Office of Recovery

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SAMHSA's National Model Standards for Peer Support Certification

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PREFACE

On March 1, 2022, President Biden announced his administration's strategy to address our national mental health crisis, outlined in the 2022 Presidential Unity Agenda. This national mental health strategy seeks to strengthen system capacity, connect more Americans to care, and create a continuum of support –transforming our health and social services infrastructure to address mental health holistically and equitably. Within this strategy, and with the primary goal of accelerating universal adoption, recognition, and integration of the peer mental health workforce across all elements of the healthcare system, President Biden proposed the development and implementation of a national certification program for mental health peer specialists[1]. To meet this goal, SAMHSA collaborated with federal, state, tribal, and local partners to develop the National Model Standards for Peer Support Certification, inclusive of mental health, substance use, and family/youth peer certifications. These National Model Standards closely align with the needs of the behavioral health (peer) workforce, and subsequently, the over-arching goal of the national mental health strategy.

SAMHSA acknowledges the nuances of both the peer workforce and the communities they serve, as states often reflect the needs of their communities within their certification(s). Further, SAMHSA's National Model Standards for Peer Support Certification are not intended as a substitute for any state certifications and have instead been developed as guidance for states, territories, tribes, and others, to promote quality and encourage alignment and reciprocity across often disparate state peer support certifications. Since the 2015 release of the SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services[2], the peer workforce has flourished, resulting in the implementation of state-endorsed or state-run peer certifications across 49 out of 50 states[3]. The National Model Standards will continue 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, and implemented by our state, local, and tribal partners.

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Overview

SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services describes peer support as "offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations." The terms 'peer supporter', 'peer worker', and 'peer specialist' are interchangeably used to describe a person (including family, friends, and loved ones) with lived/living* experience involving problematic mental health and/or substance use conditions, and who engages in a wide range of activities, including advocacy, linkage to resources, sharing of experience, social support, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. Across the United States, various other terms such as recovery coach, mentor, peer provider, or peer navigator are used to describe peer workers. In the context of this document, the term 'peer worker' will be used to generally describe someone working in a peer support role (both certified & non-certified, unless specifically noted). A peer worker who is in the process of seeking certification will be referred to as a 'prospective certified peer worker', and those who have completed certification or credentialing will be referred to as a 'certified peer worker'. An

organization that is tasked with/approved to oversee all or part of the peer certification process for a state will be referred to as a 'state certification entity'**. Examples of entity types include, but are not limited to state agencies, state certification boards, and third parties (including private/nonprofit agencies).

** See 'Model Standard #1: Authenticity & Lived Experience' for more information on lived and living experience.*

*** Many states work or contract with multiple organizations/entities on certification. For example, some states may incorporate trainings through one entity, while required examination(s) may be led by another.*

What is a peer support certification and why does it matter?

For the purposes of this document, peer support certification refers to "the process required to obtain an official document which attests that an individual has the skills and knowledge required for the peer support services profession. The document is issued by an authorized body which is recognized by the state, district, tribal, or territorial behavioral health authority where an individual may provide substance use or mental health peer support services[1]." Certification processes for peer workers offer a range of benefits to the peer workforce, their employers, and the individuals being served. Employers and the public may feel more confident in the services being provided by certified peer workers. Certification often assists peer workers with finding paid positions, and in some cases allows employing organizations to bill Medicaid, Medicare, private insurers, and third-party payors for services that are provided by a certified peer worker. Furthermore, studies suggest that training and certification may enhance recovery outcomes for both certified peers and the people being served, and 60% of respondents in one study reported transitioning off or reducing public assistance while working as a certified peer worker[4]. Certifications are generally based on standards that clarify and set requirements for training, experience, and other requisite qualifications.

What are the different types of certifications?

Peer certifications are typically developed and implemented based upon the type of lived experience of the peer worker and the person receiving their services. Within the National Model Standards for Peer Support Certification, three (3) specific types of peer certification are recognized. However, it is important to note that some states and their corresponding certification entities may effectively utilize the same certification process for more than one type of certification. Commonly through a combination of mental health and substance use, this type of certification is routinely referred to as 'integrated'. While the national model standards emphasize similarities across these certification types, there may be instances where key distinctions are made between the following:

- Mental Health Peer Certifications
- Substance Use Peer Certifications
- Family & Youth Peer Certifications

** Please note that all references to mental health and substance use peer certification pertain to adult-only services.*

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What is a National Model Standard?

In the context of this document, the term 'National Model Standard' is defined as a distinct certification criterion that:

1. Promotes quality of and consistency across peer services
2. Limits barriers to expanding the peer workforce
3. Is based upon guidance from the peer workforce
4. Is based upon existing practices utilized by state certification entities*

** Applies to both state and territorial certification entities*

PROCESS

How were the National Model Standards Developed?

In the fall of 2022, SAMHSA's Office of Recovery (OR) was tasked with the development of the National Model Standards. The OR, in partnership with federal, state, tribal, and local expert partners across the peer workforce, oversaw five (5) critical phases in the development of the standards:

1. Updating the Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States[3], in partnership with SAMHSA's Peer Recovery Center of Excellence.
2. Convening a diverse set of technical experts with a range of identities, lived experience, and professional expertise to develop a framework and key considerations for the National Model Standards (titled 'SAMHSA's Technical Expert Panel on Peer Support Certification', or TEP for short).
3. Utilizing the TEP framework, Comparative Analysis of State Requirements, various state certifications, and other resources such as SAMHSA' Core Competencies for Peer Workers to draft the standards.
4. Employing a public comment process to solicit and incorporate additional feedback and expertise from the peer workforce.
5. Publishing the National Model Standards for Peer Support Certification.

Several distinct steps were integral to defining and developing each National Model Standard. These steps include:

1. **Identify a Domain**: domains that are *critical* to the peer workforce and *common* across mental health, substance use, and family/youth peer support certifications were identified. A domain was determined as **critical to the peer workforce** via discussion with local, state, and federal expert partners, and **common across multiple certifications** via analysis of resources, including the Comparative Analysis of State requirements and various state certifications for peer workers. Only domains that were identified as both critical and common were included for consideration. An example of an identified domain meeting these requirements is the general significance of *lived experience* to the peer workforce and across peer certifications.

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2. **Develop a Model Standard**: for each identified domain, a distinct criterion (or set of criteria) was developed that is based on existing (certification) requirements and has been identified through a collaborative process as being widely accepted, effective, and adaptable across state peer support certifications. Each standard was written based upon the needs of *a) the peer workforce* and *b) the people that the peer workforce serves*. Over the course of several days, the TEP identified key considerations for each domain through a series of activities and discussions. These key considerations, along with various other resources, were then utilized to draft each standard. A recommendation that certified peer workers have relevant lived experience based upon the needs of the population they serve (e.g., mental health, substance use, family & youth) would be a broader example of this.

What are some key applications and objectives for the National Model Standards?

As noted in the preface section of this document, the National Model Standards for Peer Support Certification were created to accelerate universal adoption, recognition, and integration of the peer workforce across all elements of the healthcare system. In discussions with TEP, an additional set of key applications and objectives were identified to help guide both the development and usage of the standards. It is our hope that SAMHSA's National Model Standards for Peer Support Certification will:

1. **Encourage reciprocity** and partnership between state certification entities.
2. **Promote quality** of peer services being delivered across the country.
3. **Protect the authenticity** of peers through promotion of and emphasis on lived and living experience.
4. **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.
5. **Expand and support the peer workforce** by elevating the profession & bringing national attention to the critical services they provide.
6. **Reinforce the scope** of the peer role through distinct certification criteria.
7. **Strengthen diversity, equity, inclusion, and accessibility (DEIA)** efforts across the peer workforce.
8. **Establish** career pathways for peer workers and peer supervisors

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Model Standard #1: Authenticity & Lived Experience

> **"People with lived experience must be front and center in the creation, development, and adoption of (peer certification) standards - at federal, state, and local level."**
>
> **"Nothing about us without us—centering the lived experience of peers."**
>
> -TEP Members on maintaining authenticity in peer support

Overview

The term *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[5]." In the context of this document, *lived experience* specifically refers to those directly affected by social, health, public health, or other issues associated with mental health and/or substance use conditions (including family members, caregivers, and youth), and whom have experience with the strategies that aim to address associated challenges[6,7]. The term *lived experience* typically suggests a past connotation involving challenges related to a mental health and/or substance use condition, while the term *living experience* often refers to those presently encountering these same challenges. However, issues related to mental health and/or substance use may resurface throughout one's life, and some individuals may better relate to the term living experience despite identifying as being in recovery. In the context of this document, *lived experience* will refer to both current and former challenges related to mental health/substance unless specifically noted *.

SAMHSA, in discussions with the TEP, confirmed that lived experience is a critical component of the peer role, and should be addressed in all mental health, substance use, and family & youth peer certifications. Furthermore, SAMHSA determined that people with lived experience, including those in the peer workforce, should be meaningfully involved in the development, adoption, and revision of national, state, and local peer certifications. Through collaboration with our expert partners and analysis of various resources, and in keeping with SAMHSA's working definition of recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential", the following National Model Standard on Authenticity and Lived Experience was developed.

Recommended Standard

SAMHSA's National Model Standard on Authenticity & Lived Experience recommends that state certification entities incorporate the following requisites on lived experience:

- A prospective certified mental health/substance use peer worker should be able to self-attest their personal experience related to a mental health and/or substance use condition *, either standalone or co-occurring, and describe strategies utilized to address associated challenges.

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- A prospective certified family & youth peer worker should be able to self-attest their personal experience related to a family member's or loved one's mental health and/or substance use condition, and describe strategies utilized to address challenges associated with their family member/loved one's condition.

** SAMHSA's national model standard on authenticity and lived experience acknowledges the existence of multiple pathways of recovery. SAMHSA also recognizes that people with both lived and living experience are critical components of the peer workforce when embedded in the appropriate setting, role, or organization (e.g., harm reduction organizations). For additional information on recovery pathways, please see Standard #8: Recovery.*

Model Standard #2: Training

Overview

Training has been identified as a being critical to peer workforce and a common requirement across peer certifications. In discussions with our expert partners, several parameters for defining a model standard on training were identified. These include *1) the quantity of training (hours)* and *2) content within the training(s)*. It acknowledged that training requirements, including the length and content, should promote a high-level of quality of peer services while attempting to limit barriers that prospective certified peers may encounter when seeking certification. It was also recommended that state certification entities contract with peer run organizations and people with lived experience in the development and provision of any required training(s). While a wide variation in the quantity of training exists (ranging from <25 to 480 hours), there is some commonality across certifications. Most state certifications require between 40 and 46 hours of training for individual's seeking certification and include a wide variety of topics that are integral to providing peer services. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Training was developed.

Recommended Standard

SAMHSA's National Model Standard on Training, recommends that:

- **Quantity of Training Hours** (applies to mental health, substance use, and family & youth peer certifications)
  - Trainings requirements range from 35 to 55 hours. This amount encompasses the common range identified across peer certification programs (40-46 hours) and was considered by expert partners as a quantity that promotes quality services while limiting potential barriers of prospective certified peers.

- **Content of Training(s)** (variation across mental health, substance use, and family & youth certifications may occur)
  - People with lived experience play a leading role in the design, application, and revision of peer certification trainings.
  - Include principles outlined in SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services

- Cross-cutting and population-specific content areas for mental health, substance use, and family & youth peer certification trainings, identified in conjunction with expert partners with lived and professional experience, include:

Cross-Cutting Content Areas *

- Role, scope, & purpose of peers
- Values & principles of peer support & recovery**
- Recovery resources & tools** (local, state, national)
- Self-help/mutual support groups
- Navigating community resources (e.g., employment)
- Legal systems and resources
- Diversity, Equity, Inclusion, and Accessibility (DEIA)***
- Computer & digital health literacy
- Ethical responsibilities
- Communication and group skills (e.g., storytelling)
- Self and system advocacy and reducing stigma
- Crisis management
- Trauma-informed approaches
- Co-occurring disorders & disabilities
- Self-determination & choice

Population-Specific Content Areas *

Mental health

- Overview of mental disorders & associated services
- Mental health awareness trainings
- Basic information of medications used for mental health treatment

Family and Youth

- Child welfare systems & social service
- Parenting skills
- Family relationship building

Substance use

- Basic information on medications used for addiction treatment
- Harm reduction
- Overdose prevention/overdose reversal

** Exact breadth and content may differ across mental health, substance use, and family & youth peer certifications, and population-specific content areas are not necessarily mutually exclusive in nature. For example, a mental health peer certification may include more extensive content on mental disorders and associated services compared to its substance use counterpart. Similarly, a family & youth certification may incorporate additional topics or content related to child welfare & social services, but still include a broader focus on harm reduction services. Please note that other important content areas for training may exist, and this list may not be exhaustive in nature.*

*** Please see SAMHSA's Core Competencies for Peer Workers in Behavioral Health Services for more information*

**** Please see Model Standard #8 (Diversity, Equity, Inclusion, & Accessibility) for additional information on DEIA-specific content areas*

Model Standard #3: Examinations

Overview

Forty-eight (48) state certifications incorporate either written or written & oral examinations into their requirements. Frequently the last step following mandatory trainings, examinations provide an opportunity for prospective certified peers to demonstrate core competencies and reveal a working knowledge of the peer support role. Through discussions with expert partners and analysis of various resources, a list of key considerations was developed, leading to the following National Model Standard on Examinations.

Recommended Standard

SAMHSA's National Model Standard on Examinations* recommends that:

- **Content** (of examinations):
  - relates directly to and is appropriately based on the peer role (mental health, substance use, family & youth).
  - only reflects information explicitly covered in trainings.
  - Includes a general focus on the competencies of peer support.

- **Accommodations** (for examinations):
  - incorporate oral exams, braille exams, interpreters, and other accommodations for people with disabilities.
  - include alternative language versions or interpreters for people whose first language is not English.

- **Development & Revision** (of examinations):
  - is led by certified peer workers to promote fidelity and reliability.
  - involves collaboration with other state certification entities to encourage alignment and reciprocity.

- **Format** (of examinations):
  - offers alternative testing methods such as vignettes, case studies, and scenario/role-playing based questions to encourage content application.
  - provides multiple testing locations and remote testing for individuals with limited transportation and individuals in rural communities
  - allows individuals to re-take an examination as many times as needed with minimal delay
  - offers multiple dates/times to take an examination throughout the year

** Allowing peers who can provide proof of certification in another state to take an examination as the sole requirement for certification is a strongly encouraged.*

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Model Standard #4: Formal Education

Overview

In the context of this document, the term 'education' refers to formal, structured teachings that occur through an academic institution and follow an official curriculum, not inclusive of any structured training(s) a prospective certified peer worker may complete as part of their certification. High school diplomas or GEDs are a common formal educational requirement, and many state Medicaid programs integrate these prerequisites for billing/reimbursement purposes. It is important to note however that not all state certification entities require formal educations, and these were identified as common barriers for the peer workforce and the organizations seeking to hire certified peer workers (and subsequently bill for services provided by them). Apart from promoting general literacy and fluency, formal educational requirements appear to have a limited positive impact on the peer workforce, and alternative pathways to meet these requirements were identified as a critical strategy to expanding the peer workforce. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Formal Education was developed.

Recommended Standard

SAMHSA's National Model Standard on Education recommends that*:

- In lieu of any formal educational requirements, prospective certified peer workers should be able to demonstrate general literacy and fluency in the language in which they will be providing services, either through required examinations or other application requirements. If a prospective certified peer is unable to demonstrate literacy and/or fluency while applying for certification, it is recommended that a formal training and subsequent examination be offered in lieu of denial from a certification.

** States may wish to revisit & revise policies that require formal educations for reimbursement (e.g., third-party payors) and seek to incorporate parity across reimbursement standards & requirements for mental health, substance use, and family & youth peers.*

Model Standard #5: Work Experience

Overview

Paid or volunteer work experience was identified as a requirement across 22 out of the 55 state peer certifications via the Comparative Analysis of State Requirements. A wide range of required hours was also noted, with four (4) state certifications requiring less than 200 hours, 11 requiring 500 hours, and 3 requiring 2000 hours. Conversely, 31 state certifications do not require work experience at all. In discussions with expert partners, required work experience was identified as a potential barrier for prospective certified peers, which can inhibit the growth of the peer workforce. Additionally, it was determined that trainings and examinations are an accurate instrument for promoting quality of services and competency across the peer workforce. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Work Experience was developed.

Recommended Standard

SAMHSA's National Model Standard on Work Experience recommends that:

- Work experience requirements range from 0 hours to 120 hours of paid and/or volunteer work. In cases where state certification entities do require work experience, it is recommended that prospective certified peers be provided with a list of vetted and approved mental health, substance use, and/or family & youth organizations offering paid experience for peers seeking certification, and both paid and volunteer work are accepted to meet these requirements.

Model Standard #6: Background Checks

Overview

Many people who experience a mental health and/or substance use condition find themselves involved in the criminal justice system (e.g., probation, incarceration, diversion courts, parole). While these are often thought of as the main consequences following arrest and conviction, justice-involvement may result in other lasting effects on the individual—including ramifications stemming from permanent convictions such as difficulty finding employment and housing. With the current mental health and substance use crisis facing the nation, it is important to note that 44% of those in jail and 37% of those in prison have a mental illness[8], while 63% of people in jail and 58% in prison have a substance use disorder[9]. Peer support plays a critical role in promoting recovery and reducing recidivism across these populations[8].

36 peer certifications were identified as having no background check requirements, 10 were identified as requiring background checks, and five (5) were identified as requiring self-disclosure of arrests and/or convictions[3]. Across the 15 certifications that require either a background check or self-disclosure, varying levels of response were noted, depending on the nature and severity of the charge, and resulting in either a case-by-case review (4), permanent automatic disqualification (9), and temporary automatic disqualification (2). For example, disqualifying offenses for both mental health and substance use peer certifications in one state ranged from class A misdemeanor alcohol or drug offenses during the five years preceding the date of application, to lifetime convictions of sexual offences involving a child. As such, background checks and related requirements have been identified as a key area of concern across the peer certification landscape, and wide range of often disparate disqualifying offenses can make obtaining certification difficult for many well-qualified, ethical, and law-abiding peer workers. While in some cases, background checks may protect vulnerable populations from being exploited, they may also act as barriers to peers that bring a unique and valuable lived experience. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Background Checks was developed.

Recommended Standard

SAMHSA's National Model Standard on Background Checks recommends that:

- Background checks be the responsibility of hiring organizations rather than part of the certification process.

- In instances where a state certification entity chooses to obtain criminal background information on prospective certified peers *, it is recommended that they:

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1. Clearly outline potentially disqualifying offenses
2. Limit potentially disqualifying offenses to those that pose a risk to the people being served. **
3. Utilize an initial process of self-disclosure that solely focuses on the identification of potentially disqualifying offenses.
4. Conduct background checks for confirmation purposes or where additional information is needed.
5. Review applications flagged for potentially disqualifying offenses on a case-by-case basis.

** Particularly for peers that may serve critically vulnerable populations (e.g., youth)*

*** Examples of offenses that may pose a risk include but are not necessarily limited to crimes against children, crimes involving sexual violence, and other forcible felonies. SAMHSA recommends that any mention of, investigation into, or required disclosure of drug & alcohol related crimes, non-violent felonies, and similar offenses be excluded from the mental health & substance use peer certification process.*

Model Standard #7: Recovery

Overview

As noted in Standard #1 (*Authenticity & Lived Experience*), recovery associated with a mental health and/or substance use condition is a common and critical component of lived experience across the peer workforce. The term 'abstinence' or 'abstinence-based recovery' describes a traditional view on recovery typically involving a process of change that involves refraining from the use of all mood or mind-altering substances. This has been interpreted over the years to include some medications used in the treatment of mental health and substance use conditions. While abstinence may be a pathway for some, SAMHSA recognizes and supports the existence of multiple pathways of recovery, and in turn supports a peer workforce that reflects the varying needs and diverse makeup of the populations being served. In discussions with our expert partners, recovery pathway-specific requirements for peer certification were identified as a potential barrier to expanding and strengthening the peer workforce, and only two (2) state certifications were identified as having abstinence-specific requirements for prospective certified peers[3]. Through collaboration with our expert partners and analysis of various resources and staying consistent with SAMHSA's working definition of recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential", the following National Model Standard on Recovery was developed.

Recommended Standard

SAMHSA's National Model Standard on Recovery* recommends that:

- Recovery pathway-specific requirements, including those that are abstinence-based, be excluded from certification requirements. Instead, hiring organizations should consider pathway-specific recommendations that meet the needs of the population(s) they serve.

** SAMHSA's national model standard on authenticity and lived experience acknowledges the existence of multiple pathways of recovery. SAMHSA also recognizes that people with both lived and living experience are critical components of the peer workforce when embedded in the appropriate setting or organization (e.g., harm reduction organizations). To learn more about SAMHSA's harm reduction work, please visit https://www.samhsa.gov/find-help/harm-reduction.*

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Model Standard #8: Diversity, Equity, Inclusion, and Accessibility

Overview

DEIA in Action*

The Wisconsin Peer Specialist Employment Initiative offers "community-specific Certified Peer Specialist trainings available to people throughout the state with specific cultural identities and lived experiences that experience systemic marginalization or are under-represented in the workforce." Additional services supported through this initiative include networking gatherings, professional development offerings, and exam study supports specific to Black, Indigenous, and people of color (BIPOC) current or aspiring Certified Peer Specialists and Certified Parent Peer Specialists[6].

Strategies and principles for incorporating diversity, equity, inclusion, and accessibility (DEIA) into peer support certification have been identified as a critical need of the peer workforce. DEIA is a cross-cutting standard that can be incorporated across peer certification requirements (e.g., training & examinations), general strategies utilized by state certification entities, and practice competencies used by individual peers. With a primary focus on protecting and uplifting both under-resourced and under-represented populations through behavioral health equity strategies, some key populations that benefit from DEIA include Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer/questioning and intersex (LGBTQI+) persons; veterans; persons with disabilities; older adults; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Diversity, Equity, Inclusion, and Accessibility (DEIA) was developed.

** SAMHSA does not endorse any specific state or national peer certifications. Instead, this example is being offered to showcase how state certifications incorporate DEIA initiatives.*

Recommended Standard

SAMHSA's National Model Standard on Diversity, Equity, Inclusion, and Accessibility recommends the following strategies for incorporating DEIA across peer certifications:

Incorporating Diversity, Equity, Inclusion, & Accessibility (DEIA)*

Training & Examinations

- Include content on cultural & structural competency and DEIA practice
- Cover anti-racism, discrimination, privilege, implicit bias, and other content areas on DEIA response
- Are offered in multiple formats & languages
- Are designed and facilitated by individuals from diverse and under-represented populations.

State Certification Entities

- Recognize tribal sovereignty by establishing reciprocity where tribal nations may exist across state lines
- Target recruitment and promote pathways to certification for diverse and under-represented populations.
- Hire or contract with consultants and trainers from diverse and under-represented populations.
- Offer scholarship programs in instances where certification cost is a barrier.

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Model Standard #9: Ethics

Overview

Peer Worker Codes of Ethics in Peer Support Certifications*
• Wisconsin Certified Peer Specialist Code of Ethics: https://dhs.wisconsin.gov/publications/p00972a.pdf • California Mental Health Services Authority Code of Ethics: https://www.capeercertification.org/code-of-ethics/ • National Federation of Families Code of Ethics: https://www.ffcmh.org/certification-cfps-code-of-ethics • National Practice Guidelines for Peer Supporters: https://www.peersupportworks.org/resources/national-practice-guidelines/) • NAADAC's National Certified Peer Recovery Support Specialist (NCPRSS) Code of Ethics: www.naadac.org/assets/2416/nccap-peer-recovery-support-specialist-code-of-ethics-final06-22-16.pdf)

Ethical standards elevate the quality of services, and in turn the well-being of the people being served by the peer workforce. Often in the form of a Code of Ethics or Code of Ethical Conduct, these guidelines are a common component of national and state peer certifications, with prospective certified peers frequently being required to review, sign, and adhere to a Code of Ethics to obtain and maintain their certification. Some examples of Codes of Ethics across national and state certification entities are represented in the table to the above. In discussions with expert partners, a Code of Ethics was identified as critical for peer workers and the people they serve. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Ethics was developed.

** Please note that state certification entities commonly partner with national organizations on various certification requirements, including but not limited to trainings, examinations, and ethical standards. SAMHSA does not endorse any specific state or national peer certifications. Instead, these examples are being offered to showcase how state certifications may incorporate a Code of Ethics.*

Recommended Standard

SAMHSA's National Model Standard on Ethics recommends that*:

- Prospective certified peers be required to read, sign, and adhere to a Peer Worker Code of Ethics.
- State certification entities implement a publicly available, anonymous process for reporting an alleged breach of ethics.
- State certification entities employ an impartial committee or board to review breaches of ethics.
- State certification entities provide continuing education on ethical standards every 3 years.
- 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

** As outlined in Model Standard #2 (Training), detailed training content on ethics, including ethical dilemmas such as dual relationships, is strongly encouraged.*

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Model Standard #10: Costs & Fees

Overview

Fees associated with application, trainings, examinations, and recertification have been identified as significant barriers to the certification of the peer workforce. 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. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Costs & Fees was developed.

Recommended Standard

SAMHSA's National Model Standard on Costs & Fees recommends that:

- State certification entities work with their state to find resources to subsidize all costs or fees.
  - Potential sources of funds might include but not be limited to state general revenues, SAMHSA's block grants (SUBG/MHBG), other formula or discretionary grant funding programs, other public and/or private sources.

- If costs are associated with a certification, state certification entities offer scholarship opportunities to individuals with limited resources.

- In cases where the above is not possible, or where revisions associated with these changes are in progress, state certification entities clearly outline the exact costs or fees associated with each of the following, if applicable:
  - General application fee
  - Trainings
  - Examinations
  - Recertification, including costs associated with any Continuing Education Units (if applicable) *
  - Total cost of certification

** SAMHSA strongly encourages that costs associated with re-certification be integrated into general application fees.*

Model Standard #11: Peer Supervision

Overview

Supervision is a professional and collaborative activity between a supervisor and a worker in which the supervisor provides feedback and guidance to support a worker's performance. This promotes competent and ethical delivery of services and the continued development and growth of a worker's abilities, knowledge, skills, and values[17]. Although supervision is not necessarily a component of the general certification process for peer workers, supervision has been identified as a vital component

to the re-certification process, and an important operating standard for the peer workforce. In 2014, the Pillars of Peer Support Supervision were developed, with five pillars emerging from an ongoing series between SAMHSA, the National Association of State Mental Health Program Directors, and other expert partners. It was determined that those taking on supervision tasks should have a deep understanding of the nature of peer practice, knowledge of the peer worker's role and of the principles and philosophy of recovery, and familiarity with the code of ethics for peer workers in the state[18]. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Peer Supervision* was developed.

** SAMHSA's National Model Standard on Supervision has been specifically written for, and only applies to, peer supervisor certifications.*

Recommended Standard

SAMHSA's National Model Standard on Supervision recommends that:

- State certification entities incorporate the core elements outlined in the 5 Pillars of Peer Support Supervision into certification requirements.
- In addition to any supervisor-specific training requirements, state certification entities require prospective certified peer supervisors have direct experience as a certified peer worker.
- Prospective certified peer supervisors have experience as a certified peer worker and a deep knowledge of the skills needed to work as certified peer worker.
- State certification entities incorporate the following requirements on lived experience for prospective certified peer support supervisors:
    - A prospective certified mental health/substance use peer supervisor can self-attest their personal experience related to a mental health and/or substance use condition*, either standalone or co-occurring, and describe strategies utilized to address associated challenges.
    - A prospective certified family & youth peer supervisor can self-attest their personal experience related to a family member or loved one's mental health and/or substance use condition, and describe strategies utilized to address challenges associated with their family member/loved one's condition.

** Resources to help supervisors understand the role of peer workers and how to supervise peer workers in the behavioral health settings are available able at SAMHSA's webpage Bringing Recovery Supports to Scale Technical Assistance Strategy Spotlight for Supervision of Peers.*

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REVISIONS AND RECIPROCITY

Strategies to Expand Reciprocity
1. Establish reciprocity boards or committees within the entity or organization(s) that is tasked with the certification process.
2. Create an interstate compact or other binding document that can be used to establish reciprocity between states.
3. Connect with a national reciprocity organization to discuss strategies for implementing reciprocity.
4. Develop a simple certification process for peer workers that are certified in another state. An example of this could be requiring a peer worker to submit documentation showing out-of-state certification, and then allowing that peer worker to sit for an examination that demonstrates competency.

SAMHSA strongly encourages that states utilize this document to revise, strengthen, and align their peer support certifications. It is important to emphasize that each state certification brings its own unique set of strengths and challenges, and SAMHSA is confident that the (certification) processes being utilized across the United States are developing strong, committed, and knowledgeable certified peer workers. It is for this reason that SAMHSA is recommending that state certification entities strengthen collaboration efforts and implement additional processes for expanding reciprocity. A few potential strategies were identified for doing so and are outlined in the table above. Additionally, a set of guiding questions (below) were developed for state certification entities to consider during revisions and when exploring strategies for increasing reciprocity and expanding the peer workforce.

Guiding Questions for Revising Peer Certifications
1. Does our certification ensure that prospective certified peers have lived or living experience that aligns with the population(s) they may serve upon certification?
2. Barring any formal education requirements, how can prospective certified peers demonstrate literacy and fluency in the language in which they will be serving?
3. Does a prospective certified peer already have professional experience working as a certified peer in another state? If so, what process(es) can we take to expedite/transfer their certification?
4. If a prospective certified peer does not have any experience working as a certified peer worker, what core trainings are critical to their success? And can they be successful without any work experience?
5. Does our certification train peer workers on DEIA? And similarly, how does our certification incorporate DEIA principles for expanding the peer workforce?
6. After the completion of any training requirements, what examination process would limit barriers and what content can be used to determine competency and expand accessibility?
7. Will a background check pose a barrier to expanding the peer workforce in my state? Conversely, does the lack of a background check put any special populations (e.g., youth) at risk?
8. How can we collaborate with other state certification entities to write or adopt an examination that can be used when certified peers move? And what steps can we take to process an interstate compact?
9. Are there any tribal nations that share a border between our state and another's? If so, how can we ensure that tribal peer workers can provide services across their tribe?
10. Are there any other parts of our certification process that may be barriers to expanding the peer workforce and certifying qualified peer workers?

CONCLUSION

Over the course of the development of the National Model Standards for Peer Support Certification, SAMHSA reviewed dozens of documents and engaged with hundreds of subject matter experts with varying types and levels of lived experience and professional peer support expertise. The analysis and collaboration processes have yielded critical information about the peer workforce and current state of peer certification, resulting in a product that seeks to draw attention to and create parity across certification requirements. In conclusion, SAMHSA strongly believes that the standards and strategies outlined in this document will benefit state certification entities, the peer workforce, and the people being served. As the mental health and substance use crisis evolves, new challenges related to mental health, substance use, and family & youth peer certification and practice will emerge, making innovation and collaboration across federal, state, and local partners even more critical. The Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, and United States Government remain committed to supporting these efforts, and most importantly—the peer workforce that is leading the way.

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Exhibit A—SAMHSA's Technical Expert Panel on Peer Support Certification

JASON ROBISON	Emotional Health Association/SHARE!	Chief Program Officer
JONATHAN P. EDWARDS	New York City Department of Health and Mental Hygiene	Program Consultant
MARK MCDONALD	Ozark Center New Directions and the Missouri Credentialing Board	counselor, supervisor, board member
LISA ST GEORGE	RI International	Vice President of Peer Support and Empowerment
MOLLY WELCH MARAHAR	Michigan Department of Health & Human Services	Manager, Strategic Alignment & Engagement
RUTH RIDDICK	ASAP-New York Certification Board	Communications, Training & Peer Recovery SME
CHERENE CARACO	Promise Resource Network	CEO
STACY CHARPENTIER	CCAR	Director of Training
KERIS MYRICK	Inseparable	VP partnerships
NOAH ABDENOUR	Texas HHSC	Director of Peer Support and Recovery
KELLY DAVIS	Mental Health America	Associate Vice President of Peer and Youth Advocacy
ERIC SCHARF	Depression and Bipolar Support Alliance	Federal Advocacy Advisor
ALEXIA WOLF	Office of Lt. Governor Bethany Hall-Long	Behavioral Health Consortium Director
KYNETA LEE	Copeland Center for Wellness and Recovery	National Director of Peer Training
DR. KAREN KANGAS	Hartford Healthcare	Director of Recovery and Family Affairs
ANNETTE HUBBARD	Ninilchik Traditional Council	Case manager/peer support
ARC TELOS SAINT AMOUR (TAY)	Youth MOVE National	Executive Director
SUE SMITH	Georgia Parent Support Network	CEO
CINDY HERRICK	2020 Mom (Soon to be The Policy Center for Maternal Mental Health)	Special Projects & Peer Support Lead
AMY SMITH	Health Solutions, Pueblo, Colorado	peer specialist
CHERYLE PACAPELLI	Harbor Care	Project Director FO Peer Recovery Support Services
JOSEPH ROGERS	National Mental Health Consumer's Self Help Clearinghouse	CEO
CLARENCE JORDAN	Beacon Health Options	VP Wellness and Recovery
ELIZABETH BURDEN	National Council for Mental Wellbeing	Senior Advisor
ADAM VIERA	Peer Recovery Center of Excellence	Co-Director
LYNDA GARGAN	National Federation of Families	Executive Director
RITA CRONISE	Rutgers University	Coordinator, Academy of Peer Services
MARK BLACKWELL	Virginia DBHDS	Director, Office of Recovery Services
MILLIE SWEENEY	Family-Run Executive Director Leadership Association (FREDLA)	Director, Learning and Workforce Development
ERIC MARTIN	MHACBO; MetroPlus Association of Addiction Peer Professionals	Director
KIMBERLY GOVAK	Faces and Voices of Recovery	Program Manager
JESSE WYSOCKI	The Mcshin Foundation	Chief Operating Officer
ANTHONY FOX	Tennessee Mental Health Consumers' Association	CEO
TERI BRISTER	NAMI - National Alliance on Mental Illness	Chief Program Officer

KRISTINA PADILLA	California Consortium of Addiction Programs and Professionals (CCAPP)	Vice President of Education and Strategic Development
PETER GAUMOND	Office of National Drug Control Policy	Senior Policy Analyst
MIRNA HERRERA	University Health	Peer Manager/ Certification trainer
KHATERA ASLAMI TAMPLEN	Alameda County Behavioral Health	Office of Peer Support Services Manager
ELSA ROMAN	SAN ANTONIO CLUBHOUSE	Peer Support Supervisor
MARK A JENKINS	Connecticut Harm Reduction Alliance	Executive Director
JOE POWELL	APAA - Association of Persons Affected by Addiction	President/CEO
REBECCA GLOVER-KUDON	Centers for Disease Control and Prevention (CDC), Division of Overdose Prevention	Behavioral Scientist
AMY BRINKLEY	National Association of State Mental Health Program Directors	Recovery Support Systems Coordinator
AMY FARRINGTON	Florida Certification Board/National Certification Board for Behavioral Health Professionals	Director of Certification
DANA FOGLESONG	National Association of Peer Supporters	Immediate-Past President, Board of Directors
JESSE HEFFERNAN	Helios Recovery Services LLC	Co-Owner / Consultant / Trainer
MIRANDA GALI	Centers for Disease Control - Division of Overdose Prevention	Public Health Analyst/PMF Fellow
MARK ATTANASI	IC&RC	Executive Director
JUDITH DEY	HHS/OS/ASPE	Economist
PAM WERNER	Michigan Department of Health and Human Services, Bureau of Specialty Behavioral Health	Manager of Peer Services
PATSY CUNNINGHAM	HRSA	HRSA Behavioral Health Advisor
ANN HERBST	Young People in Recovery	Executive Director
LISA KEARNEY	U.S Department of Veterans Affairs (VA)	Senior Advisor for Health to the Secretary
PATRICIA J. SWEENEY, PSY.D.	Veterans' Health Administration (VHA), Department of Veterans Affairs	National Director of Peer Support Services, VHA Office of Mental Health and Suicide Prevention
CYNTHIA MORENO TUOHY	NAADAC, the Association for Addiction Professionals	Executive Director
MARK ATTANASI	International Certification & Reciprocity Consortium	Executives Director
CHRISTINA RAMSEY	HRSA	Public Health Analyst/ Project Officer
NICOLE M. WILKERSON	HRSA	Management Analyst / Project Officer
ANDREA KNOX	HRSA	Acting Team Lead/Public Health Analyst
KAREN A SCOTT	Foundation for Opioid Response Efforts	President
JANE ADAMS	Keys for Recovery	Executive Director
CYNTHIA GUNDERSON	Indian Health Service	Vice Chair, National Committee on Heroin, Opioids, and Pain Efforts (HOPE)

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