and nuances emerged between different states and jurisdictions.

The rollout of SAMHSA's National Model Standards for Peer Support Certification has been met with differing degrees of interest, mainly based on a state's familiarity with the Core Competencies, SAMHSA's Working Definition of Recovery, and other resources developed to

[6] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

assist with understanding and defining peer recovery support. Many states have strong relationships with peer recovery communities that help inform the development of peer recovery support services and ensure that authenticity of voice is represented in such services and supports. Other states have utilized curricula developed by licensure or certification bodies that mainly work with clinical services. The National Model Standards offer an opportunity to measure curricula and certification requirements for states and jurisdictions that have started from different places. These standards offer states foundational requirements intended to protect service recipients. They offer a chance for reciprocity across state lines, and they offer guidance and support for the progression of peer recovery support providers as a valuable part of the behavioral health workforce.

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Findings

Overview

The project team found significant variation among states in certification bodies, processes, position titles, standards, and resources. States have developed credentialing systems and requirements at different rates since 2001 when Georgia's mental health peer certification began, likely prompted by the fact that the state had received Centers for Medicare and Medicaid Services (CMS) approval to reimburse peer support in 1999. In 2018, a survey article focused on mental health peers reported that 15 states had initiated certification between 2001 and 2007 and that 25 more states had begun certifying between 2008 and 2015.[7] By 2023, 48 states and the District of Columbia had certification programs covering peer recovery support for SUDs. States and certification bodies continue to change their programs, adding or combining credentials, increasing or reducing required experience and education hours, and creating new opportunities for peers in an effort to improve the quality of the peer workforce.

Context

Certification Bodies

Varying types of organizations serve as certification bodies for substance use peer recovery specialists. Two jurisdictions (HI, SD) have no systems to certify peer support workers, while the remaining 49 jurisdictions have 51 certification bodies among them. Indiana and New Jersey each have *two* recognized credentialing bodies for Medicaid-reimbursable peer services. In Indiana, both the state behavioral health division and an IC&RC member board are recognized; in New Jersey, there is both an International Certification and Reciprocity Consortium (IC&RC) board and a NAADAC affiliate. Of the 51 active bodies, 21 (42%) are state agencies or divisions of larger agencies, of which 19 are SSAs or state behavioral health divisions. Within state health and human service agencies, the mental health or behavioral health division typically serves as the certifying body, often through offices of peer programs (consumer and family affairs, office of equity and inclusion, office of peer recovery and engagement) or divisions of licensure and certification. The two state agencies that are not part of a behavioral health agency are New Hampshire's Office of Professional Licensure and Montana's Board of Behavioral Health, located within the state's Department of Labor and Industry. In 24 states (48%), certification is determined by state certification boards; in 22, this role is played by IC&RC member boards, while the other two are Maine's independent Recovery Coach Certification Board and the Alaska Commission for Behavioral Health Certification. Four certification bodies (8%) are third-party organizations (the California Mental Health Services Authority, the Colorado Providers Association, the Georgia Council for Recovery, and North Carolina's Certified Peer Support Specialist program within the University of North Carolina School of Social Work). One state, Arizona (2%), has no statewide organization but instead designates 40 individual provider organizations that certify.

[7] Wolf, J. (2018). National trends in peer specialist certification. *Psychiatric Services, 69*(10), 1234–1236.

Almost all jurisdictions credential through a statewide organization, but three states (AZ, CT, KY) delegate certification to some or all of their designated training organizations. In Kentucky, the training organization documents completion of training, and the state considers this to be the equivalent of certification. Arizona has approved 40 Peer Support Employment Training Programs (PSETP), which train and credential peers.

Credentials and Requirements

Certification bodies credential one to five types of substance use peer support workers. There is no naming convention for substance use peer support workers; titles include peer mentor, peer recovery specialist, peer counselor, addiction recovery coach, and peer support professionals. It should be noted that within the peer community there is considerable disagreement about the use of the peer counselor designation since it references a clinical function.

Of the 51 certification bodies, 35 (70%) credential through integrated standards across mental health and substance use, while 15 (30%) utilize separate standards for the two. However, some jurisdictions with integrated credentials may have different requirements for mental health and substance use. In states with separate credentials for substance use and mental health but no reciprocity between them, many peers acquire both credentials.

The Certification Process

In several states (IN, KS, MA, TX), peer recovery specialists can practice as such — and their employer can bill Medicaid — before the worker is fully certified. In Massachusetts, a peer recovery coach providing services under the MassHealth (Medicaid) benefit must have obtained (or must demonstrate that they are working to obtain) a credential, and must attain certification within two years. Kansas certifies a peer mentor in training (KPMT) who can provide up to 20 hours of direct client contact per week with one hour of supervision for each 20 hours of direct service. They have up to one year (minimum 90 days of supervision) before they qualify to take the level II training. Upon supervisor recommendation, training completion, and passing of a related test, they apply for full certification as a Kansas Certified Peer Mentor who can provide up to 30 hours of direct services per week, with one hour of supervision for each 30 hours of direct service. In Texas, after a two-day core training, peer workers begin an internship, take a five-day certification training, and can bill after that though they are not fully certified until supervised work experience has been completed and they have passed an exam.

Some states (AZ, WA, VA) impose additional requirements on the credentialed peer; in Arizona, the peer worker must also qualify as a Behavioral Health Professional or Behavioral Health Technician, while Washington requires certified peer counselors who are employed by licensed behavioral health providers to be credentialed by the Department of Health as “agency affiliated counselors.” Virginia requires certified peer specialists working for authorized Medicaid employers to register with the Department of Health Professions, Board of Counseling. Registration requires a background check and submission of the National Practitioner Data Bank self-report, which asks for information about medical malpractice payments and adverse actions related to practitioners.

In almost all states, certification is voluntary unless the state’s Medicaid plan covers peer support services or peer support workers as allowable providers of other Medicaid benefits. In this case, almost all states require certification, although providers can choose whether or not to enroll in Medicaid. In some states (IA, ME, VT) no certification is required for individuals employed as peer support specialists. Only a few states (MO, NJ) require that all peer recovery

support specialists employed by agencies contracted with the state behavioral health agency have the peer support credential. Connecticut and Iowa will soon set the same requirement.

Registration, Certification, and Licensure

While voluntary certification is the norm, a few states (MT, NV, VA) use a licensure approach for peer credentials that establishes “title protection” for these practitioners. In these states, all peers must be certified — and in Virginia's case, must be registered with the Board of Counseling. Nevada moved from a voluntary to a mandated process several years ago when legislation required peer recovery support specialists to be certified and peer support recovery organizations to be licensed. The Nevada Division of Public and Behavioral Health certifies by endorsement applicants who are licensed, certified, or hold a credential issued by another jurisdiction. In 2023, Montana enacted legislation that a person could not practice peer support unless licensed by the Board of Behavioral Health, which is located in the Department of Labor and Industry. Licensure legislation has been introduced in several other states, with Massachusetts’ legislature currently considering it; the bill would mandate licensure and establish penalties for an unlicensed person who implies they are an authorized recovery coach.

Similarly, almost all jurisdictions consider certification to be the only peer credential; in two states (ME, VT), both ‘registration’ and ‘certification’ are types of credentials. In each case, individuals can practice as recovery coaches after receiving training through a recovery coach curriculum; trained recovery coaches can choose to attain the Certified Recovery Coach credential, which is offered by a statewide certification board.

Certification Components

In most states, the certification process begins with an application, but some states require other pre-screening activities, such as: certificate of completion for a significant number of online courses (OH); a course that provides an overview of the certification process (CT); completion of a self-assessment or mental health knowledge assessment (MO, TX); or a training program application that asks questions about motivation, ability to satisfy program requirements, intention to practice peer support, and comfort with types of activities involved in training (AZ). These required activities are intended to provide an orientation to the certification process for applicants.

Regardless of the type of certification body credentialing peers, there are four key components of the process:

- The articulation of core competencies and development of a job analysis;
- Creation of a training curriculum based on the job analysis that educates applicants on the skills, knowledge, and abilities required for the position;
- Preparation of training sessions/modules based on the training curriculum; and
- Development of an exam that “only reflects information explicitly covered in trainings.”[8]

[8] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

Curricula and Training

From publicly available information, it seems that very few jurisdictions have a formalized process for curriculum development or assurance that the curriculum is based on the core competencies, the training is driven by the curriculum, and the exam is based on the training. There are some promising developments, however. The Missouri Credentialing Board has a single, standardized curriculum and Kentucky is developing a plan for a revised certification process that will include a single curriculum. The Rhode Island Certification Board has developed a new single training curriculum in collaboration with the state; with this development it is considering moving to a single training organization if it cannot assure quality across many organizations. The New York Certification Board lays out a ten-point "Certification Development Process," posted on its website, that details the relationship among a role delineation study, an inventory of knowledge/skills/abilities, development of certification standards, approved training, and the issuance of certificates.

Certification bodies use three methods to identify training organizations and trainers for certification applicants: "suggested," "designated," or "approved/certified." The number of training organizations or trainers can range from several to hundreds across the states. Typically, the training organizations offer 'training sessions', not specific modules that have been developed from the certification bodies' core competencies. Certification bodies may approve and contract with training organizations, contract directly with trainers, or just provide a list of organizations or trainers for applicants to use to select training opportunities. In some jurisdictions (CT, ME, MA, NJ, RI, VT), the state SSA or behavioral health agency contracts with one or more training organizations, while the certification is offered by an independent body. In these circumstances it is not always clear what the relationship is between a uniform set of core competencies and the training curriculum. In many cases, the training organization's curriculum is not submitted to the certification body for approval.

Many states said their certification bodies or training organizations could not currently meet the demand for training. Most states have waiting lists of applicants, so training is scheduled months out and often prioritizes peers who are already employed. Such backlogs occur for various reasons: insufficient overall training capacity, a high number of hours required for certification, or trainings offered only during regular business hours. The latter oversight is particularly problematic in states that require a substantially greater number of hours than the Model Standards and those in those where 500 or more hours of work experience is required. Several states also noted that a significant number of peers who are trained do not apply for certification. This is an important issue, since training is always the most expensive component of the certification process.

There are a few examples available on certification bodies' websites of specific approval processes for training organizations. The Arizona Health Care Cost Containment System (AHCCCS) and the Virginia and Texas certification boards have specific application processes and criteria for approving organizations that include some or all of the following: submission of program material for review; details of specific trainings; experience in training or sponsoring training that uses adult learning principles; use of state pre-approved training curricula; and description of reasonable accommodations and alternative formats for accessibility to all audiences. AHCCCS bases approval of the PSETP on the program's compliance with peer and recovery support services core competencies.

A few statewide certification bodies contract for training delivered by people with lived experience (Missouri Credentialing Board), provided by peer recovery organizations

(Washington Health Care Authority), or overseen by peer supervisors (Kansas' certification education partner, Wichita State University). All the states we interviewed reported that peers were involved in standards and curriculum development, although there is little indication of this on states' or certification bodies' websites. In early 2024, North Carolina recruited peer applicants for a standardized peer support curriculum committee. Georgia and New Jersey both provide strong examples of peer engagement not only in curriculum development, but also in certification standards. Georgia engaged a 25-person advisory committee composed of people with lived experience in the development of its standards. The committee remains active today and is involved in reviewing the training as well as other components of certification standards. People with lived experience make up 75% of New Jersey's Peer Professional Advisory Committee, which advises the state on certification standards. The committee was successful in advocating for a waiver process that would allow individuals without a high school diploma or GED to apply for certification in alignment with the National Model Standards.

Reciprocity

Our review of certification practices identified only two states that offer reciprocity for certified peers. In Arizona, AHCCCS recognizes credentials issued in states and by training programs in compliance with CMS requirements, as specified in the State Medicaid Directors Letter #07-011 issued in 2007. Individuals credentialed in another state submit their credential to Arizona's Office of Individual and Family Affairs, which adds the individual to the master registry; an email confirmation of registration serves as verification.[9] California offers reciprocity and requires that applicants submit evidence to satisfy the requirements for initial certification (e.g., high school diploma or equivalent degree, self-attestation of experience with recovery, etc.) and additionally one year of paid or unpaid employment of 1,550 hours in three years of employment in a peer worker role. While California does not require employment experience for initial certification, it does require 80 hours of training.[10]

Most states are supportive of reciprocity. Only two of the states we interviewed said they were not supportive of reciprocity because their standards exceeded the Model Standards. Three states we interviewed (KS, KY, WA) are currently considering offering reciprocity. Kentucky said it would need to evaluate other states' training curricula to determine whether reciprocity would be possible. The Washington State Department of Health is currently making rules to specify which trainings and experience will support reciprocity and what that process will look like. Missouri indicated a willingness to consider offering reciprocity as the Model Standards are adopted and national consistency in training continues to develop; notably, the Missouri Credentialing Board and the state's Department of Mental Health recently completed updates to both the Certified Peer Specialist and Family Support Provider trainings, incorporating many of SAMHSA's National Model Standards for Peer Support Certification.

Given that 22 of the state certification boards are IC&RC members, there is opportunity for reciprocity in these states so long as each board offers a "reciprocal credential" that meets the International Consortium's minimum requirements. These requirements include 500 hours of work experience and 46 hours of training. Because of these stipulations, not all IC&RC member boards offer reciprocal credentials for every certification they issue.

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[9] Arizona Health Care Cost Containment System (n.d.). AHCCCS Medical Policy Manual (AMPM). See Chapter 963, "Peer and Recovery Support Service Provision Requirements." Accessed August 16, 2024.

[10] See https://www.capeercertification.org/.

According to the IC&RC national website, individuals holding a credential through an IC&RC member board may be eligible for reciprocity with other IC&RC member boards. Boards may offer reciprocity to certified or licensed professionals in other jurisdictions, and have the authority to set reciprocity requirements for entry to their jurisdiction. Not all certifications and licenses are eligible for reciprocity. It is important that certified professionals investigate reciprocity prior to relocating to another jurisdiction, because this can be a complicated process. IC&RC can only facilitate reciprocity from one member board to another.[11]

When the Model Standards were issued in June 2023, IC&RC announced its adoption of the proposed standards in the form of a new credential, explaining that this national entry-level peer credential would be "the first rung of a career ladder that will lead to strong SUD workforce development."[12] IC&RC's website currently notes that a peer recovery associate exam is forthcoming, though based on our conversation with leadership, the decision of whether or not an exam is incorporated into the requirements will be left up to the states.

State IC&RC member boards' websites contain similar descriptions of the reciprocity process. As an example, Connecticut's specifies that an individual requesting reciprocity must contact the board where they are currently certified to request an application. (Note: the IC&RC does not allow member boards to post the reciprocity application online.) The individual sends the application to their current board who verifies it and sends it to the IC&RC Home Office where it will be reviewed by staff; if the individual is eligible, the application will be sent to the new board. The individual will be contacted by the new board when the process is completed. In some instances, the new board may require additional steps to become certified, so it is important to determine that in advance. The originating board does not have information about what other boards may require once the individual attempts to reciprocate to their state. The individual is asked to contact the new board directly to inquire about additional requirements.[13]

Reviews of many state IC&RC board websites found almost no listings for the credentials that were reciprocal, and no details on the reciprocity process itself. Several boards we interviewed said that it was important to require potential applicants to contact the board directly rather than having details on the website, so that boards would not receive misdirected applications from individuals seeking other types of certifications, e.g., barbers. Most boards we interviewed were either not able to provide data on the frequency with which they granted reciprocity or reported very small (sometimes single-digit) numbers.

Most states we interviewed with IC&RC boards reported limited collaboration with their respective certification boards. However, exceptions include Missouri, New Jersey, Rhode Island, and Texas, where active engagement in standards and training development was noted. For instance, Missouri described its relationship with the Missouri Credentialing Board as 'independent but collaborative'. Other states knew little about the IC&RC system, and in some cases expressed concern with the boards' administrative capabilities, transparency in sharing information, and speed in processing applications.

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[11] See https://internationalcredentialing.org/.

[12] International Certification & Reciprocity Consortium (2023, June 25). IC&RC adopts SAMHSA Model Standards for peers (press release).

[13] Connecticut Certification Board (n.d.). Reciprocity. Accessed August 16, 2024.

Our interviews did identify several IC&RC member boards' activities that may facilitate future reciprocity. The Pennsylvania Certification Board has management contracts to staff the Delaware, Rhode Island, and Virginia boards. The standards across these states are very similar. In Delaware, Rhode Island and Virginia the exams are identical, and each state only credentials one peer specialist title. These three boards offer reciprocity, however those seeking reciprocity to Virginia will have to apply directly with that Board. Pennsylvania has two separate credentials (mental health and substance use) that are not reciprocal, so many peers have two certifications. ICAADA, the Indiana IC&RC member board, is familiar with the IC&RC's work on the peer recovery associate credential and is working with five surrounding boards to promote its adoption. ICAADA's executive director also reported that some states have entered into discussions with their IC&RC boards about creating a similar entry-level credential.

Looking beyond peer support certification, there are practices that could increase the portability of the credential. The two predominant methods for accomplishing this portability are state-to-state reciprocity for licensure or certification, and interstate compacts for licensed practitioners. Because the 10th Amendment of the U.S. Constitution gives states the authority to protect public health and safety, it is not possible for the United States to offer a national license. Since the responsibility for licensing and regulating health care professionals lies with the states, states must develop systems for reciprocity.

Social work reciprocity is an example of a state-to-state process offered in most states. Applicants who have already passed the national Association of Social Work Boards (ASWB) clinical licensing examination and hold a current clinical social work license in one jurisdiction may be eligible to apply for a new jurisdiction's counseling license via a reciprocity process. Reciprocity applicants must submit a copy of the laws and regulations from each state where they currently hold a license; this allows the reviewing body to determine if the license standards under which the applicant's current licensure was granted are substantially similar to those in the new jurisdiction.

If the other state's licensing standards are substantially similar, then the applicant may obtain their new jurisdiction's license via reciprocity. If the jurisdiction's license standards are not substantially similar, the applicant must either: 1) have practiced for a certain number of years to still be eligible for reciprocity (and may be able to substitute this work experience for deficits in licensure requirements); or 2) apply via the traditional licensing process, providing documentation of individually meeting *all* of the new jurisdiction's licensure requirements.[14]

The Council on State Governments' (CSG) National Center for Interstate Compacts (NCIC) is the nation's only technical assistance provider on interstate compacts, offering education, development, and administrative services. An interstate compact is an agreement or contract between member states. Many compacts create interstate commissions made up of member state representatives to implement the contract. This commission is a government agency made up of member state representatives acting jointly as a union. A license is granted in an individual's home state and a compact "privilege to practice" is granted by other compact member states.

In 2019, the American Counseling Association (ACA) contracted with CSG to assist with the creation of the "Counseling Compact"; the ACA funds this effort. Currently, 37 states have

[14] Zencare (2022, April 8). How to get licensed as a social worker in every US state.

joined the compact.[15] The Counseling Compact enables professionals who meet uniform licensure requirements to obtain a privilege to practice, which is equivalent to a license to practice counseling in another state. This particular compact ensures reciprocity so that licensed counselors can provide telehealth services in any state that is part of the counseling compact without having multiple licenses.

In 2021, the U.S. Department of Defense awarded a grant to CSG for the development of an interstate compact for social work practice. CSG oversaw the development of the compact while the ASWB served as lead on the effort, with the National Association of Social Workers (NASW) and the Clinical Social Work Association (CSWA) as partners. In 2023 the group completed work to develop a licensing compact for social work practice mobility. Model legislation was finalized in March of that year and by April 2024, seven states had enacted it — which meant the compact was "active." Currently 22 states have passed legislation to join the compact.[16] The first meeting of the Commission will occur this fall, and CSG estimates that social workers will be able to apply for multistate privileges in the fall of 2025.[17] The compact specifies that licensees who want to use the compact must pass a national qualifying examination; currently the only national social work exam available to states is the ASWB exam, which 50 states and the District of Columbia already require for social work licensure.

The Health Resources and Services Administration (HRSA) recently announced its Licensure Portability Grant Program investment in the multistate social work licensure compact.[18] This program also supports ongoing efforts by the Interstate Medical Licensing Project and the Psychology Interjurisdictional Compact (PSYPACT). The current awards will support ASWB, the Association of State and Provincial Psychology Boards, the Federation of State Medical Boards of the United States, and the Federation of Podiatric Medical Boards.

Alignment: Overview

This section offers perspective on the extent to which states' certification requirements align with each of the 11 SAMHSA Model Standards. This analysis was completed as described in Appendix B. Both convergence and variation will be highlighted to provide a basis for states to both remove barriers and revise standards to more closely align with the Model Standards.

While most states saw themselves as aligned with SAMHSA National Model Standards for Peer Support Certification, information provided via interview, the University of Texas at Austin's Common Data Set, and state and certification agency websites indicates significant variation.

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[15] AL, AZ, AR, CO, CT, DE, FL, GA, IN, IA, KS, KY, LA, ME, MN, MD, MS, MO, MT, NE, NH, NJ, NC, ND, OH, OK, RI, SC, SD, TN, UT, VT, VA, WA, WV, WI, & WY.

[16] AL, AZ, CO, CT, GA, IA, KS, KY, LA, ME, MO, MN, NE, NH, OH, RI, SD, TN, UT, VT, VA, WA. Information accessed at the National Center for Interstate Compacts: Social Work Compact on August 16, 2024.

[17] Social Work Licensure Compact (n.d.). Compact commission. Accessed August 16, 2024. The Council of State Governments.

[18] Health Resources & Services Administration (2024, July 16). Biden-Harris administration launching initiative to build multi-state social worker licensure compact to increase access to mental health and substance use disorder treatment and address workforce shortages (press release).

Examples: States' Perceptions of Alignment

"In Georgia, the Department of Behavioral Health and Developmental Disabilities (DBHDD) is the certifying body. We partner with three advocacy organizations: the Georgia Council for Recovery, the Georgia Mental Health Consumer Network, and the Georgia Parent Support Network to train, test and certify all four peer specialist guilds (CPS-MH, CPS-AD, CPS-P, and CPS-Y). We created a *Consistency Analysis of Georgia's Certified Peer Specialists Curricula Peer Specialist* matrix in 2018 as a quality improvement tool to assure all of the DBHDD-supported curricula have the same fundamental elements and core competencies undergirding the standard definition of a Certified Peer Specialist, promoting consistent understanding and expectation of the workforce guild. DBHDD has been convening the Peer Specialist training vendors and reviewing a tool created through SAMHSA Transformation Transfer Initiative funds via the National Association of State Mental Health Program Directors. The team engaged in collective norming, breakout self-assessment, and then sharing to record their achievements and refining opportunities. The state is considering the combined opportunities for grants and other training opportunities."

– Dana McCrary, Director, DBHDD Office of Recovery Transformation, Georgia

"We have done a crosswalk. There are things in there that I would say we are already ahead of. We have a different process in our state…. I wanted to be here today to learn how we would be able to accept the universal standard of certification and yet retain what we have in Michigan… Here is one example — the supervised work experience: We have never really believed in that in our state. We don't believe that people with lived experience need to be supervised before they can graduate and earn work. That is one huge red flag in there. We require the person to be working the day of the training…it's quite a bit different."

– Pam Werner, Manager, Recovery Services and Supports, Michigan

In interviews, the rationale offered by states for variation from the Model Standards, as well as variation between states, was consistently that their standards, while different, were higher or more consistent with quality and consumer safety. However, assertions of higher quality and stronger protections for consumer safety are unsupported by available data. Rather, the variation among states in the degree of adherence to any given standard is more often the result of experience, belief, or history than of empirical data.

Data on alignment was gathered from interviews and published sources for standards that can be considered in three categories. Some standards contain specific indicators that are dichotomous, or require counts (for example, Standard #1: Lived Experience Yes/No). Others contain guidelines and examples that lack prescribed measures or indicators, for example, Standard #8: Diversity Inclusion, Equity and Accessibility, which suggests flexibility for multiple certification functions for cultural, linguistic, mental, and physical health capacities and offers no particular tool to measure degree of compliance. Finally, there are standards that contain both specific indicators and guidelines. For example, Standard #11: Peer Supervision is dichotomous (yes or no) and if yes, several guidelines are recommended that are challenging to measure.

Review of States' Alignment with Individual Standards

Model Standard #1: Authenticity and Lived Experience

On OxfordReference.com, "lived experience" is defined as "personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people." Lived experience (LE) is a fundamental principle embodied in peer recovery support, and it was found or referenced in all the data sources used in this analysis. The definition of LE had three different variations in state standards. It is used primarily to reflect a person's direct personal experience with a substance use or mental health disorder; in a second instance, it is used to reflect a person's experience with a family member's or partner's experience with a substance use or mental health diagnosis; and in a rare instance, it included deep knowledge of SUD or mental health conditions. The majority of states (37) require personal LE, while 11 others also include experience with a family member or significant other as meeting eligibility requirements. Two states also consider allyship to recovery with deep knowledge as eligible.

States also vary in how they verify compliance with their definition of LE. Lived experience can be established by a simple self-declaration or check box; a signed, personal attestation; a third party's written reference to the applicant's personal LE; or an extensive written summary by the applicant of their experience with mental health and/or substance use disorders.

Another untallied variation noted between states is the length of time in recovery that a person with LE is expected to have in order to become a peer support worker. Some states require a minimum of one year in recovery; others require two years of recovery; and others, in alignment with SAMHSA's Model Standard #1, do not define a length of time.

Model Standard #2: Training

A training component is required in all states for peer recovery support certification. Key elements of the Model Standard on training include the quantity of training (hours) required and the content of these training(s*).* Training hours, trainers, and training curricula vary widely between states. Of the 51 certification bodies, 36 (72%) require between 40 and 60 hours as suggested by SAMHSA Model Standard #2; one state allows training organizations to set the required number of hours; a few bodies require between 20 and 40 hours; and eight bodies require between 61 and 100 hours.

Expectations for trainers and for training organizations vary among states. One state has over 40 provider organizations designated to train, others select or designate a limited number of organizations to offer training, and still others designate individuals as recognized trainers. Given that few states require an application from training organizations or trainers that is reviewed for adherence to the certification body's core curriculum, the designation of multiple numbers of organizations and individuals makes it difficult to assure quality across the training landscape.

The design and development of training content/curricula also varies. One state gives its trainers the responsibility of curriculum development; most states delegate content review and approval to the certifying entity and/or state agency. IC&RC promotes four overarching domains to organize curricula: Advocacy, Ethical Responsibility, Mentoring and Education, and Recovery and Wellness Support. However, IC&RC does not develop curricula for the exams it creates and offers.

The states we interviewed consistently reported the direct involvement of persons with LE in the development and/or review of training content. Persons with LE could be involved in initiating certification processes, as members of curriculum development and review committees and work groups, and as members of overall governing and policy boards for certifying entities as well as state agencies. At this point, no systematic review and documentation of the extent, roles, or functions performed by people with LE in state curricula and training processes is available to report.

In some cases, work experience, supervised work, or volunteer experience are prerequisites to training, based on the rationale that the work experience 'tests' an applicant's commitment to and understanding of the role. This issue is discussed further under Model Standard #5: Supervised Work Experience.

State Innovation: Workforce Training and Development

Indiana

In Indiana, ICAADA partners with the Department of Labor. This allows for innovation across several areas including supervised work experience, training, and covering the costs associated with certification.

"The benefits of partnering with state/local workforce agencies and the Department of Labor include: Training/credentialing become recognized by respected workforce agencies which increases access to funding and data options, workforce agencies provide supplemental services such as adult education, and supportive employment services, the ability to advocate for Standard Occupation Classification (SOC) codes specific to peer role which [allows for access to] funds that cover all training and certification fees and better tracking availability of specific workforce data on the peer role….and paid access to gaining experience, hours which aligns with other valued certification programs."

– *Justin Beattey,* ICAADA Executive Director

Model Standard #3: Examinations

The Model Standard on exams identifies content, development, revision, structure, format, and accommodations for examinations. All states but one offer an examination for peer recovery certification, and 48 require the exam for certification. Wyoming requires 36 hours of training that includes an exam, but does not otherwise require an exam for certification.[19] The Alaska Commission for Behavioral Health Certification does not require exams for Peer Support Professional and Traditional Peer Support Professional certifications.[20]

[19] Substance Abuse and Mental Health Services Administration (2020). State-by-state directory of peer recovery coaching training and certification programs (p. 124). Substance Abuse and Mental Health Services Administration, Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS-TACS).

[20] Alaska Commission for Behavioral Health Certification (n.d.). ACBHC Peer Support Certification Program Frequently Asked Questions (FAQs). Accessed August 16, 2024.

There are 22 states that certify peer recovery staff through IC&RC affiliation. IC&RC membership includes design, management, and delivery of the exam for peer recovery credentialing. The IC&RC exams are developed by a psychometric company, which involves a variety of subject matter experts including individuals with lived experience.

In the almost 50% of states that are not IC&RC members, local certifying bodies, either state agencies or independent third-party certification boards, develop examinations. Anecdotal data from state agency and certifying board interviews reported a 'review process' of exam content and appropriateness that included reviewers with lived experience; there is no information indicating methodology or criteria employed in this oversight function.

Information is not consistently available to assess either geographic or adaptive (for other personal conditions) accessibility to the exam (e.g., formats that are electronic, paper, remote, or site-based).

Model Standard #4: Formal Education

Model Standard #4 states that "In lieu of any formal educational requirements, prospective certified peer workers should be able to demonstrate literacy and fluency in the language in which they will be providing services."[21]

The great majority of states (all but six) require a GED or high school diploma in their eligibility requirements for certification. In states that do not require a GED or high school diploma, our interview data suggested that reading comprehension and writing capacity could be substituted, which aligns with the standard.

Model Standard #5: Supervised Work Experience

Model Standard #5 states that "supervised work experience refers to hours worked in a paid or volunteer capacity within an organization or setting that provides peer support services."[22] The standard recommends 120 hours of work experience as a maximum requirement.

In our interviews, we encountered three approaches to supervised work experience: 1) No work/volunteer experience is required; 2) The individual must be employed as a peer support specialist at the time of application; or 3) Experience must be complete before the individual applies for certification. In the latter two types, supervised work experience is a prerequisite to certification. As referenced earlier, the rationale for requiring work experience prior to being certified is 'to test commitment and fit,' a justification that lacks evidentiary support.

The majority (31) of states do not require 'supervised work experience' (paid or volunteer) as a prerequisite to certification. For states that require work experience, the hours required include less than 200 (under 5 weeks, four states), 500 (more than 12 weeks, eleven states), and 2,000 (1 year FT, three states). Twenty-five percent of state boards, compared with eighty-seven percent of IC&RC boards, require work experience.

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[21] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

[22] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

The work experience prerequisite may cause unintended consequences, for instance by creating barriers to potential applicants who lack access to a position/supervisor, or who cannot afford to accumulate such experience due to low pre-certification wages. Another risk is that applicants who do acquire work experience prior to training will develop inefficient, inaccurate, or unsound skills. Most practice-based professional education programs (e.g., in medicine, counseling, or teaching) do not require 'work in the professional role' as a condition to education, but rather incorporate work experience into the education as internships, practicums, and residencies supervised by an academically affiliated practitioner.

State Innovation: Balancing Education with Supervised Work Experience

New Jersey

"In New Jersey, the Division of Mental Health and Addiction Services (DMHAS) plays a crucial role in supporting peer recovery specialists by providing funding for peer programs. These programs are designed to help peers pursue certification pathways that validate their skills, experience, and commitment to recovery work. The New Jersey Prevention Network (NJPN) actively supports this initiative by offering resources, training, and guidance to those working toward certification. There are two primary certification pathways for peer recovery specialists in New Jersey. Both certification pathways offer unique benefits. The CPRS certification is accessible to individuals who may not have completed high school or who prefer to build their qualifications through practical experience, while the NCPRSS certification provides a quicker route to certification but with an emphasis on formal training and examination.

"NJPN supports peer recovery specialists in pursuing either pathway by providing reimbursement for both certifications using funding received from NJ DMHAS, recognizing the value of both certifications in fostering a skilled and effective peer workforce. By providing access to training, resources, and guidance, NJPN helps peers navigate these pathways, ensuring they are well-equipped to support individuals in recovery and contribute to the broader recovery community."

– Breyonna Kelton, Peer Program Director, New Jersey Prevention Network

Model Standard #6: Background Checks

Model Standard #6 is clear that background checks are the responsibility of the hiring organization rather than part of the certification process. Where background checks are required, there should be transparency, and an equally transparent review process for disqualifying offenses.

Background checks may take the form of a formal state criminal background check (11 states); a self-declaration of a felony arrest and/or conviction (5 states); or an employer-conducted process. The great majority of states do not require background checks for certification. For the states that require a background check or self-disclosure, the UT Comparative Analysis reports (with a few exceptions that list disqualifying offenses), a lack of transparency in public data sources regarding disqualifying offenses as well as the review process employed to determine waivers and exemptions. Approaches taken by states to disqualification include automatic ineligibility, a specified time limit or number of years for ineligibility, and case-by-case individual

review. The relationship between SUD and criminal justice system encounters is strong and well-documented, especially for people of color and low-income people. For people with LE, criminal background checks can be a barrier to recovery.

Model Standard #7: Recovery

Model Standard #7 states that "pathway-specific requirements, including those that are abstinence-based, [should] be excluded from certification requirements. Instead, state certification entities should allow hiring organizations to consider pathway-specific recommendations that meet the needs of the population(s) they serve."[23]

The standard essentially suggests that there be no particular or designated 'path to recovery' to qualify for peer recovery support certification. Our review of sources indicated one state that requires 'abstinence-based recovery', but all others have no specified pathway for recovery. Alignment on this standard is strong.

Model Standard #8: Diversity, Equity, Inclusion, and Accessibility (DEIA)

Model Standard #8 describes DEIA as a cross-cutting standard that can be incorporated across peer certification requirements (e.g., training and examinations), general strategies utilized by state certification entities, and practice competencies used by individual peer workers.

The standard suggests a high degree of flexibility for application, training, and testing procedures based on the cultural, linguistic, mental, and physical capabilities of the applicant. There is no analysis of state practices that catalogs all the potential options that might be available for every cultural, linguistic, mental, and physical capability.

Model Standard #8 gives no indication of the 'amount of flexibility' needed to meet the standard. For example, IC&RC exams are pre-scheduled and sometimes offered more than once a year as determined by a state; exams were reported to be available in Spanish and English, but likely not in Cambodian or Portuguese. There are no criteria in such cases to determine, for example, whether two exams per year, in three locations, offered in written and verbal English and Spanish, represent full, partial, or zero alignment with the standard.

Model Standard #9: Ethics

Model Standard #9 requires a formal code of ethics and processes to report and review potential violations.

The six guidelines offered in the Model Standard are specific: an independent peer-based ethics committee; a signed affidavit of compliance; a public and anonymous process of violation reporting; an independent peer-based committee to review breaches; an ongoing annual continuing education process; and five specific content areas in the code. Available published data and state interviews indicate the presence of an ethics component for every state reviewed. However, no available data source has documented and catalogued either how, or the extent to which, each state addresses the six specific guidelines. As a consequence, no information is available, for example, on the number of states that have an accessible, transparent method to anonymously file a report of an ethical violation. At least two states

[23] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

interviewed noted challenges in adjudicating ethical complaint violations due to lack of resources to process the number of complaints filed.

Model Standard #10: Costs and Fees

Model Standard #10 recommends that "State certification entities work with their state to find resources to subsidize all costs or fees for both certification and recertification."[24] Available data indicates that fees can be associated with a variety of certification-related functions including application, registration, training, and exams.

The National Model Standards provide summary data on fees: "The Comparative Analysis of State Requirements identified 20 state certifications that offer free peer support training, 20 state certifications that include costs that vary depending on the training provider utilized, and 10 states with costs ranging from $99 to $900. Approximately one-half of the certification entities that were analyzed also included initial application fees ranging from <$100 to $299, with an average cost of $130."[25] The charges for the various functions are sometimes bundled (all functions included, from application to testing) and sometimes itemized (a separate fee for every function). A few states that charged fees indicated in interviews the availability of 'scholarships' to mitigate the barrier imposed by fees. However, information regarding availability, amount, and processes to apply for scholarships was not available in public sources.

State Examples of Certification-Related Costs and Fees

- Kentucky training costs $350
- Indiana charges a $35 registration fee
- Iowa charges a bundled rate of $165 for registration, training, and exam
- Michigan charges a $300 fee for training but mandates that the peer's employer pay it. Free boarding is provided for individuals traveling over 40 miles for training.

State Innovation: Supporting the Cost of Certification

Michigan

In Michigan, peers must be working in order to attend training. Michigan recognizes that the cost of training may be a barrier to some peers who want to enter the workforce. The state insists that the person's employer pay the cost of training. In addition, the state covers the cost of lodging for anyone traveling more than 40 miles to the training, for the entire duration. According to Pam Werner, Manager of Recovery Services and Supports:

[24] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

[25] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

> "We provide lodging for anybody that is 40 miles or further away for free. We use block grant funding to significantly underwrite the training… We require that the employer pay $300 because once the person is certified, they are a Medicaid provider and then the employer is financially benefiting from the individual's practice… Initially back in 2007 we didn't require people to work, and it ended up becoming a glorified volunteer force."

Model Standard #11: Peer Supervision

The Comparative Analysis describes all states as having a supervision mechanism for peer recovery specialists, but it includes no information on *certification* for the supervision role. Model Standard #11 does not specify distinct requirements for the certification of peer recovery supervisors; rather, it references the same requirements used for peer recovery specialists, i.e., lived experience, work experience, ethics, and 'advanced' (undefined) training. There is great variation among states in the requirements for their existing peer supervisors, including several *licensed* medical and behavioral health credentials (e.g., psychologist, psychiatrist, nurse, social worker).

Several states are currently developing standards and content for certifying peer recovery supervisors, and IC&RC is currently developing an exam for this role.

Analysis

Since the 2015 release of SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services, the peer workforce has grown, with state certification programs now in 49 out of 50 states. Contributing factors to the significant increase in the peer workforce include recognition of the critical role of peers throughout the continuum of care for SUDs, growth of a recovery-oriented system of care, a severe behavioral health care workforce shortage, and growing need illuminated by the nationwide overdose epidemic. As more state Medicaid programs have added peer support as a reimbursable service, it has become increasingly evident that it is important to develop and support certification processes that attest to the achievement of professional competency and provide some assurance of protection for recovery support recipients.

Like the recovery movement itself, the development of the peer certification process has been localized and often informed by grassroots, community-based priorities that reflect the nuances of the communities being served. States created multiple pathways to incorporate core competencies into training content and delivery systems which have been reviewed, refined, and continued for many years. It is easy to understand that as states identify the positive impact of peer support services across the system, the training programs and certification requirements that contributed to their workforce are perceived as critical to their continued success.

Philosophy Leads, Evidence Lags

In many states, the philosophy driving peer support credentialing is to ensure a high standard of care and professionalism while fostering accessibility for those with lived experience. Differences in training content and hour requirements, supervised experience requirements, recovery experience, and exams reflect each state's interpretation of this task against a backdrop of political will, legislative influence, advocacy of certain groups, need, opportunities, and challenges. For example:

- **Kansas** emphasizes a flexible and individualized definition of recovery, allowing for varied paths and experiences, which aligns with the state's broad credentialing approach.
- **Michigan** employs a standardized certification process with specific training and experience requirements. The rationale is to ensure that well-prepared peers are embedded in the state's peer culture.

Yet there is limited data on whether either approach translates to a more prepared workforce or better service delivery outcomes. The gap between philosophical ideals and empirical evidence highlights a need for ongoing research and evaluation to refine credentialing processes to demonstrate their impact on workforce preparedness and peer support effectiveness.

Balancing Regulatory Rigor with Demand for Access

In states that have experienced the positive outcome of an engaged peer workforce, a strong affinity for the certification process that led to its development may hinder consideration of change, especially when there is fear that change implies lowering standards and may risk

harm. The challenge of balancing regulatory rigor with accessibility is evident across states. Overly burdensome processes or requirements can lead to unintended consequences, such as creating a bottleneck where fewer individuals are able to become certified. This might result in a shortage of peer support professionals, particularly in underserved areas. Additionally, potential peer supporters might be discouraged from pursuing certification due to the perceived difficulty or expense, reducing the overall pool of available support.

- **Illinois** showcases a highly structured certification process with significant training, and supervised experience requirements. While this ensures thorough preparation, it may deter potential peers due to its length and cost.
- **Iowa** faces a different issue with its current model, where a lack of formal certification requirements and a diverse approach to training have led to questions of consistency in service delivery and challenges with Medicaid reimbursement.

States must carefully consider whether their certification processes may inadvertently limit access to peer support services, and strive to find a balance that maintains quality without excluding capable individuals from entering the field.

The Relationship between Core Competencies, Training Curricula, and Exams

The interaction between core competencies, training curricula, and exams is crucial for effective credentialing. The goal is to ensure that a curriculum aligns with core competencies and that exams accurately assess the knowledge and skills deemed essential. In addition, SAMHSA National Model Standards emphasize the importance of centering the development of all three components on the input of individuals with lived expertise.

- **Core Competencies**: These are the essential skills and knowledge that a peer supporter must possess. Core competencies typically include communication skills, empathy, understanding of SUDs, and the ability to provide support in a non-judgmental manner. These competencies are the foundation of the certification process and inform the development of the training curriculum.
- **Training Curriculum**: The curriculum is designed to impart the core competencies to prospective peer supporters. It should be comprehensive and relevant, covering both theoretical knowledge and practical skills. The effectiveness of the curriculum is critical in preparing candidates for real-world scenarios and ensuring that they are equipped to meet the expectations of the certification.
- **Exam**: The certification exam tests the knowledge and skills acquired through the training curriculum. It serves as a measure of whether candidates have achieved the core competencies. The exam should be designed to fairly assess the ability of candidates to apply their knowledge in practical situations. Ideally, it should be rigorous yet accessible, ensuring that it validates the competencies without being overly restrictive.
- **Interrelationship**: The relationship between core competencies, the training curriculum, and the exam forms a “golden triangle” where each component must align to ensure these components of certification. A mismatch in any part — whether the competencies are not adequately covered in the training, or the exam does not accurately measure the competencies — can undermine the certification’s effectiveness.

IC&RC provides a framework for core competencies, and testing that is developed using concise definitions of the tasks, knowledge, skills, and abilities necessary for job performance. IC&RC engages subject matter experts identified by member boards who work with their professional testing company to develop questions for the exam based on these competencies. However, training is left up to the states and may not necessarily align with the exam content.

Effective credentialing systems should ensure that curricula are updated to reflect current core competencies and that exams are designed to accurately measure those competencies. Regular reviews and updates are necessary to keep pace with best practices in the field.

Reciprocity May be Available; Process is Not Transparent

Reciprocity among states can facilitate workforce mobility and address regional disparities. Ideally, a peer support certification should be recognized across various states or counties, allowing individuals to practice in different locations without having to undergo additional certification processes. However, lack of certification standardization, expectations that individuals adhere to state-specific requirements, and lack of transparency in the reciprocity process all create barriers. Many states said they were willing to consider reciprocity for the peer credential, but felt there needed to be alignment of certification requirements, especially training content and quality, before consideration. In general, there appeared to be a distrust of curricula and training processes other than their own. The process for achieving reciprocity is often not well-defined or transparent. This lack of clarity can create confusion and obstacles for peer supporters who wish to practice in different jurisdictions. Without a clear understanding of how reciprocity is granted or how different certifications are recognized, individuals may face bureaucratic hurdles or duplicative certification requirements.

The IC&RC acts as a conduit between member boards to facilitate a reciprocity process, but does not itself grant reciprocity. Individuals certified in a member state need to contact their board to initiate a reciprocity request. As certification requirements may differ across IC&RC states, reciprocity is not promised, and the process is not always transparent. Only a few of these states, like Rhode Island and Delaware, have automatic reciprocity.

Some states have entered into discussions regarding regional compacts that would facilitate reciprocity, even with IC&RC non-participants.

"Fearless Inventory" of Standards and the Certification Process

Conducting a fearless inventory of standards involves critically examining the strengths and weaknesses of current credentialing processes and identifying areas for improvement. Credentialing process requirements should be simplified, standardized, and widely accepted to facilitate SAMHSA's goals to "accelerate universal adoption, recognition, and integration of the peer workforce, and to strengthen the foundation set by the peer workforce, reinforced by the Core Competencies, and implemented by our state, local, and tribal partners."[26] A 2018 Office of the Assistant Secretary for Planning and Evaluation (ASPE) report noted that credentialing processes that are complex, burdensome, and unclear are a major barrier to addressing critical

[26] Substance Abuse and Mental Health Services Administration (2023), Office of Recovery. *National model standards for peer support certification*. Publication No. PEP23-10-01-001.

behavioral health workforce shortages. The report also indicated that significant certification variation across states served as a disincentive to entering the field by limiting career mobility.[27]

A fearless inventory would examine whether the current standards are truly reflective of the needs of the communities served, whether they are aligned with best practices, and if they effectively prepare individuals for their roles as peer supporters. The assessment should also scrutinize the certification process itself, looking for areas where the process may be unnecessarily complex, costly, or exclusionary. The goal is to streamline the process while maintaining high standards of quality.

Many states are in the process of evaluation and revision. Moving forward, regular reviews and updates should be conducted to ensure that certification standards and processes remain relevant and effective. Engaging with stakeholders, including current peer supporters and training providers, can offer valuable insights into potential improvements and help address gaps or inefficiencies.

- **Kentucky** is considering moving towards more structured certification to address issues with misuse and oversight. The state recognizes the need for better alignment and quality control but faces challenges due to capacity issues and historical resistance to investment in certification processes.
- **New Jersey**, to address challenges with cost and accessibility, is exploring ways to streamline and improve its process. The state's approach highlights the need for balancing cost, accessibility, and the effectiveness of certification.

In evaluating standards and certification processes, it is important to address issues such as the adequacy of training, the relevance of core competencies, and the effectiveness of exams. States should also consider the impact of certification requirements on workforce development and access to peer support services.

[27] Isvan, N., Gerber, R., Hughes, D., Battis, K., Anderson, E., & O'Brien, J. (2020). *Credentialing, licensing, and reimbursement for the SUD workforce: A review of policies and practices across the nation*. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Achieving Alignment and Reciprocity in Peer Certification

Several strategies could be employed to facilitate steps toward peer certification portability and comportment with National Model Standards. Facilitated and organized cross-state dialogues and small-scale, regional efforts could build toward reciprocity agreements or compacts. Conversations regarding how states and jurisdictions approach alignment with the National Model Standards could serve to build consensus on strengths to be replicated and improved.

Multistate Comparisons

Before moving to facilitating reciprocity across states, SAMHSA could encourage state certification bodies to review their standards against those of other states; the PR CoE State Certification Database could be used for this purpose. States could identify burdensome standards that are inconsistent with the national trend. A 2021 comparison of Pennsylvania's occupational licensure requirements with those of other states recommended that state officials evaluate the health and safety protections associated with licensure against the impact of employment restrictions on workers and businesses. The report concluded by saying that "a reduction of overbearing requirements, to be consistent with other states, will keep Pennsylvania competitive in attracting licensed professionals and keep pace with sister states in relation to workforce development and job growth."[28] This type of analysis could produce similar benefits for the peer workforce and potentially lead individual states to evaluate their own programs against these criteria.

State peer support certification processes differ greatly, depending on a variety of factors including when they started and who administers them — including examinations, continuing education, and recertification. There are states with one peer recovery specialist certification for individuals with mental illnesses and SUDs, and others with separate peer recovery specialist certifications for each of those conditions. The National Model Standards allow for these differences.

Taking an Inventory of Alignment

Two states we interviewed (GA, MO) reported that they had conducted a formal "crosswalk" of SAMHSA's National Model Standards and their current state certification processes. Missouri's crosswalk was conducted by staff in its Office of Recovery Services and was disseminated from that office. Missouri's crosswalk is available as an example in Appendix E. Georgia's crosswalk was conducted by the Georgia Council on Recovery, the statewide recovery community organization charged by the state with peer certification. The TAC team examined these documents and found them different in format but similar in content. Missouri's crosswalk shows a description of each Model Standard, followed by a description of current certification efforts and whether the national standard is met; if it is not met, a date is given when alignment is

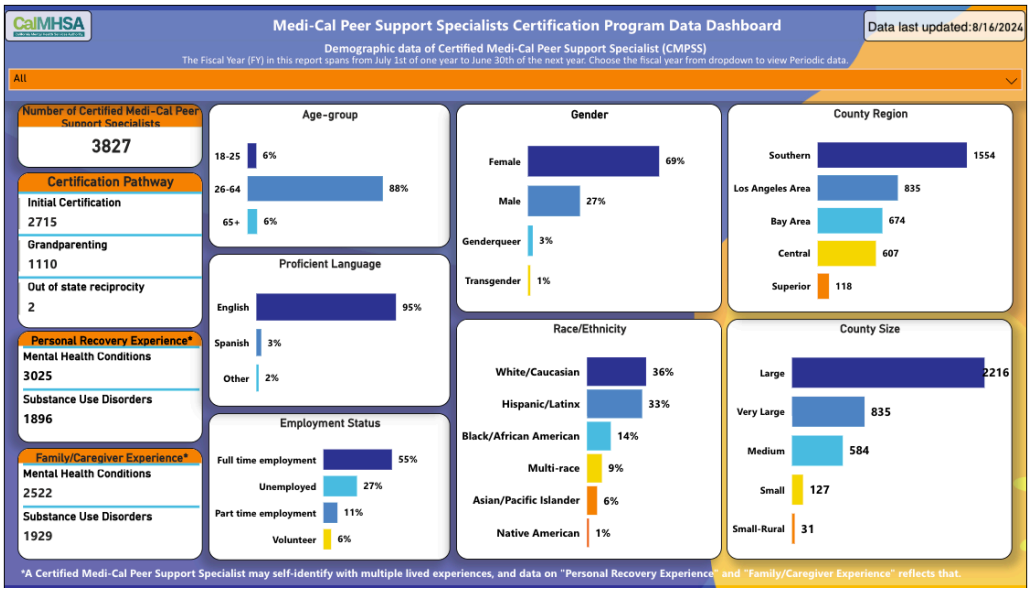
[28] Commonwealth of Pennsylvania (2021). 50 State Comparison Report. Commonwealth of Pennsylvania, Department of State.

expected. Georgia's document describes the focus of each Model Standard and describes how the certification process meets the standard.

These two examples demonstrate that quantifying alignment is possible. As the standards are often general and open to interpretation, the more states and jurisdictions that take on this task, the more the standards can perhaps take concrete shape and clarify some of the questions that have arisen. Peer recovery support services began as informal, nonclinical approaches to serving individuals with a focus on personal connection through lived and living recovery experience. The recovery movement that launched the conversations and early implementation of these services warned against "formalization" and predicted the challenges the behavioral health field would face. With the establishment of SAMHSA's National Model Standards comes the opportunity for states to quantify, develop, and evaluate their processes, curricula, and standards. SAMHSA has also commissioned the development of a self-assessment tool that state training and certification bodies can use to evaluate their alignment with the Model Standards.[29] This tool provides the opportunity for information on alignment to be evaluated and collected in a uniform way.

The development of meaningful metrics relative to a robust and sustainable peer workforce can be a next step toward states aligning with the National Model Standards. States can measure and track the number of peers who 1) apply for certification, 2) obtain and retain certification, 3) attain training and do not become certified, and 4) become certified, enter the workforce, expand employment opportunities, and enter into supervisory roles. Additionally, measurement regarding the type of employment that certified peers obtain and retain can reflect the quality of the certification process. Metrics regarding ethics complaints and resolution could be an important barometer to gauge how well a specific standard is being addressed. California's Peer Support Specialist Certification Program Data Dashboard is an example of a data transparency approach that could serve to inform progress and process.

Figure 1: Peer Support Specialist Certification Program Data Dashboard for California



[29] Mental Health Technology Transfer Center Network (2024, August 6). *Measure for measure: An overview of "The National Model Standards for Peer Support Certification" (Session 1)* [Webinar]

Facilitated Regional Convenings

In some SAMHSA regions, regional administrators have begun to convene their states' recovery coordinators to discuss peer workforce development, certification standards, and challenges faced by states; this work could pave the way for reciprocity efforts. Through facilitated discussions, states may come to understand their peer states' approaches to developing certification standards, why they selected certain standards and the stringency of those standards, and the benefits and challenges presented by those choices. Training curricula could be reviewed in order to determine consistent components and identify variation across states. Over time, with the addition of metrics to these discussions, states could begin to evaluate the impact of the standards on workforce size, training completion, and certification retention.

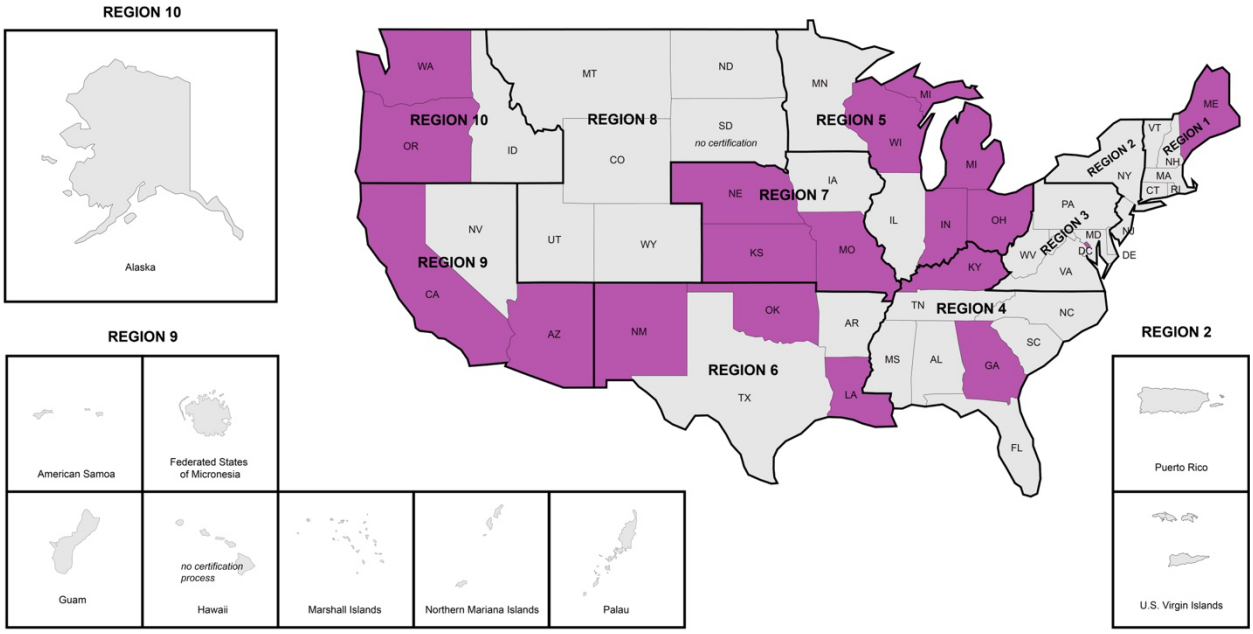
Building on initial regional efforts to help states understand each other's certification systems, SAMHSA's regions could look for internal reciprocity opportunities. For example, of the 21-state agency or third-party organization certification bodies, 18 require no work experience; greater alignment exists for the Model Standards training hours. The maps below show alignment for these two standards across SAMHSA regions. Since peer worker certification is a credential in most states and not governed by a licensure board, the executive branch agency could potentially create a policy to grant reciprocity unless that function is expressly prohibited by statute. States within a region could individually decide whether or not to grant reciprocity; total consensus would not be required with this approach.

Regional Offices

Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 | Region 7 | Region 8 | Region 9 | Region 10

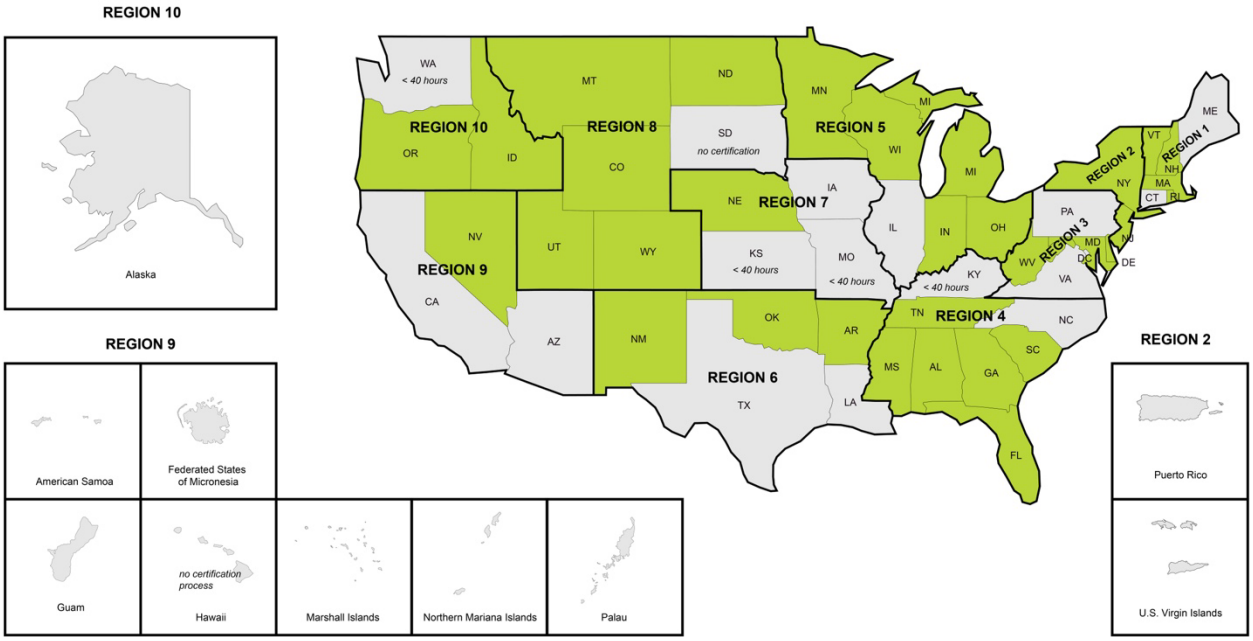
State Certification Bodies Requiring No Work Experience (*shown in dark pink*)

Note: HI and SD have no certification process.



States Certification Bodies Requiring Between 40 and 60 Training Hours (*shown in lime*)

Note: WA, KS, KY, and MO have state certification bodies requiring fewer than 40 training hours. HI and SD have no certification process.



Models for Reciprocity

There are examples of regional reciprocity agreements, with one being administered by the National Council for State Authorization Reciprocity Agreements (SARA) that provides "a voluntary, regional approach to state oversight of distance education."[30] SARA is overseen by a national council and administered by four regional higher education compacts. One of the four, the Western Interstate Commission for Higher Education, which includes 15 states, has a specific mental health program. Another, the South Regional Education Board, ran an annual mental health conference for decades; it is possible that one of these two compacts could play a role in peer certification reciprocity.

As IC&RC has reciprocity as one of its primary objectives, the organization created a new credential (PR-A) in order to align with the National Model Standards as their minimum requirements for work experience and a high school diploma or equivalency degree for the current peer recovery credential exceed the Model Standards. Requirements for the new PR-A credential mirror the Model Standards. Each state member board will establish criteria for its credential that fall within SAMHSA's guidelines, e.g., 40 to 60 hours of training, no more than 120 hours of supervised work experience, etc. IC&RC is hopeful that states and member boards will appreciate the opportunity the entry level credential offers to expand the peer workforce and create a career ladder for peers. If the new credential is to facilitate reciprocity, state agencies that function as certification bodies must be willing to follow the Model Standards, and an

[30] NC-SARA (n.d.). *The state authorization guide*. Accessed August 16, 2024.

assessment of any additional requirements would be needed to ensure they don't create barriers to credential portability

Along with state agency certification bodies, IC&RC could make a significant contribution to the field of credentialing by leading the way in evaluating work experience requirements, examination content, and training curricula in the interest of creating empirical knowledge about the impact of these standards on the quality and availability of the peer workforce. Volunteer-run state member boards could consider entering into management contracts with larger boards that credential peer workers so there could be cross-state collaboration on certification. State member boards could also evaluate the transparency of their websites and create a consistent reciprocity protocol across boards.

Other parts of the health care field have longstanding umbrella organizations that promote uniform standards and facilitate information exchange across states (e.g., the National Council of State Boards of Nursing, the American Association of State Counseling Boards, and ASWB). The ACA, for example, was formed in part to "develop consistency among practice and ethical standards for the counseling profession."[31] Before its work with NCIC, the ACA had created "20/20: A Vision for the Future Counseling" through which ACA members reached consensus on the definition of counseling and the importance of strengthening professional identity, and formed the *Building Blocks to Portability Project* to address issues like educational requirements and number of required supervised hours.[32] ACA brought this legacy work to its partnership with NCIC. Similarly, HRSA's social work compact, which establishes reciprocity, benefitted from the strong partnership with ASWB, NASW, and CSWA.

For any large-scale reciprocity, some model similar to the NCIC's work is necessary. A single organization or formally organized collective would need to manage the process, with lead content expert organizations as partners. Because an interstate compact requires consensus among all members, it demands an extensive deliberative process with stakeholder groups, and the development of a model compact bill to be considered through a state's legislative process. Compacts establish uniform guidelines, standards, and procedures for member states and require funding for development and administration. It may take several years for the provision of the compact to take effect; efforts on the social work compact began in 2021 and NCIC estimates that social workers will be able to apply for multistate privileges in the fall of 2025.

Any of these collaborative information exchanges or development efforts will require dedicated leadership, cross-state interest, and a multistate umbrella organization to spearhead an agenda and build consensus on critical issues in peer certification.

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[31] Elliott, A., Bohecker, L., Elliott, G. M., Townsend, B. J., Johnson, V., Lopez, A., Horn, E. D., & Roach, K. (2019). Interstate licensure portability: Logistics and barriers for professional counseling. *The Professional Counselor, 9*(3), 252–266.

[32] Elliott, A., Bohecker, L., Elliott, G. M., Townsend, B. J., Johnson, V., Lopez, A., Horn, E. D., & Roach, K. (2019). Interstate licensure portability: Logistics and barriers for professional counseling. *The Professional Counselor, 9*(3), 252–266.

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Recommendations, Opportunities, and Areas for Further Exploration

During our interviews with states and certification entities, the review of existing documents, and collection of available data, it became clear that there are many spaces where additional focus and exploration are needed in order to support the effective implementation of the National Model Standards. The opportunities highlighted below are not comprehensive but are meant instead to reflect the most consistently identified areas for further exploration.

Create a Platform for Advancement

An opportunity exists at this time to support the longevity and sustainability of the National Model Standards through co-creation and co-ownership of the next steps in their evaluation and implementation. By partnering with national peer-led organizations, states, and a select group of state certifying bodies on the continued development of the Model Standards, SAMHSA would model a significant change in the way that peer-oriented documents and processes have historically been handled, demonstrating trust in the peer workforce and in peer credentialing leaders.

Taking on the potential opportunities and exploration laid out above through a partnership between SAMHSA and national peer-led organizations would create the opportunity for the peer workforce to have greater input and direct control over the development and implementation of documents directly related to them. This approach would also help to streamline some related processes that might move faster through nonprofit organizations than through governmental bodies.

In addition to demonstrating trust and streamlining processes, partnering on the next steps with the Model Standards will help to ensure that they remain a living document. The peer workforce and national organizations have a vested interest in seeing the National Model Standards reviewed, evaluated, and updated on a regular basis. SAMHSA shares this interest but has a much broader swath of focus areas beyond peer support that may limit its ability to focus on the Model Standards to the same level as national peer organizations. Therefore, utilizing a partnership or co-ownership model to navigate the next steps in the development and implementation of the National Model Standards is the most efficient way forward.

Periodically Evaluate SAMHSA's National Model Standards

The National Model Standards were published in 2023 after a rigorous development process including SAMHSA's Peer Recovery Center of Excellence updating the *Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States*; convening 68 leaders in the peer workforce for SAMHSA's Technical Expert Panel on Peer Support Certification; reviewing relevant supplementary documents; and completing a public comment process on a draft version of the document. The process was intended to capture a diverse array of opinions and points of view from thought leaders across the continuum of peer services and certification in order to create a robust and functional document that could serve as a base level from which to align existing state certifications.

Since the publication of the National Model Standards, some state- and national-level certifying bodies, including IC&RC, have mapped their current certification processes and training content onto them. Simultaneously, the publication of the National Model Standards and their ongoing implementation across the country have given rise to the question of maintaining the quality and functionality of the Model Standards on an ongoing basis. Certifying entities, states, and the peer workforce are eager to ensure that the Model Standards continue to reflect best practices in certification, peer services delivery, and workforce development.

To this end, it is recommended that the National Model Standards undergo rigorous evaluation on a regular basis, at least every five years. In this way, SAMHSA can proactively ensure that the standards reflect the continuing evolution of peer credentialing, training content, and delivery of services. This can be done through a variety of means including continuously reviewing newly published documents, updating SAMHSA documents related to peer credentialing, generating relevant data, and reconvening the Technical Expert Panel on Peer Support Certification. Utilizing well-established evaluation tools to review the Model Standards will support their recognition as a credible document to guide peer credentialing across states.

Research the Evidence Behind the National Model Standards

The National Model Standards cover 11 important areas of peer training and certification and were created in a robust and collaborative process described previously in this document. Though the process was largely focused on the collective voice of national peer leadership and a review of existing state certification systems, there is significant room for growth in building the evidence base behind the individual Model Standards. Research will build stronger justification for each standard, a clearer path towards implementation of the standards, and a stronger case for the utilization of the Model Standards in peer certification and training processes.

For example, Model Standard #5: Supervised Work Experience recommends that “for state certification entities that currently institute a supervised work experience requirement, a maximum of 120 hours of supervised work experience should be required”; however, the current certification processes range from 0 to 2,000 hours of supervised work experience. Many of the certifying entities with work experience requirements that were not in alignment with the Model Standards expressed in our interviews that there was no evidence to demonstrate that aligning with the Model Standards would improve the quality of their state’s peer workforce or certification process. In fact, those states with work requirements higher than the Model Standards recommendation suggested that aligning with the Model Standards might *diminish* the quality of their workforce.

In this instance, the ability to demonstrate the research and evidence base behind the 120 hours of work experience for peer certification might support certifying entities in adopting the Model Standards more fully while simultaneously shoring up credibility of the standards. Likewise, building the research and evidence base behind the specifics of the remaining 10 Model Standards will encourage adoption of the standards by certifying entities.

An important aspect of developing credible evidence to support the Model Standards is the utilization of well-established, independent organizations to conduct the research. There are several organizations that are well established to take on the work of conducting the research, primarily the National Institute of Drug Abuse through the Clinical Trials Network. Additionally, the Agency for Healthcare Research and Quality could play a role in building the evidence base.

Develop and Standardize Curricula

One area that requires consistent focus and collaboration is the alignment of peer trainings with peer certification processes. Throughout the interviews we conducted with certification entities, they made clear that they are generally not responsible for oversight of the curricula used to train peer specialists who are looking to become certified. Although most states have only one or two entities that certify peer specialists, there are frequently multiple — in some states, as many as 13 — different curricula used to train the peer workforce.

With each state navigating the development and maintenance of peer training curricula independently, there is very little structure in place to ensure that the training received by peer specialists is consistent across the country. Using the National Model Standards as a guide, states and organizations developing peer training curricula are encouraged to adopt and implement content that is shared across states in order to build consistency.

National peer workforce organizations, in collaboration with state training entities and SAMHSA, must work together to create free-to-use curriculum modules centered on the National Model Standards that state training entities can adopt and integrate into their training processes. Offering the modules independently from one another will allow state training entities to implement trainings aligned with the National Model Standards in the ways that will work best for their systems, which will allow the largest number of states to align with the standards.

Methods for Moving the Conversation Forward

There are many opportunities to advance the implementation and continued development of the National Model Standards. As mentioned previously, leading experts in peer training and certification could be convened through Technical Expert Panels to continue the conversation on improving the Model Standards over time. This would allow new voices and perspectives to influence the Model Standards as new leaders emerge, while ensuring that the standards remain up to date and relevant.

SAMHSA should consider partnering with national peer organizations to collect data from stakeholders across the country to create a clearer picture of the national response to the Model Standards including workforce opinion, stakeholder interest, implementation status, and more. National peer organizations such as the National Association of Peer Supporters, Faces and Voices of Recovery, and the National Alliance on Mental Illness (NAMI), among others, have access to robust constituencies that can easily be tapped to provide data that can guide next steps in the evolution and implementation of the National Model Standards.

In fact, in July 2024, NAMI presented data from a nationwide survey of NAMI affiliates and those unassociated with the organization in which they asked respondents to provide feedback on their support of the individual Model Standards and the role they felt NAMI should play in their implementation. The results demonstrated that survey participants felt least aligned with Model Standard #7: Recovery, which may indicate that clearer messaging and education are needed to support more widespread implementation.[33]

Through ongoing surveys and dialogue between national peer organizations, their constituencies, and SAMHSA, it may be possible to create a clearer picture of the status of

[33] National Alliance on Mental Illness (2024). *Next steps in peer credentialing: What else is needed now that we have national model standards from SAMHSA* [webinar], June 28, 2024.

implementation of the Model Standards, and what is needed for certification entities to implement them more fully.

In addition to regular dialogue between SAMHSA and relevant stakeholders, one specific method of advancing the conversation is to convene policy academies for states and certification entities. These academies would present the opportunity to provide technical assistance directly to those implementing the Model Standards while simultaneously eliciting direct feedback on barriers to implementation and ideas for advancement.

Gauging Stakeholder Interest in Alignment and Reciprocity

A critical step in advancing the implementation of the National Model Standards is to determine the level of interest that states, certification entities, the peer workforce, and other relevant stakeholders have in developing reciprocity processes and moving towards alignment. Historically, there has been anecdotal consensus that all relevant stakeholders have a vested interest in moving towards implementing reciprocity processes. Some states and certification entities have demonstrated this interest through the implementation of reciprocal credentials, such as those offered through IC&RC, however, our interviews with several states and certification entities revealed a higher degree of uncertainty about reciprocity than was previously recognized.

Before encouraging the adoption of alignment and reciprocity between certification entities, SAMHSA should learn more about the current landscape and stakeholders' future plans. This could include gathering data on existing state and regional reciprocity efforts, and finding out which states and certification entities are (or are not) interested in making this shift.

SAMHSA could then facilitate further dialogue, 1) with those states and certification entities that are not interested in reciprocity, in order to further identify their specific reservations and potentially address them, and 2) with those that *are* interested in alignment and reciprocity in order to learn what drives their interest and identify scalable projects and next steps towards implementation of reciprocity agreements and interstate compacts.

Conclusion

The benefits of certifying peer recovery professionals include a common baseline of responsibilities and accountability for employers and payers; a recognized identity for the professional; and, most important as IC&RC describes, 'public protection', or assurance that the recipients of services are getting what they need within the scope of practice, in a safe, efficient, competent, and timely manner. The peer support credentialing process is complex and multifaceted, with varying approaches across states reflecting different philosophies, regulatory rigor, and levels of evidence. States must navigate the balance between maintaining high standards and ensuring accessibility, while also addressing issues of reciprocity and the alignment of core competencies, curricula, and exams. A thoughtful and evidence-based approach to certification can help improve the quality of peer support services and ensure that peers are well-prepared to contribute effectively to the recovery process.

This report offers examples of state certification standards for peer recovery professionals that align with or differ from the National Model Standards. It also describes differences in the organizations, processes, and practices used by states to certify competence. All of this variety provides an opportunity to fill in the blanks of what we do not know. For example, while required training hours range from the 20s to more than 400, the relevant Model Standard suggests between 40 and 60 because this is the amount that the majority of states require. It would be useful to understand if there is evidence to support the higher, lower, or standard range. Questions about the evidence supporting specific standards, processes, and practices surfaced throughout our data review.

While this analysis shows both significant alignment with standards and progress on certifying peer recovery support, ongoing work is necessary to fully assure that certification of peer recovery support fulfills its primary function of public protection. The gaps in our knowledge suggest that the work ahead needs to focus on refining and specifying the model standards and how they are implemented in states. The gaps in evidence behind practices and standards need to be narrowed. This work can be done by states and certifying bodies working together in regional or national collaborations coordinated by a voluntary central body that emerges from early multi-state and certifying-body work groups. These work groups can share and compare practices; begin to build tracking and data systems that document results; and broaden the circle of involvement. This is a roadmap followed to certify other health care professions. With multi state and certifying-body ongoing collaboration, the next stage of peer recovery support certification will be strengthened.

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Appendices A–E

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Appendix B. Methodology

Raw Data Analysis

The TAC team came together to identify the key elements of each of the 11 Model Standards against which alignment could be measured. These identified elements, listed in the table below, were compared with the raw data from the *Comparative Analysis* in a first attempt to assess alignment. It quickly became clear that not all standards had elements that could be measured definitively. The standards whose key elements were measurable were compared against the available data and information from state public websites, and then subjected to an inter-rater reliability process for three of those standards to establish initial impressions about alignment. To gain a deeper understanding of how states were using and interpreting the standards and assessing their own alignment, TAC conducted key informant interviews and attended regional and national convenings to speak directly with staff involved in certification.

Table A1: Key Elements of the National Model Standards

Standard	Key Elements
#1	• Requires substance use lived experience • Requires a self-attestation statement • Requires meaningful involvement of people with lived experience in the development, adoption, and revision of state and local peer certifications
#2	Training requirements range between 40 and 60 hours. Core content areas as represented by: • Role, scope and purpose of the peer • Values and principles of peer support, recovery and resilience • Self-care and wellness • Self-determination, choice and shared decision-making • Ensure that certified peer workers with relevant lived experience play a leading role in the design, application and revision of peer certification training and state certification entities utilize a clear and transparent process for procuring new training organizations
#3	• Examinations provide an opportunity to reveal a working knowledge of the peer support role and responsibilities • Examination content reflects the core training areas (above) • Training is accessible, e.g. frequency, method of delivery, etc. • Development and revision of examinations are led by certified peer workers to promote fidelity and reliability

Standard	Key Elements
#4	• Requires literacy and fluency in lieu of formal education. • If a prospective certified peer is unable to demonstrate literacy and/or fluency, state certification entities should provide a list or formal education training/opportunities that may help them achieve certification
#5	• If supervised work experience is required, 120 hours is the maximum • If minimum requirement, any combination of paid, volunteer, virtual or out-of-state hours count
#6	• Requires background checks • If required, there is a clearly identified and limited list of disqualifying offenses • There is an appeals process
#7	• Excludes recovery pathway-specific requirements
#8	• Training examination and content reflects the diversity of the peer population • Target recruitment and promote pathways to certification for diverse and under-represented and under-resourced populations
#9	• There is a Code of Ethics • There is a system for reporting breaches and taking action • State certification entities utilize an ethics committee made up of certified peer workers to develop a Code of Ethics and to ensure they are non-clinical in nature
#10	• There is a system for waiving costs or fees for certification and recertification • Information on all costs associated with the costs of certification is available to applicants
#11	• There is a peer supervisor certification process • Prospective certified peer supervisors have direct experience as a peer worker, relevant lived experience and a deep understanding of the peer role • State certification entities partner with hiring organizations to develop and implement supervisor-specific career pathways for certified peer workers

Key Informant Interviews

The team interviewed state staff, certification bodies, and others with involvement in the certification process to further assess alignment, use, and interpretation of the standards, and to identify innovations in the peer training and certification process. A full list of persons interviewed can be found in Appendix B. TAC contacted Single State Agency (SSA) staff whose responsibilities included peer certification in each of SAMHSA's seven regions and scheduled six small group interviews. TAC then developed a set of interview questions that sought to elicit a clearer understanding of state processes, use of (or desire for) reciprocity, and perceived alignment. Many states provided additional information by email.

Examples of State Recovery Coordinator Interview Questions

- How are you or aren't you aligned with the SAMHSA Model Standards?
  - Have you crosswalked your standards with the model standards? Can you give specific examples?
- Have you compared your certification standards against the Model Standards? If so, what did you take away from that comparison?
  - Are you making any efforts to further align with them?
- Do you feel your state's standards facilitate the employment of a qualified peer workforce? If so, how?
- Do standards create any barriers to facilitating the development of the peer workforce?
- If you were involved in creating your state's standards, how did you engage people with relevant lived experience in their development?
- What is your relationship to the certification process? How are you currently involved? How would you like to be involved?
- Does your state employ a process for reciprocity? How important is reciprocity to you? Why?

SSA Recovery Staff Interview Schedule

March 28, 2024, 2:00 to 3:00 pm — New York, Arizona, Missouri
April 4, 2024, 11:00 am to 12:00 pm — Georgia, Washington, Michigan
April 29, 2024, 11:00 am to 12:00 pm — Massachusetts
May 8, 2024, 12:00 to 1:00 pm — Kansas, Texas
May 9, 2024, 12:00 to 1:00 — Kansas, Rhode Island, Kentucky
June 11, 2024, 12:30 to 1:30 — Connecticut, Iowa

It became apparent in talking to staff from the SSAs that to fully understand states' processes and practices in peer certification it would also be necessary to speak to state member boards of the International Credentialing and Reciprocity Consortium (IC&RC) as well as National IC&RC board members. TAC selected member boards from states where we had already interviewed SSA staff to see how these entities did or did not work together in the certification process. As with SSA staff, TAC developed a question guide and scheduled seven interviews.

Examples of State and National IC&RC Interview Questions:

- What is the process for certification? Examination?
- What is your relationship with National IC&RC like?
- Does National IC&RC provide you with any guidance on best practices? Oversight?
- How does your state board and certification process support states in managing the peer workforce?
- How does your state board support peers and the development of the peer workforce through the certification process?
- Can you describe the process you went through to become a state board?

IC&RC National Board Questions:

- What is the process for reciprocity state to state?
- What is the process when states add requirements before granting reciprocity?
- How do you inform applicants about the certification and/or reciprocity process?
- What is the relationship between state boards and IC&RC nationally? Are your overall functions the same, different? In what ways?
- What is the mechanism by which National IC&RC oversees state member boards?
- What is the process for monitoring the quality of these boards?
- What is the national IC&RC doing to verify that state member boards are in alignment with the National Model Standards?
- How could a national certification help support the development of the peer workforce?
- Looking ahead, are there planning efforts to implement a more formalized reciprocity process?

IC&RC Certification Boards

June 18, 2024, 12:00 to 1:00 pm — Pennsylvania Certification Board*
June 20, 2024, 3:00 to 4:00 pm — Texas Certification Board
June 26, 2024, 11:00 am to 12:00 pm — Massachusetts Certification Board
June 27, 2024, 11:00 am to 12:00 pm — Missouri Certification Board
July 1, 2024, 2:00 to 3:30 pm & July 29, 2024, 10:30 to 11:00 am — IC&RC National
July 9, 2024, 10:30 to 11:30 am — Indiana Certification Board/ICAADA

** The Pennsylvania Certification Board is also the certification board for Virginia and Delaware.*

Lastly, to follow up on specific policy or practice questions in Massachusetts and New Jersey, TAC interviewed Maryanne Frangules, Executive Director of the Massachusetts Organization for Addiction Recovery on July 5, 2024 and Breyonna Kelton, Peer Program Director for the New Jersey Prevention Network, on July 22, 2024.

Regional Meeting Attendance

In order to engage more state recovery staff, the TAC team attended two SAMHSA regional recovery coordinator meetings; the Region 5 Work Group on April 8, 2024; and the Region 7 peer support workforce convening on April 26, 2024. Lastly, team members attended the 2024 National Council for Mental Wellbeing conference in St. Louis, MO, April 13, 2024 — engaging state leaders who attended a pre-conference session, “Grounding Systems in Recovery: Building, Supporting, and Enhancing a Diverse Portfolio of P/RSS” to collect additional information and facilitating a conversation about states’ understanding and use of the National Model Standards.

Review of State Websites

The TAC team reviewed the websites of state agencies responsible for certification, independent certification boards, and national certification bodies in order to triangulate and verify information while also collecting data about state processes, practices, and requirements.

Appendix C. Key Informants

Key Informant Interviews and Discussions with State Leaders

**Starred key informants were engaged in discussions at the 2024 national conference of the National Council for Mental Wellbeing.*

State Recovery Coordinators

Arizona	Susan Kennard, *Administrator*, Arizona Health Care Cost Containment System Division of Community Advocacy & Intergovernmental Relations, Office of Individual and Family Affairs
Arizona	Susan Kennard, *Administrator*, Arizona Health Care Cost Containment System Division of Community Advocacy & Intergovernmental Relations, Office of Individual and Family Affairs
Arkansas	*Casey Copeland, *Director of Peer Recovery Services*, Arkansas Department of Human Services, Office of Substance Abuse and Mental Health
Colorado	*Alia Andrews, *Recovery Services Coordinator*, Colorado Department of Human Services
Connecticut	Elsa Ward, M.S., *Director of Recovery Community Affairs*, Connecticut Department of Mental Health and Addiction Services
Georgia	Dana McRary, *Director Office of Recovery Transformation*, Georgia Department of Behavioral Health and Developmental Disabilities
Illinois	Nanette Larson, *Deputy Director for Wellness & Recovery*, Illinois Department of Human Services Division of Mental Health
Iowa	Cody Crawford, *TIEH Project Director*, Iowa Department of Health and Human Services Division of Behavioral Health
Kansas	Charles Bartlett, *Director of Adult Services*, Kansas Department of Aging and Disability Services Behavioral Health Services Commission
Kentucky	Phyllis Millspaugh, *Assistant Director of the Division of Behavioral Health*, Kentucky Department of Behavioral Health and Developmental & Intellectual Disabilities
Massachusetts	Danielle Lydon, *Recovery Support Coordinator*, Massachusetts Department of Public Health Bureau of Substance and Addiction Services
Michigan	Pamela Werner, M.A., *Manager*, Michigan Department of Health and Human Services Peer Services and Supports
Minnesota	Darren Reed, *Peer Recovery Services Coordinator*, Minnesota Department of Human Services Behavioral Health Division

Missouri	Rosie Anderson-Harper, M.A., *Director of Recovery Services*, Missouri Department of Mental Health
Nebraska	Brenda Moes, *Administrator of the Office of Consumer Affairs*, State of Nebraska Division of Behavioral Health
New York	Brenda Harris-Collins, M.A., *Assistant Director*, New York State Office of Addiction Supports and Services
Oklahoma	*M.J. Clausen, *Director of Recovery Support Services*, Oklahoma Department of Mental Health and Substance Abuse Services
Ohio	Zandia Lawson, *Bureau Chief of Recovery Supports*, Ohio Department of Mental Health and Addiction Services and *Jose Flores, *Mental Health Administrator*, Ohio Department of Mental Health and Addiction Services, Bureau of Recovery Services
Rhode Island	Sarah St. Laurent, *Administrator of Peer Based Recovery Support Services*, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals
Tennessee	*Lisa Ragan, *Director of Consumer Affairs and Peer Recovery Services,* Tennessee Department of Mental Health and Substance Abuse Services
Texas	Felicia Mason-Edwards, M.A., *Workforce Manager Peer and Recovery Services*, Texas Health and Human Services Commission.
Washington	Maureen Bailey, *Peer Support Program Administrator*, Washington Health Care Authority

IC&RC State Member Boards

Massachusetts	Haner Hernandez, *President of the Board of Directors*, Massachusetts Board for Voluntary Certification of Drug and Alcohol Counselors
Missouri	Stacey Langendoerfer, *Executive Director*, Missouri Credentialing Board
Pennsylvania, Delaware, Virginia	
	Mary-Jo Mather, *Executive Director*, Pennsylvania Certification Board
Texas	Joe Powell, *Executive Director*, Texas Certification Board
Indiana	Justin Beatty, *Vice President of Credentialing and Education*, ICAADA

IC&RC National Board

- Mark Attansi, *Executive Director*, International Certification and Reciprocity Consortium

Other

- MaryAnne Frangules, *Executive Director*, Massachusetts Organization for Addiction and Recovery
- Breyonna Kelton, *Peer Program Director*, New Jersey Prevention Network
- Robert Morrison *Executive Director and Director of Legislative Affairs* and Melanie Whitter, *Deputy Executive Director*, National Association of State Alcohol and Drug Abuse Directors
- Tim Saubers, CPS *Executive Director*, National Association of Peer Supporters

Appendix D. State and National Certification Websites

State	URL for Peer Certification Information
Alabama	https://mh.alabama.gov/certified-recovery-support-specialist-training-program/
Alaska	https://akcertification.org/peer-support-professionals/
Arizona	https://azahcccs.gov/AHCCCS/HealthcareAdvocacy/OIFA.html
Arkansas	https://ctcertboard.org
California	https://www.capeercertification.org
Colorado	https://hcpf.colorado.gov/peerservices
Connecticut	https://ctcertboard.org/ https://portal.ct.gov/DMHAS/Divisions/Office-of-Workforce-Development/RecoveryUniversity
Delaware	https://www.decertboard.org/certified-peer-recovery-specialist-cprs
Florida	https://flcertificationboard.org/certifications/certified-recovery-peers-specialist/
Georgia	https://dbhdd.georgia.gov/recovery-transformation/cps
Idaho	https://www.bpahealth.com/idaho-peer-cert/
Indiana	https://www.iowabc.org/mhpss https://mhai.net/education/ https://icaada.org/credentials-2/
Kansas	https://kdads.ks.gov/provider-home/providers/peer-support-services/peer-support-training

State	URL for Peer Certification Information
Kentucky	https://dbhdid.ky.gov/dbh/ebpi-recovery.aspx
Louisiana	http://ldh.la.gov/index.cfm/page/2578
Maine	https://www.maine.gov/dhhs/samhs/mentalhealth/wellness/intentional_peer.shtml
Maryland	http://mapcb.wordpress.com/cprs/
Massachusetts	https://www.mass.gov/doc/peer
Michigan	https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder36/Folder2/Folder136/Folder1/Folder236/MCPSSP_Application_Approval_Process.pdf?rev=a38b8276d1744c7d9ca39f7bb1a4a4fb
Minnesota	https://mn.gov/dhs/people-we-serve/adults/healthcare/mental
Mississippi	https://www.dmh.ms.gov/service-options/peer-support/
Missouri	https://dmh.mo.gov/behavioral-health/treatment-services/specialized-programs/peer-support-services
Montana	http://boards.bsd.dli.mt.gov/bbh
Nebraska	https://dhhs.ne.gov/Pages/Peer-Support-Training-Certification.aspx
Nevada	https://nevadacertboard.org/prss/requirements/
New Hampshire	https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/peer-support-specialist-certificate-program-requirements.pdf
New Jersey	https://www.nj.gov/humanservices/dmhas/resources/services/recovery/peer_recovery.html

State	URL for Peer Certification Information
New Mexico	https://newmexico.networkofcare.org/mh/content.aspx?cid=8113
New York	https://oasas.ny.gov/recovery/become-certified-recovery-peer-advocate
North Carolina	http://pss.unc.edu/
North Dakota	https://www.hhs.nd.gov/behavioral-health/peer-support/certification/apply
Ohio	https://mha.ohio.gov/home/peer-supporters-draft/certified-peer-recovery-supporter-cprs-adult
Oklahoma	https://oklahoma.gov/odmhsas/learning-and-education/certified-peer-recovery-supportspecialist.html
Oregon	https://www.oregon.gov/oha/HSD/AMH-PD/Pages/Training-Certification.aspx
Pennsylvania	https://www.pacertboard.org/ https://www.pa.gov/en/agencies/dhs/resources/mental-health-substance-use-disorder/peer-support-training.html
Rhode Island	https://www.ricertboard.org/certifications
South Carolina	https://www.scshare.com/certification
Tennessee	https://www.tn.gov/behavioral-health/cprs.html
Texas	https://www.tcbap.org/ https://www.hhs.texas.gov/providers/behavioral-health-services-providers/peer-support-services/certification-peer-support-a-medicaid-benefit
Vermont	https://recoveryvermont.org/recovery-coaching/
Virginia	https://dbhds.virginia.gov/office-of-recovery-services

State	URL for Peer Certification Information
Washington	https://www.hca.wa.gov/billers-providers-partners/program-information-providers/peer-support
Washington DC	https://dbh.dc.gov/publication/application-2019-peer-specialist-certification-training
West Virginia	https://www.wvcbapp.org/
Wisconsin	https://www.dhs.wisconsin.gov/peer-services/peer-specialists.htm
Wyoming	https://health.wyo.gov/behavioralhealth/mhsa/peer-specialists/

Appendix E. Missouri Crosswalk

This crosswalk between the Missouri Certification Standards and the SAMHSA Model Standards was created, completed, and generously shared by Rosie Anderson-Harper, M.A., *Director of Recovery Services*, Missouri Department of Mental Health; Kimberly Crouch, *Assistant Director,* Missouri Credentialing Board; and Mark McDonald, *Curriculum Specialist,* Missouri Credentialing Board.

SAMHSA National Model Standards for Peer Support Certification Crosswalk to Missouri Peer Certifications

Model Standard	SAMHSA Standard Description	Missouri Standard
Model Standard #1: Authenticity and Lived Experience	<u>Authenticity and Lived Experience</u> State certifications entities include a self-attestation requirement (e.g., a written narrative, questions, check box) that promotes the following statements of authenticity across the peer workforce: 1. Mental Health (MH) and Substance Use (SU) Peer Certifications: Require the participant to be able to describe lived experience related to a MH and/or SU condition and describe strategies utilized to address associated challenges. 2. Family Peer Certifications: Require the participant to be able to describe their lived experience as a primary care giver of an individual with a MH and/or SU condition, and describe strategies utilized to address associated challenges.	<u>Authenticity and Lived Experience</u> Met: Certified Peer Specialist (CPS), Family Support Provider (FSP), and Youth Peer Specialist (YPS) sign the Attestation of Authenticity and Lived Experience Statement in the certification application. CPS, FSP, YPS: Complete the training application, which respectively asks about having lived experiences with MH/SU condition (for CPS and YPS) or as a primary care giver of an individual with a MH/SU condition (for FSP).
Model Standard #2: Training	<u>Quantity</u> 1. Training requirements range from 40-60 hours for mental health, substance use, and family peer certifications. <u>Content and Facilitation</u> 1. Incorporate the accommodations outlined in Model #8 (Diversity, Inclusion, and Accessibility). 2. Ensure that certified peer workers with relevant lived experience play a leading role in the design, application, and revision of peer certification trainings, and state certification entities utilize a clear and transparent process for procuring new training organizations.	<u>Quantity</u> 1. Current training hours are: CPS, 35 hours and FSP, 24 hours. Revisions are in process and target date of 6/30/24 for both of those training hours to be 40+ hours. <u>Content and Facilitation</u> 1. Met 2. Met: anytime the curriculum needs to be revised, the team consists of Missouri Credentialing Board (MCB) staff, Department of Mental Health (DMH) staff and a panel of current peer trainers, who are themselves peers.

	3. Include principles outlined in SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services (for MH and/or SU peer certifications) 4. Include principles and core competencies outlined by family-run organizations (for family peer certifications). 5. Address the following cross-cutting core content areas: • Role, scope, and purpose of the peer (mental health, substance use, integrated, or family) • Values and principles of peer support, recovery, and resiliency • History of recovery movements in mental health, substance use, and families • Recovery and resiliency resources and tools (e.g., recovery planning) • Self-help/mutual-support groups • Community resources (e.g., social, prevention, education, employment) • Legal systems and resources • Diversity, Equity, Inclusion, and Accessibility (DEIA) • Computer and digital health literacy (e.g., computer skills, virtual peer support) • Ethics • Harm reduction (including suicide and overdose prevention) • Communication, language, and group skills (e.g., peer-to-peer engagement, storytelling) • Advocacy (self and system) and reducing prejudice/discrimination (e.g., stigma) • Crisis response • Trauma-responsive approaches • Understanding and identifying mental health, substance use, and cooccurring conditions • Self-care and wellness (e.g., physical, mental)	3. Met 4. Met 5. Most are met, the rest will be met by 6/30/24. 6. Met

	• Self-determination, choice, and shared decision making 6. Include information on child-serving systems and social services, parenting skills, building resiliency in family peer support, and family relationship building (for family peer certifications).	
Model Standard #3: Examinations	<u>Content of Examinations</u> 1. Relates directly to and is appropriately based on the peer role (mental health, substance use, or family). 2. Only reflects information explicitly covered in trainings. 3. Includes a general focus on the competencies of peer support. 4. Is incorporated into a study guide or similar resource(s) that is provided between training and examination. <u>Development and Revision of Examinations</u> 1. Is led by certified peer workers to promote fidelity and reliability. 2. Involves collaboration with other state certification entities to encourage alignment and reciprocity. <u>Structure, Format, and Accommodations of Examinations</u> 1. Includes alternative testing methods such as vignettes, case studies, and scenario/roleplaying–based questions to encourage content application. 2. Provides multiple testing locations and virtual testing for individuals with limited transportation and individuals in rural communities. 3. Incorporates all accommodations outlined in Model Standard #8 (Diversity, Equity, Inclusion, and Accessibility 4. Offers multiple dates/times to take an examination throughout the year. 5. Allows individuals to retake an examination up to three times before they may be required to retake	<u>Content of Examinations</u> 1. Met 2. Met 3. Met 4. Met <u>Development and Revision of Examinations</u> 1. Met 2. Met <u>Structure, Format, and Accommodations of Examinations</u> 1. Currently the exam is multiple choice and taken virtually. 2. Met 3. Met: Presently the only format is in English and does not meet the requirements for multiple formats and languages. Captioning is available during training videos and Zoom. No information is provided in braille; however, special accommodations for people with disabilities can and have been requested/allowed from the MCB office. 4. Met 5. Met: Individuals can take the examination as many times as needed.

	certification training. ***Allowing peers who can provide proof of certification in another state to immediately sit for an examination, as the sole requirement for certification, is strongly encouraged.*	***Missouri does not currently allow proof of CPS training in another state to suffice for certification. We require a standardized training.*
Model Standard #4: Formal Education	<u>Formal Education</u> 1. In lieu of any formal educational requirements, prospective certified peer workers should be able to demonstrate literacy and fluency in the language in which they will be providing services, either through required examinations or other application requirements. 2. If a prospective certified peer is unable to demonstrate the literacy and/or fluency needed to complete the certification process, it is recommended that state certification entities provide a list of formal educational trainings/opportunities that may help them achieve certification. ***States should consider revisiting policies that require formal education of certified peer workers for reimbursement (e.g., third-party payors) and seek to incorporate parity across reimbursement standards and requirements for mental health, substance use, and family peers.*	<u>Formal Education</u> 1. Exceeds Standards 2. Exceeds Standards ***Due to the professional environments peers work in, and the rigorous standards to be upheld in regards to peer services and documentation of services, all Missouri peer certifications require verification of at minimum, High School level education.*
Model Standard #5: Supervised Work Experience	<u>Supervised Work Experience</u> 1. For state certification entities that currently institute a supervised work experience requirement, a maximum of 120 hours of supervised work experience should be required. 2. For state certification entities that institute a minimum requirement, any combination of paid, volunteer, virtual, and out-of-state hours should be accepted. 3. In cases where state certification entities do require supervised work experience, prospective certified peers should be provided with a list of vetted mental health, substance use, and/or family organizations that:	<u>Supervised Work Experience</u> 1. Met: Not Applicable (N/A); Missouri previously and currently does not require any supervised work experience to obtain a peer certification. 2. N/A (Met) 3. N/A (Met)

	• Offer opportunities for paid and/or volunteer supervised work experience, and, • Are able and prepared to provide reasonable accommodations according to the American with Disabilities Act (ADA) and Title 6 of the Civil Rights Act of 1964.	
Model Standard #6: Background Checks	<u>Background Checks</u> 1. Background checks be the responsibility of hiring organizations rather than part of the certification process. 2. In instances where a state certification entity chooses to obtain criminal background information on prospective certified peers, it is recommended that they: • Clearly outline potentially disqualifying offenses and include guidelines for time after which such offenses will no longer be considered. • Limit potentially disqualifying offenses to those that pose a risk to the people being served, and preclude or avoid mention of, investigation into, or required disclosure of misdemeanors, drug and alcohol-related crimes, nonviolent felonies, and similar offenses. • Utilize an initial process of self-disclosure that solely focuses on the identification of potentially disqualifying offenses. • Conduct background checks for confirmation purposes or where additional information is needed. • Review applications flagged for potentially disqualifying offenses on a case-by-case basis within 90 days of submission. • Incorporate a process that allows prospective certified peers to appeal disqualifications due to criminal offenses.	<u>Background Checks</u> 1. Met 2. Met

Model Standard #7: Recovery	<u>Recovery</u> Recovery pathway–specific requirements, including those that are abstinence-based, be excluded from certification requirements. Instead, state certification entities should allow hiring organizations to consider pathway-specific recommendations that meet the needs of the population(s) they serve.	<u>Recovery</u> Met
Model Standard #8: Diversity, Equity, Inclusion, and Accessibility	<u>Diversity, Equity, Inclusion, and Accessibility</u> <u>Training and Examination (Accessibility)</u> 1. Incorporate captioning, signed video materials, braille materials, interpreters, and other accommodations for people with disabilities. 2. Include alternative methods such as vignettes, videos, and scenario/role play components. 3. Offer multiple formats and languages. 4. Are provided at multiple locations and include remote/virtual options to promote equitable access and certification. 5. Offer multiple dates/times to take accessible trainings/ examinations throughout the year. 6. Allow for individuals to choose a different training entity if the original choice does not meet their accessibility needs or cannot do so. 7. Provide reasonable accommodations according to the Americans With Disabilities Act (ADA) and Title 6 of the Civil Rights Act of 1964. <u>Training and Examination (Content)</u> 1. Address antiracism, discrimination, privilege, implicit bias, and structural barriers. 2. Are designed and facilitated by individuals from diverse and under-represented populations. 3. Incorporate accessibility-specific trainings for peers who may work with protected populations.	<u>Diversity, Equity, Inclusion, and Accessibility</u> <u>Training and Examination (Accessibility)</u> 1. Met 2. Met for training; Not met for examination 3. Not met: Presently the only format is in English. 4. Met 5. Met 6. Met: Participants are allowed to change their proctor if the original selected proctor becomes unavailable 7. Met: Accommodations can be requested through the MCB office and have been allowed; such as, allowing the proctor to read the questions and potential answers to a visually impaired participant, etc. <u>Training and Examination (Content)</u> 1. Met 2. Met 3. To be completed by 6/30/24 4. To be completed by 6/30/24 5. To be completed by 6/30/24 <u>General Strategies</u> 1. Met (N/A) 2. Met

	4. Include content on cultural and structural competency and DEIA practice and implementation. 5. Include content on barriers to service access for marginalized groups. <u>General Strategies</u> 1. Recognize tribal sovereignty by establishing reciprocity where tribal nations may exist across state lines. 2. Target recruitment and promote pathways to certification for diverse and underrepresented populations. 3. Hire or contract with consultants and trainers from diverse and under-represented populations. 4. Offer scholarship programs in instances where certification cost (including testing and examinations) is a barrier. 5. Offer funding and scholarships where the cost of Communication Access Realtime Translation (CART), American Sign Language (ASL) interpretation, and other language accessibility solutions are a barrier to certification.	3. Met 4. Met when funding is available (example: Department of Social Services (DSS) sponsored a CPS training June 3-7, 2024 that is completely free to all that registered, as long as they meet certain requirements) 5. Met
Model Standard #9: Ethics	<u>Ethics</u> 1. State certification entities utilize an ethics committee made up of certified peer workers to develop a Code of Ethics or revise an existing one to ensure that the ethical guidelines are applicable to the peer role and are nonclinical in nature. 2. Prospective certified peers be required to read, sign, and adhere to a Peer Worker Code of Ethics. 3. State certification entities implement a publicly available, anonymous process for reporting an alleged breach of ethics by certified peer workers and hiring organizations. 4. State certification entities employ an impartial committee or board, made up of certified peer workers	<u>Ethics</u> 1. Met 2. Met 3. Not met: Missouri does not offer anonymous process for reporting an alleged breach of ethics. The process is the same for peers as it is for all other certifications/credentials issued by the MCB. 4. Met 5. Met 6. Met

	and unaffiliated with the certification entity, to review breaches of ethics and take appropriate action when necessary. 5. State certification entities provide continuing education on ethical standards annually. 6. Codes of Ethics include, but are not necessarily limited to, ethical standards that require agreement/attestation to: • The defined role, scope, and responsibilities of the peer • Maintaining personal and professional boundaries • Preventing conflicts of interest • Confidentiality • Mandated reporting	
Model Standard #10: Costs and Fees	<u>Costs and Fees</u> 1. State certification entities work with their state to find resources to subsidize all costs or fees for both certification and recertification. • Potential sources of funds might include, but not be limited to, state general revenues, SAMHSA's block grants (Substance Abuse Prevention and Treatment Block Grant/Mental Health Block Grant), other allowable formula or discretionary grant funding programs, other public and/or private sources. 2. State certification entities work with their state to find resources to subsidize all costs or fees associated with reasonable accommodations (e.g., CART, ASL interpretation and other disability or language access accommodations). 3. If costs are associated with a certification, state certification entities offer scholarships to any individuals who are unable to pay for their certification. 4. In cases where the above is not possible, or where revisions associated with these changes are in progress,	<u>Costs and Fees</u> 1. Met 2. Met 3. Met (example: special DSS sponsored CPS training) 4. Met

	state certification entities clearly outline the exact costs or fees associated with each of the following, if applicable: • General application fee • Trainings • Examinations • Total cost of certification • Total cost of recertification, including costs associated with any continuing education units (if applicable)	
Model Standard #11: Peer Supervision	<u>Peer Supervision</u> 1. State certification entities consider the development and implementation of a certification process for peer supervisors that includes the following characteristics: • State certification entities require that prospective certified peer supervisors have direct experience as a peer worker; relevant lived experience; and a deep understanding of the skills, values, and principles of the peer role. ○ Substance Use and Mental Health Peer Supervisor Certifications - State certification entities incorporate the core elements outlined in the five Pillars of Peer Support Supervision into certification requirements. ○ Family Peer Supervisor Certifications - State certification entities incorporate the core elements associated with resilience into certification requirements. • State certification entities require certified peer supervisors to receive training that includes, at a minimum, the recommendations outlined in Model Standard #2 (Training). • State certification entities incorporate the recommendations outlined in Model Standard #4	<u>Peer Supervision</u> 1. Not met: Missouri DMH encourages but does not require direct experience as a peer worker as a critical component of supervision of peer support. This is due to federal Centers for Medicare and Medicaid Services requirements for billing peer support services. The other components of Peer Supervision are met. 2. Met

	(Formal Education) into peer supervisor certifications. • State certification entities incorporate, at a minimum, the strategies outlined in Model Standard #8 (Diversity, Equity, Inclusion, and Accessibility) into peer supervisor certifications. • State certification entities require certified peer supervisors to adhere to a code of ethics that includes, at a minimum, the recommendations outlined in Model Standard #9 (Ethics). 2. State certification entities partner with hiring organizations and peer and family-run entities to develop and implement supervisor-specific career pathways for certified peer workers.	

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