NEBRASKA PEER SUPPORT CERTIFICATION STUDY

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SECTION 1: STUDY OVERVIEW AND METHODS

To improve the lives of people with behavioral health challenges, Nebraska has invested resources in developing and providing peer support services (services provided by "persons with lived experience with a behavioral health condition" to support other consumers). These services include both adult peer support and family peer support. The state is justified in funding these services since peer support services have been demonstrated to be effective in improving the lives of persons with mental health and substance abuse challenges. To ensure peer support services are high quality, the Nebraska Department of Health and Human Services, Division of Behavioral Health, Office of Consumer Affairs has developed a standard curriculum and certification process for adult peer support services. Curricula are being developed for family peer support services, core competencies have been identified, and discussions are occurring about a certification process for family peer support.

This study is designed to examine Nebraska's current certification process for peer support services and to identify strengths and areas for improvement. The questions we hope to answer through this study include the following:

1. Nebraska desires to have a valid and reliable peer support certification process. What is the role of the state in establishing standards for competency, training, and certification?
2. What are the standards for effective certification processes and to what extent does Nebraska meet those standards?
3. How well does the process support all components of behavioral health (adult mental health, adult substance abuse, family peer support)? Does peer support apply differently to each area?
4. How does Nebraska's peer support certification process fit with emerging national efforts to standardize peer support competencies, training, and certification (e.g. National Federation of Families)?

We employed four primary methods for this study: 1) a review of the literature on peer support with a focus on certification processes and an analysis of Nebraska's current certification process in relation to this literature, 2) a review of legal and technical standards for certification processes and an analysis of Nebraska's current certification process in relation to these standards, 3) a survey of peer support specialists regarding their perspectives on peer support certification, and 4) focus groups conducted in each region with adult and family peer support specialists.

SECTION 2: OVERVIEW OF NEBRASKA'S CERTIFICATION PROCESS

To orient the reader to Nebraska's Peer Support and Wellness Specialist Training and Certification Process, it may be useful to define and distinguish among four different terms:

1. Current Certification Process. Nebraska currently has a certification process for adult behavioral health peer support specialists. The details of this process are discussed below. "Certification" indicates an individual has met certain requirements such as attending training, passing a written examination, and meeting other requirements of the certification process. Once the individual meets certification requirements, that person may claim to be a certified peer support specialist; however, unlike "licensure" discussed below, certification is not intended to restrict practice to individuals who meet these requirements. Individuals who are not certified may still provide peer support services; however, they may not claim to be "certified" peer support specialists. Nebraska's current peer support certification process has not gone through the formal State rules and regulations process. Because Nebraska's current certification process has no legal basis in regulation or statute, there is no authority to restrict the credential of "peer support and wellness specialist" to individuals who have met the requirements for certification.

2. Formal Certification Process. Formal certification refers to a certification process that is implemented through Nebraska's rules and regulations procedures, and thereby has the force of law behind it. Formal certification would allow title protection for peer support and wellness specialists by allowing the imposition of sanctions on uncertified individuals claiming certification, providing a legal basis for background checks, and including provisions for revocation of certification. Promulgating regulations in Nebraska is a four step process:

    a. Regulation Drafting – State agencies develop draft rules and regulations and often include stakeholders in this process. This is a period of public input and free exchange of ideas about how the certification process should work and what stakeholders will support.
    b. Public Notice – Once the draft certification process is ready, the draft regulations must be made available for the public to review. The state agency must provide notice of the public hearing at least 30 days in advance.
    c. Public Hearing – The hearing provides an opportunity for citizens and stakeholders to comment on the draft regulations. Comments may be taken at the hearing and online. All comments are documented and available for review.

d. Submission for Review and Adoption – After the public hearing, the draft regulations are submitted to the State Attorney General to review for compliance with Nebraska law, then to the Governor for policy review and approval, then to the Secretary of State for final adoption and publication.

3. Licensure. Licensure indicates a process adopted through statutory or formal rules and regulations procedures that restricts the practice of a profession to only those individuals who have met the licensure requirements. For example, if Nebraska had a peer support licensure process, an unlicensed person could be subject to legal sanctions for providing peer support services. Most states rely on certification processes to regulate peer support specialist; however, at least one state has considered peer support licensure (Montana Legislature, 2012). In Nebraska, physicians and clinical psychologists are examples of professions that have licensure requirements.

4. Accreditation. Certification and licensure refer to processes to regulate individual professional such as peer support specialists. Accreditation, on the other hand, is designed to provide standards and assess organizations and programs such as those delivering peer support services. For example, the Council on Accreditation of Peer Recovery Support Services (CAPRSS) LLC, has established an accreditation process for peer support services (CAPRSS, 2013).

In this section, we describe Nebraska's current Peer Support and Wellness Specialist Training and Certification Process (often, throughout this report, we use "certification process" to refer to the current Nebraska approach). Through a Transformation Transfer Initiative (TTI) grant from the National Association of State Mental Health Program Directors, the Nebraska Department of Health and Human Services, Division of Behavioral Health (DHHS) developed core competencies for peer support and wellness specialists. Through this same grant, DHHS developed a training curriculum based on the core competencies, code of ethics and the Intentional Peer Support approach. This process involved an extensive involvement of stakeholders. The Behavioral Health Division contracted with the University of Nebraska Public Policy Center (PPC) to administer a competitive bid process to select a highly qualified organization to develop and provide the peer support training across Nebraska as well as training trainers to provide Peer Support Training. The PPC in consultation with the Division, created a Peer Support Steering Committee to develop a Request for Proposals (RFP) and to participate in the review process. This Steering Committee consisted primarily of consumers of behavioral health services. The Steering Committee began meeting on July 27, 2009 and developed the Request for Proposals that was issued September 15, 2009. Proposals were received and reviewed and Focus on Recovery – United was selected to develop the curriculum and conduct the training for Nebraska. The curriculum is available to use in Nebraska and the initial "train the trainers" session was conducted in 2010.

DHHS sponsored train the trainer sessions to sustain the training initiative and in August 2013 conducted a new round of train the trainers for ten additional trainers. The state currently provides peer support training using these trainers and the curriculum. The training is 40 hours and is conducted in-person rather than on-line or self-study and is held twice per year.

Certification of adult peer support specialists is administered by the DHHS Office of Consumer Affairs. Individuals who have behavioral health challenges and who have completed 40 hours of any peer support training are eligible for certification. DHHS administers a 34-item written test that assesses knowledge about the core competencies, ethics and other aspects of peer support based on the training curriculum and code of ethics. The test takes approximately 30 minutes to complete. Individuals must meet a certain standard on the test to be certified as a peer support specialist. The exam has about a 74% pass rate. Individuals seeking certification as peer support specialists must also participate in an interview with three reviewers and answer seven oral questions. Based on the interview, reviewers can approve or disapprove peer support certification.

To keep certification active, peer specialists are expected to maintain a minimum of six hours of continuing education per year and to participate in quarterly two-hour call-in co-supervision sessions. Co-supervision focuses on what is and what is not working well related to the four tasks of Intentional Peer Support. When an individual submits continuing education hours and participates in co-supervision calls, these hours are recorded and maintained in a DHHS data base. If an individual does not keep up their certification requirements, they are expected to take the test again and be re-certified. However, since there was not a defined process for revoking certification, co-supervision and continuing education are no longer required for continued certification. In addition, there is no formal or standard process for de-certification in instances of ethics violations.

A standard training evaluation is administered after each training session. The questionnaire is a paper and pencil survey that asks trainees to rate aspects of the training such as objectives, materials, trainers, etc. There is no pre-post evaluation. DHHS has done a telephone survey of peer support and wellness specialists; however, this was a one-time evaluation. There is no ongoing required evaluation of certified peer support specialist competencies.

Through the leadership of the Nebraska Federation of Families for Children's Behavioral Health, its local affiliates, and the Office of Consumer Affairs, there has been substantial progress in developing core competencies for family peer support specialists. These core competencies may form the basis for developing a family peer support certification process in Nebraska. The competencies are as follows (it should be noted that these competencies are still in development and may evolve over time):

1. Effective use of lived experience
2. Listening skills and cultural competence
3. Confidentiality and ethics (including the Code of Ethics)
4. Effective and assertive written and verbal communication
5. Mentoring leadership in others
6. Cultural diversity and the use of family-driven and youth-guided resiliency-/recovery-oriented approach to emotional health
7. Current issues in children's developmental, emotional, behavioral (including substance use) or mental health
8. Parenting for resiliency and wellness
9. Coaching for personal change and crises prevention
10. Development and use of community resources, including natural support
11. Advocacy across and within systems (education, health, public benefits, behavioral health, etc.)
12. Data collection, evaluation & achieving outcomes
13. Networking

SECTION 3: LITERATURE REVIEW

1. Origin and development of peer support services

The first President Commission on Mental Health (1978) and *The New Freedom Commission Report (2003)* favored the transformation of traditional mental health services into *client-centered community-based mental health services focusing on clients' recovery*. This transformation proposed an evolution from passive to proactive clients advocating for their own recovery. In this sense, peer support services have had a key role in both enhancing the connection between the community and mental health costumers and empowering costumers so they could become advocates of their own recovery.

Three important trends have facilitated the integration of peer support within current behavioral health delivery systems; first, is the increasing research base demonstrating the efficacy and cost effectiveness of peer support services (Repper & Carter, 2011); second, based on the recognition of peer support services as effective interventions, the trend to finance these services through traditional financing mechanisms such as Medicaid and Federal Mental Health Block Grant funding (Sabin & Daniels, 2003); and third, the development of peer support services gave rise to suggestions for ensuring and enhancing the quality of services through mechanisms such as certification of peer support specialists (Daniels et al., 2010).

2. Definition and types of peer support services

Peer support services are currently defined as those services in which consumers, who are successful in their recovery and have experience in navigating the behavioral health system, are employed or volunteer in the mental health system to offer guidance and assistance to current consumers (Mead, Hilton, & Curtis, 2001). While this specific role of successful peers as models for current clients has been recently developed, other roles of peer providing advice and assistance have a long tradition.

Davison, Chinman, Kloos, Weingarten, Stayner, and Tebes (1999) identified three different types of peer support. The first two originated as an alternative of traditional mental health system and have a long tradition. These types are *Natural mutual support* and *Consumer-run organizations*. The third type considers *peer specialists as mental health providers* and has received major attention from empirical and practical perspectives. This is the most recognized type of peer support and when policy makers refer to peer support in general, they usually refer to this specific type.

Natural mutual support is the least sophisticated form of peer support in which two persons share common experiences that help to understand their situation (Davison, Chinman, Kloos,

Weingarten, Stayner, & Tebes, 1999). The recovery process in this type of peer support is based exclusively on mutuality between the provider and the costumer (Repper & Carter, 2011). An example of this service is the GROW organization (Gracia et al, 2005). This type of intervention has led to positive outcomes in inpatient populations with severe mental illness (Bouchard & Gross, 2010). Goldstrom et al. (2006) estimated that there are 3,315 groups in the U.S. under the category of mutual support groups with an approximate attendance of 41,363 persons per meeting.

Consumer-run organizations are the second type of peer support. In this type, consumers run structured programs that do not operate under the conventions of therapeutic work. There is currently a trend in which these programs cooperate with state mental health agencies (Davison et al., 1999; Repper & Carter, 2011). Current literature supports the effectiveness of these types of programs in clients' recovery (Segal, Silverman, & Temkin, 2011; Tanenbaum, 2012a; Tanenbaum, 2012; Yates et al., 2011). Goldstrom et al. (2006) estimated that there are 1133 groups in the U.S. under the category of consumer-operated services serving a total of 534,551 clients a year.

Peer specialist as a mental health provider is the most widespread role in peer support services. Contrary to the other two types, the peer specialist is a part of the staff in a mental health agency. Therefore, peers specialists receive formal training and are supervised by another mental professional (Solomon, 2004). To date, approximately 30 states have certified peer support workers and 16 of these states are obtaining Medicaid reimbursement for this service (Daniels et al., 2010; Grant, Reinhart, Wituk, & Meissen, 2012).

3. Peer support specialists as mental health providers

A. Efficacy and effectiveness of peer specialists as mental health providers

Efficacy and effectiveness of peer providers' interventions has been supported by randomized and non-randomized control trials with different populations, in different settings, different forms of intervention, and with different treatment delivery options.

Population and settings

Peer support has led to positive outcomes with clients with *severe mental illness* in *randomized* (Cook et al., 2012; Davinson, Chinman, Sells, & Rowe, 2006; Sells, Davinson, Jewell, Falzer, & Rowe, 2006; Sledge, Lawless, Sells, Wieland, O'Connell, & Davinson, 2011) and *non-randomized* (Demartis, Galanter, Trujillo, Rahman-Dujarric, Ramaglia, & LaGressa, 2006) control trials with both *inpatient* (Demartis, Galanter, Trujillo, Rahman-Dujarric, Ramaglia, &

LaGressa, 2006; Sledge, Lawless, Sells, Wieland, O'Connell, & Davinson, 2011) and *outpatient* (Cook et al., 2012; Sells, Davinson, Jewell, Falzer, & Rowe, 2006) populations. Similarly, peer support has become a crucial tool in the prevention (Cuijpers, 2002) and treatment (Blondell et al., 2011) of *substance abuse*, reducing the impact of *catastrophes/trauma survivors* (Hardiman & Jaffee, 2008; Renner, Bänninger-Huber, & Peltzer, 2011), coping with *bereavement* (Aho, Tarkka, Astedt-Kurki, Sorvari, & Kaunonen, 2011; Barlow et al., 2010), and other general Medicaid problems such as *hosing* (Tsai & Rosenheck, 2012).

Further supporting the efficacy of peer specialist interventions, literature showed that these types of interventions are equally effective compared to the best available treatments in randomized control designs. Thus, in the case of depression (Pfeiffer et al., 2011), and trauma survivors (Renner, Bänninger-Huber, & Peltzer, 2011) the effect of peer support interventions was equal to empirically based treatments and superior to usual care or minimal attention conditions in reducing clients' symptomatology.

Forms of intervention

Literature indicates that there are some major training programs that are considered specific peer-led interventions which have showed to be efficient in helping psychiatric clients recover in randomized control trials. These specific interventions are currently part of the certification and training program of peer specialists. Among them, the most relevant are the *Wellness Recovery Action Planning* (WRAP) (Cook et al., 2012), *Health and Recovery Peer* (HARP) (See Cook, 2011), *Building Recovery of Individual Dreams and Goals* (BRIDGES) (Picket et al., 2012) and other specific interventions within the NAMI Training Programs (Burtland & Nemec, 2007).

Different forms of treatment delivery

With respect to service delivery, while the majority of the studies highlight client-peer specialist interactions occurring in group sessions or individual meetings, current studies are expanding on these forms of treatment delivery to incorporate other forms such as online chats (Fukkink, 2011) or phone calls (Dalgin, Maline, & Driscoll, 2011).

B. Peer support specialist benefits and challenges when promoting clients' recovery

Repper and Carter (2011) reviewed seven randomized control trials in order to uncover the impact of the employment of peer support specialists as mental health providers. These authors noted that benefits for consumers of peer support services were varied in nature but could be summarized in major areas. First, engaging in positive relationships with peer specialist exposes costumers to different role models that increase their understanding of their own illness. Second, gaining understanding increases self-acceptance and reduced the negative impact of social

stigma. Third, with self-acceptance comes hope in a better future. Fourth, the increase in hope results in costumers becoming active agents of their own recovery. Fifth, by facilitating adaptation, costumers feel empowered and able to find their own solutions in the community services. Sixth, increases in problem-solving skills translate into decreases in the hospital admissions rates and increases in the sense of belonging to the community.

In addition to the positive outcomes for mental health costumers, current literature indicates that providing peer support is not only beneficial for those who receive the service (Repper & Carter, 2011;Moran, Russinova, Gidugu, Yim, & Sprague, 2012) but also for those delivering the service (Bracke, Christiaens, & Verhaeghe, 2008).

While benefits of peer support interventions are sound, the development of the peer support profession has experienced challenges. Repper and Carter (2011) identified four issues: 1) the impact of boundary crossing in peer-costumer relationships because peers specialists are usually perceived as "friends" and not mental health professionals, 2) formalizing peer support may move the peer support relationship away from the original goal of mutuality of peer relationships, which increases power imbalance, 3) the possibility that peer specialists might experience stress by their occupation (including vicarious trauma and compassion fatigue) and experience relapse in their own recovery, and 4) issues around how peer specialists might be held accountable for interventions.

C. State mental health administration: Certification of peer specialists and Medicaid reimbursement

To date, there is wide variability of certification programs that states can follow. Similarly, there are alternatives to incorporate peer support services under Medicaid programs. How each program is certified and incorporated under Medicaid programs is highly dependent on each state's needs. However, in some instances most states follow the Georgia and Arizona models because they were the first states incorporating peer support to their Medicaid programs in 2001.

Certification process

Requirements for peer specialists

Johnson (2008) found that the common requirements for peer support specialists were:

1. Have reached certain age (i.e., 18 or 21 years old)
2. Certain education level, which usually was GED
3. Have a primary diagnosis of mental illness
4. Be a current or former customer of mental health services

5. Demonstrate leadership and advocacy skills
6. Have a strong dedication to recovery
7. Some states incorporate the requirement to have work experience

Training process

Johnson (2008) analyzed the different options that states can adopt in order to meet the requirement of formal training of peer support specialist if Medicaid reimbursement for this service was one of their goals. These programs could either be module-based training or require a minimum number of hours (Daniels et al., 2010). These options are:

1. States could develop their own training curriculum. This option is the case of Washington and Maine.

2. States could adapt the Georgia 40-hour training program. This option was the case of Hawaii, Michigan, South Carolina, Washington DC, and Iowa for example.

3. Pennsylvania and North Carolina have adopted **the Recovery Opportunity Center (META)**.

4. Approximately 17 of the remaining states have adopted **the ROC Peer Employment Training** (80-hour course).

The state of Nebraska adopted the Transformation Transfer Initiative from SAMHSA or TTI Grant in 2009. This grant allowed the state to purchase training from Focus on Recovery United, which included Heather McDonald of FOR-U, Chyrell Bellamy of Yale University, and Shery Mead and Chris Hansen of Shery Mead Consulting. A curriculum for the State of Nebraska's Office of Consumer Affairs was purchased that focuses on trauma-informed Intentional Peer Support. The state of Nebraska offers one or two trainings a year.

Certification exams

According to Johnson (2008), only Pennsylvania and North Carolina do not require a certification exam. The rest of the states have their own certification exams (e.g., Washington, Georgia, Illinois, Missouri, and Hawaii) or if they have adopted the ROC Peer Employment Training, there was a specific test designed for its content.

In the state of Nebraska, all persons that take the 40 hours of any Peer Support training are invited to sit for a statewide exam to become Certified Peer Support and Wellness Specialists. To

keep one’s certification in Active Status, the State recommends a person maintain quarterly co-supervision and six hours of continuing education annually.

Ethical sanctions

Similar to other mental health professionals, peer support specialists are bound to specific codes of conduct that provide a standard of practice that they might follow. While each state has its own ethical code, they usually include the following major elements:

1. Maintain high standards of personal conduct
2. Ensure that all their interventions are destined to promote costumers’ recovery
3. Do not participate in any form of discrimination
4. Peer support specialists respect privacy and confidentiality
5. Never engage in sexual/intimate activities with consumers they serve
6. Shall not accept gifts of significant value from those they serve
7. Will not abuse substances under any circumstance
8. Acknowledge the limits of their expertise
9. Will not use relationships with people they serve to financial gain or to put that person at risk of exploitation

At present, states like Texas that are currently developing the policy and procedure manuals for peer support certification (Via Hope Texas Mental Health Resource, 2011), are incorporating not only codes of conduct, but also rules of conduct, complaints procedures, and sanctions that might be imposed if a certified peer specialist violates any professional rule.

Medicaid reimbursement

Center for Medicaid and State Operations: General requirements

On August 15, 2007, the Center for Medicaid and State Operations (CMS) offered guidance for states interested in covering peer support providers to Medicaid eligible adults with mental illnesses and/or substance use disorders. While CMS allows each state to develop its own mental health and substance use delivery system, the state Medicaid agency continues to have the authority to determine the specific service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service. In the case of peer support specialists, the policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers that have to be defined by the state. Therefore, in order to be considered for federal reimbursement states must identify the Medicaid authority and describe the service, the provider of the service, and their qualifications.

Three approaches for Medicaid reimbursement

Johnson (2008), as part of a consultant's report assessing the Minnesota Peer Support Implementation, identified three different approaches in which states incorporated their peer support services under the Medicaid programs:

> **1. Included as a discrete service -** The states of Arizona, Georgia, Pennsylvania, and Washington are examples of this approach.
>
> **2. As part of another Medicaid reimbursed service** - The states of Georgia, Hawaii, North Carolina, Maine Illinois, Wisconsin, South Carolina, Michigan, and Oregon are examples of this approach.
>
> **3. Provided through a licensed or credentialed "Peer Support organization"-** The states of Arizona, Georgia and New Hampshire are examples of this approach. Nationally, peer-run organizations have expanded greatly and have increased the types of activities they engage in, including peer support services (Lived Experience Research Network, 2013).

4. Conclusions

The need to transform the traditional mental health system in the U.S. into client-centered community-based services stresses the need to promote the role of peer support specialists. Peer support specialists empower clients to advocate for their own recovery and at the same time re-connected them with the community.

At present, peer support specialists are treated similar to other mental health providers within the mental health system. For this reason, research has been conducted to demonstrate empirical efficacy and effectiveness of peer support interventions and major efforts have been made to ensure peer support specialists have the skills needed to provide high-quality peer support services such as developing standard training curricula and establishing certification processes.

Thus, peer support is an evidence-based practice that is continuously testing its efficacy and cost-effectiveness with different populations, settings, and forms of intervention. In this sense, the different forms of interventions follow the same form of efficacy checking as psychological empirically supported treatments. This means that most of the efficacy of peer support interventions is tested using specific experimental designs (i.e., randomized control trials) by different researchers in different settings.

Similarly, peer support certification processes have emerged in many states, which includes providing peer support specialists with formal training and meeting requirements of competency-based evaluations. After obtaining certification, these specialists often are required to accomplish a certain amount of hours of continuing education.

The major consequence of the integration of peer support specialists in the mental health agencies is that these services are eligible for Medicaid reimbursement. While each state has their own requirements and accreditation process to certify peer specialist, there are common requirements they must follow. These requirements include 1) professional supervision in the setting of practice, 2) care-coordination that integrates the intervention of peer specialist within the costumers' treatment goals, and 3) specific training criteria for peer support providers.

SECTION 4: LEGAL AND PROFESSIONAL STANDARDS

Overview of Legal Liability Concerns and Certification of Peer Specialists

Peer support specialists are specially trained and certified individuals with personal experiences in addiction and recovery. As a result of their experiences and special training, they are able to provide peer support and assistance to consumers in need. As peer support approaches have become increasingly popular in recent years, concerns about liability for training and employment of peer support specialists have arisen. Certification procedures exist for peer support workers to become Certified Peer Specialists (CPS) in many states.

Professional certification is different from licensure. Certification is a public statement that a particular standard of quality or knowledge has been achieved by a professional. Licensure, in contrast, is typically a governmental permission to practice a profession or render a service after a minimum level of competence has been obtained (Institute for Credentialing Excellence).

Certification of peer specialists is considered an indication of quality, and not a license to practice, or an indication that they are professionally associated with or obligated to the certifying state government. Most legal liability concerns are raised in the licensing context because of the importance of licensing to the practice and regulation of professions. Licensing is mandatory in order to practice professionally. Certification is voluntary, and serves as a statement of quality or accomplishment. For these reasons, there is generally less legal scrutiny of the peer specialist certification processes than there would be for licensing processes; however, liability issues that apply in the licensing context should be considered in the certification context as well.

There are five general areas in which liability concerns could arise in regards to CPS: 1) Negligence, 2) Due Process, 3) Anti-trust, 4) Defamation/Libel, and 5) Civil Rights/ADA.

Negligence

A negligence concern may exist if there is fear that liability would extend to a certifying body for the acts of a peer specialist. Liability theory traditionally requires that a duty of care is owed to a potential plaintiff by a certifying body, and that a breach of duty occurred (negligently or recklessly) that caused some harm to a plaintiff. In the case of a certifying body, it is presumed that the act of certification must be somehow tied to a resulting harm, which would be a difficult causal connection to make. It is more likely that other forms of vicarious liability for the actions of a peer specialist might exist for a peer specialist's employer. A principal question determining liability is whether the certifying body had control over the actions of a certified peer specialist (Snyder v. American Association of Blood Banks, 1996). Without control, it would be difficult to assert that a certifying body should be liable for the negligent actions or omissions of a peer

support specialist (Salzer & Kundra, 2010). Nevertheless, negligence is a potential cause of action that may arise from a poorly designed certification process.

Due Process

Due process concerns traditionally involve assertions that the government is depriving "life, liberty, or property, without due process of law." In the licensing context, due process assertions are raised if the licensing body —typically a government entity—revokes a license, or denies a license, without fair procedural or substantive due process, thus depriving someone of being able to practice their profession. The federal courts have examined due process claims and created requirements for administrative hearings by government entities (Goldberg v. Kelly, 1970; Mathews v. Eldridge, 1976). Generally speaking, due process requirements in licensing reviews include providing sufficient notice, opportunities to be heard by the applicant, presentation of evidence, impartial adjudicators, and opportunities for judicial review (Garris v. Governing Board of South Carolina Reinsurance Facility, 1998). It should be noted again that due process concerns have typically been associated with licensing processes, because professional licensing dictates whether an individual can practice their profession. It is less clear how certification processes might be implicated, but as a general recommendation, it is advisable that certification processes be administered with the same standards in mind: consistently applied, transparent, and fair processes and standards.

Anti-trust

Anti-trust concerns in the licensing context are traditionally associated with allegations that licensing denial or revocation unfairly serves as a barrier to competition in commercial activity. For example, if a professional licensing process barred a class of individuals from competition with no reasonable basis for that bar (e.g. gender, race, etc.), an anti-trust claim may exist as to that licensing scheme. Because certification is not a requirement to practice, it is unlikely that certification processes would implicate anti-trust theories, especially if certification processes are transparent and reasonably related to professional competencies. Both certification and licensing processes can impose requirements or restrictions if they are rationally related to legitimate professional objectives, such as educational requirements, standards of conduct, and so on. Unrelated restrictions with no intent other than to restrain competition would be scrutinized under anti-trust theories (Havighurst & King, 1983).

Defamation/Libel

Defamation (verbal) and libel (written) concerns might arise in the certification process. This generally refers to the communication of harmful and false information about a person or entity to a third party. Defamation can occur in a wide variety of contexts not specific to certification or peer support. As a general precaution, conclusions made about a certification applicant should not be shared outside of the certification context. Considerations should be given to adequate training and screening of certification reviewers.

Civil Rights/ADA
Discrimination claims might arise in certification revocation or denial contexts. The principle legal scheme that might be implicated is the Americans with Disabilities Act (ADA). The ADA prohibits discrimination against persons with disabilities in all government activities, thereby including state licensing or certification activities. In ADA claims, a plaintiff can prove discrimination if he or she is perceived to be disabled and is qualified for a job, but is not hired, or is subjected to heightened scrutiny or different dispositions. There are several exceptions to the ADA; an important exception in the mental health area is that a hiring need not occur if there is a legitimate determination that it may result in a threat to the health or safety of others.

Within the licensing context, several ADA lawsuits have been filed asserting discrimination against mentally ill individuals (Clark v. Virginia Board of Bar Examiners, 1995; Ellen v Florida Bd. Bar Examiners, 1994). The typical concern is that a licensing board may feel compelled to reject an application or revoke a license if a person is deemed a threat to health or safety because of a mental health or medical condition. It is important to note that real risks of threat due to mental health or medical reasons can exist, and several courts have ruled that ADA protections do allow for licensing revocations in those circumstances (Kirbens v. Wyo. State Bd. of Med., 1999; Colorado St. Bd. Medical Examiners v. Ogin, 2002). However, actual "threats" to health or safety must exist, rather than just generalized fears based on an individual's mental or behavioral health condition. A rejection, revocation, or dismissal based on a generalized fear would amount to the type of discrimination that the ADA was intended to prohibit. Likewise, if an individual is unable to adhere to certain essential conduct standards of a job due to a disability, that does not entitle that person to ADA protections (Starnes, 1999). Certification processes should be designed to ensure they do not violate ADA requirements.

Overview of Certification Standards

There are a number of national accreditation bodies and institutes that provide guidance for certification processes and standards including the Institute for Credentialing Excellence, the American National Standards Institute – Standards for the Accreditation of Certification Processes and the BSI Standards for Bodies Operating Certifications of Persons. The following is a summary of relevant standards that may provide guidance for Nebraska's Peer Support Credentialing Process.

Generally, the certifying entity should have a documented objective and reliable certification process. The certification should be based on solely on competency to the skills and knowledge required to perform specified duties and responsibilities. Certification should be based solely on information gained through the certification process and not on extraneous information. The structure of the certification process must have the necessary resources, management

components and information management capacity to ensure quality, validity and reliability. The certification structure should include 1) criteria for initial certification and recertification, 2) assessment methods for initial certification and recertification, 3) surveillance method and criteria to ensure continuing adherence to standards, and 4) criteria for withdrawing certification. The certifying entity should identify and document the associated threats to its impartiality on an ongoing basis; the entity should have a documented process to demonstrate how it eliminates or minimizes those threats.

The certification entity should have documentation to demonstrate a job or practice analysis that is conducted and updated to include the following:

- Identify the tasks for successful performance
- Identify the required competence for each task
- Identify prerequisites necessary for the competencies
- Confirm the assessment mechanisms and examination content
- Identify the recertification requirements and interval required for recertification

The certification entity should ensure the certification scheme is reviewed and validated on an ongoing, systematic basis. The process should be published and readily available to any interested individual.

The certification process should include an agreement that is signed by the certified person covering the following:

- Compliance with certification process requirements such as a code of ethics
- A commitment to discontinue claims to certification if certification is suspended
- A promise to inform the certification body of matters that affect capability of the certified person
- Non-disclosure agreement to not disclose examination materials
- Consent to providing review information related to the certification process

There are a number of guidelines to ensure the certifying entity has sufficient resources dedicated to the certification process. The certification entity should provide its personnel with documented instructions describing their duties and responsibilities and require its personnel to sign a document by which they commit themselves to comply with the rules defined by the certification entity, including those related to confidentiality, impartiality and conflict of interests. The certification entity should monitor the performance of examiners and assess the reliability of examiner judgments. The certification body should have a documented description of the responsibilities and qualifications of other personnel involved in the assessment process. The certification body should have a legally enforceable agreement covering the arrangements including confidentiality and conflict of interest with each body that provides outsources work related to the certification process.

Special safeguards may be necessary when training and certification are administered within the same legal entity; this combination poses a potential threat to impartiality. Efforts should be made to ensure independence of the two processes. There should be ongoing assessment of threats to impartiality. There should be a separation of trainers and examiners; this may include restrictions such as having a defined period of time from the end of training to the point at which a trainer can act as an examiner for a former trainee. Finally, there should be no impression given that participation in the training from the certification entity will provide an advantage to the applicant.

The certification entity must have the capacity to maintain high quality records and information to support the certification process. This capacity should include maintaining records to confirm the status of a certified person, ensuring confidentiality and integrity of records, having policies for maintenance/release of information, and providing a unique certificate for each certified person. Procedures should be in place to ensure certified individuals inform the certification body about any issues that may impact the person's ability to meet the certification requirements. The certification entity should enact procedures preventing fraudulent exam practices; these procedures may include requiring candidates to sign non-disclosure statements, having adequate supervision of the testing process, and monitoring testing results for evidence of cheating.

The certifying body should maintain an ongoing evaluation system to continuously assess its testing procedures and certification processes. This evaluation system should include 1) monitoring the consistency of testing administration, including conformity with established and written testing procedures, 2) reviewing state of art in performance standards to ensure up-to-date information is included in the testing process, 3) monitoring test result data to protect against disparities based on factors such as race, ethnicity, gender, or socio-economic status, 4) managing audits to ensure all aspects of the certification process meet best certification practice standards, and 5) gathering feedback from applicants and certified persons related to the certification process. The evaluation system should include a process for identifying actions to remedy deficiencies and objective measures to document how and when deficiencies are remedied. Ideally, the evaluation system should have a process to identify and prevent potential nonconformities, document corrective actions and monitor the success of these actions.

The certifying body should have standard procedures in place for appeals related to the certification process including procedures to accept and review appeals, make decisions, and notify appellants about progress and final decisions. Standard procedures for receiving and addressing complaints about the certification process or certified individuals should be developed. The certifying body should have documented procedures for maintaining ongoing certification including any requirements for continuing education and processes to document these requirements. Procedures for recertification including any time frames for re-testing or other ongoing assessment should also be developed. The certification body should have

procedures to suspend or withdrawal certification for individuals no longer meeting certification requirements; these procedures should include requirements that the individual no longer claim certification.

SECTION 5: SURVEY AND FOCUS GROUP RESULTS

The University of Nebraska Public Policy Center conducted a survey and focus groups in each of the behavioral health regions of Nebraska during September and October 2013. Included in both the surveys and focus groups were questions about Nebraska's peer support certification process. The results from the survey and focus groups are discussed separately. It should be kept in mind this report summarizes the responses of participants in the focus groups and surveys; the University of Nebraska has not endorsed the recommendations proposed nor verified the accuracy of statements made.

Survey Results

The survey included two respondent groups: 26 Family Peer Support Specialists and 16 Adult Peer Support Specialists. There is not a separate certification process for family peer support specialists. The 26 Family Peer Support Specialist participants were asked how valuable they believed certification would be based on who administered the certification process: State of Nebraska, National Group, or Private Group. As shown in Table A1, the average respondent thought certification would be quite or very valuable for family peer support specialists. There were no substantial differences regarding the organization that should administer the certification process.

Table A1: Family Peer Support Specialist Perceived Value of Certification by Certifying Organization - Mean (Standard Deviation)

Certification Organization	Family Peer Specialist
a. Nebraska certification for family peer support	3.36 (0.90)
b. National certification for family peer support	3.27 (0.99)
c. Certification from a private agency for family peer support	3.32 (0.84)

1= Not valuable
2= A little valuable
3= Quite valuable
4= Very valuable

Fourteen of the 16 Adult Peer Support Specialists answered whether they were certified; 12 of the respondents were certified and two were not. Of the two who were not certified, one indicated he or she had not taken the test yet, and the other indicated lack of training in Nebraska had been a barrier.

Adult Peer Support Specialists were asked their opinions about the value of different areas of the certification process. As shown in Table A2, Adult Peer Support Specialists considered the state/region sponsored Nebraska IPS training and state/regional continuing educational

opportunities to have the greatest value. The state-sponsored quarterly co-supervision sessions were considered “a little valuable.”

Table A2: Adult Peer Support Specialist Perceived Value of Certification Areas - Mean (Standard Deviation)

Certification Areas	Adult Peer Specialist
1. State/region sponsored initial Nebraska Intentional Peer Support Training	3.54 (0.78)
2. The written quiz administered after the training	3.00 (1.23)
3. The oral quiz administered after the training	2.54 (1.20)
4. State/regional continuing education opportunities (e.g., state conference, webinars)	3.54 (0.66)
5. State sponsored quarterly co-supervision sessions	2.09 (1.22)

1= Not valuable
2= A little valuable
3= Quite valuable
4= Very valuable

Adult Peer Support Specialists were asked an open ended question regarding what could be done to improve the peer support certification process. The following are the responses:

- 1. Have more facilitator training; 2. Have co-supervision face to face; 3. Have a curriculum of webinars; 4. Provide networking for peer consumers; 5. Have a website with peer resources and peer contact numbers; 6. Make credentials have a higher social value
- Available to anyone who pursues regardless of ability to pay, transportation, resources (i.e. Western Nebraska - way out west)
- Have more trainers. Make it more accessible for those who can't take a week off of work to complete. Have more opportunities to "take the test" closer to when you finish the training
- Have more training so that more people can be certified. Have each certified specialist submit one or two questions for the certification test
- I believe that our state peer support certification process is amazing already. At this time; I cannot think of any improvements
- More frequent trainings
- The board of certification recognizes the credentials like they have in Iowa. I believe a national credential is soon on the horizon also. The more we can do to professionalize the career option for Peer Support the better. I think also it should be made more known as a way to transition out of disability for those skilled enough to provide Peer Support full time

- The entire process needs to be looked at - from the availability of training to the testing of competence, to ensure that peer support remains a legitimate and viable service. In addition, the existing code of ethics needs to be rewritten in a professional manner to better reflect professional work competencies, responsibilities and focus of service (see International Association of Peer Supporters Draft National Practice Standards http://inaops.org/national-standards/)
- Train region specific

Focus Group Results

Family peer support specialists were asked what they thought of certification. Many participants supported certification for family peer support specialists and thought it would provide recognition of peer support as a legitimate service. Many thought certification would provide a structure for ongoing education and ensure requirements for skill enhancement. Other comments about family peer support certification include the following:

- It is unclear what the best criteria would be for certification. Having life experience and passion is the most important characteristic of a successful peer support specialist. That is a difficult characteristic to measure or identify because it is so intangible.
- Having a certification process would be helpful because it provides a foundation for training. It also helps to keep skilled professionals in the sector. It is important that there is an incentive to keep good family support specialists working in this area. There needs to be a process to identify and recognize those individuals who are really experienced and passionate in this area.
- If there is a certification process, having both a State of Nebraska certification and a national recognition or certification process would be good. National certification recognizes evidence-based practices that have been tested elsewhere.
- There should be a way for people who have been doing the work for many years to be grandfathered in to certification without having to take any tests. It is unfair to have to test those peer support workers, particularly because many peer support specialists may be in a phase of their life where they are beyond studying and testing.
- Certification can be very important because it assures the family member that you are qualified and have undergone some form of quality assurance. However, the form of the certification process is very important. Any sort of test should be constructed by someone who is familiar with family peer support. A very good component would be to have a member of the certification board observe you in your work so they know you are competent. Thus, you need to have both a classroom test and a “field test” so the reviewers know that candidates know what they are doing, particularly in times of crisis.

- A state certification process is preferable over a national one. It needs to be geared towards Nebraska and Nebraska families. Nebraska is not Louisiana, it is not New York. The needs are too different for there to be a national certification.
- Family peer support advocates need to have a say in developing the testing process for certification. They know what works and what does not. The proper input is needed so the testing reflects the skills and knowledge that are necessary. It is hard to define or limit the roles and responsibilities of family peer support. They do it all. They encounter all sorts of different, completely unpredictable situations. They manage the best and worst of life in all situations. They are life coaches. How can one "test" to all the situations that could be encountered as part of the job?

Adult peer support specialists were asked detailed follow up questions about certification. Many participants indicated their belief that Nebraska has made great progress in recent years in peer support certification and peer support services in general. Most people felt the Nebraska Model Training – Intentional Peer Support (IPS) was good and the written and oral testing processes were appropriate and an integral part of the certification process. Some indicated the testing process was effective in filtering out candidates who are not qualified. Some participants found the testing and oral exam petrifying but thought going through the process ensured they had the requisites to do peer support. A number of participants indicated the training was based on internalizing the training and not memorizing the materials, focusing on how to use the training in one's own life and as a peer support specialist. They agreed with the philosophy from the Office of Consumer Affairs that the training was not designed to produce "trained parrots." A number of participants thought the co-supervision calls were valuable because they enable specialists to work through problems they may be experiencing and generate appropriate solutions.

Peer support specialist recommendations for improving the certification process included the following:

- Some participants suggested Wellness Recovery Action Plan (WRAP) training should be a pre-requisite for the Nebraska Model (IPS) training. Individuals are given a book on WRAP, but it is meant to be facilitated training and not just self-taught. There is little funding for WRAP training and what is offered isn't well attended. Providing funding and mandating would be worthwhile. There should be more recruiting and advertising of WRAP training and facilitators should be paid.
- Some participants recommended clear standards for certification (the standards seem to change and are not widely communicated) and they should be the same for everyone (it appears some requirements are waived for some individuals). Making the standards consistent for all people will ensure legitimacy of the certification process.

- Some participants suggested doing background checks on individuals applying for certification to make sure individuals with criminal backgrounds or sex offenders could not hold themselves out as certified peer support specialists
- Some participants indicated previously there was a requirement that facilitators had to go through IPS training before they went through facilitator training. This requirement is apparently gone, but should be reinstated.
- Some participants thought there should be three facilitators for the Nebraska IPS training. Some trainings apparently had two trainers and two was not enough. Many of the topics bring back painful memories or trauma and trainees need to step out of the training; having three trainers allows one to check on these individuals.
- There were mixed ideas about breaking up the Nebraska IPS training across multiple weeks. Some participants recognized that having it during one week makes it more likely individuals will attend all sessions because they have set aside this time for the training. If a person misses more than four hours of the training, he or she has to retake the training. However, participants also recognized advantages of extending the training over several weeks including 1) allowing more time for homework and opportunities to practice what they learn in class and 2) avoiding burnout by trainees and trainers; some believe that at the end of a full week of training, trainees were not able to retain much information and trainers were tired.
- Some respondents thought that regional level training, particularly in rural areas, is needed since issues faced by peer support specialists are often unique to each region of the State. This would reduce the need to make them travel long distances. There are few funds available to help individuals travel long distances to take the test.
- Many participants indicated they were nervous going through the oral exam. One aspect of the oral exam that made them particularly nervous was the flat effect and lack of eye contact with examiners. Although participants understood the reason for this is to provide an objective testing environment and to avoid giving unintentional clues to test takers, many thought testers could still accomplish this but should at least acknowledge that they hear and understand what the test taker has to say. The oral exam would be a more humanizing experience if testers would make eye contact and give attention to the test taker while they talk, then do their writing after the tester completes his or her response.
- Some participants thought the test should be given right after the training. Conducting the test a month after the training requires additional travel time and time away from work.
- Some individuals thought the quiz and oral exam had tricky wording that tried to catch people, so test takers would try to guess what examiners were looking for instead of concentrating on what was important in peer support. There was not consensus on this point. Many participants thought the test was fair but felt they had climbed Mount Everest when they got through it. Some thought peer support specialists should have input into the test questions and the testing process to make it less intimidating.

- There was also discussion about whether the test focused too much on Intentional Peer Support. Some thought the state had gone through an extensive process to choose the curriculum and it was appropriate to have the testing process focus on this curriculum; from their perspective, the test appropriately reflected the curriculum. Others thought the current test deviated too much from the IPS curriculum and the test questions should come directly from [Shery] Mead to more closely reflect the curriculum. Still others thought the testing should be broader and include materials from other courses.
- Participants had different ideas about requiring continuing education units for ongoing certification. Most thought Continuing Education Units (CEUs) should be required, but some participants thought the requirements were hard to meet and took time away from their work or their families. There were a number of suggestions about improving the CEU process:
    - Some participants thought there should be requirements for CEUs and they should be tracked by individual at the state level; tracking CEUs honors the people doing peer support and recognizes their efforts participating in training. Other participants thought CEUs could be tracked at the regional level.
    - Some participants would like a library with recorded trainings or web site with links to training, including SAMHSA training and other national webinars, so they could complete training on their own time and have resources for learning key topic areas. Webinars that individuals could access at their convenience would be ideal. Others however, thought that webinars were hard to access technologically for some people and the human connection is lacking. For in-person training, the trainings should be announced well in advance so that people can plan to attend.
    - Some participants thought the amount of CEU credits should be determined up front before attending in-person trainings and participating in recorded or on-line trainings. Currently, it is not clear how many credits are assigned to any given training and it is hard to know how many CEUs an individual has earned.
    - Some participants thought one person should not have the sole responsibility to determine what training is acceptable for CEUs. One option would be for the facilitators group and others to be involved in these decisions.
    - Some participants thought some agencies such as Community Alliance offer good training. These types of trainings should be recognized as eligible for CEUs.
    - Some participants thought continuing education should include specific topics such as peer support resiliency, vocational peer support, WHAM, Rent Wise, Living Well, WRAP for trauma, and smoking cessation. If people can decide what CEUs to take, they may take the path of least resistance. Determining the courses or topics up front establishes clear standards for competencies.
    - Participants were in agreement that the Transformation Transfer Initiative (TTI) focus on trauma-informed care has been a welcome addition. Many expressed the

desire for more training in this area and that this training should be required as part of CEUs.

- Some participants thought the quarterly co-supervision calls are very helpful while others thought in-person co-supervision meetings would be more beneficial than the calls. The calls sometimes include personal questions and individuals feel “put on the spot” and “humiliated.” Some people don’t feel comfortable discussing their personal issues on a call when they don’t know all of the people who may be participating on the call. Some participants indicated they did not like the directed questions by one person on the calls and “wrong” answers are corrected; they would rather have more of an open forum in which peer support specialists could have more dialogue about what works and what doesn’t. They would like more sharing of information across regions to better connect with peer support specialists across the State.
- Many respondents indicated they liked the statewide Success, Hopes and Dreams Conference. However, some thought the statewide conference seems to have grown to include more providers and administrators. While it is good these individuals are becoming more exposed to the consumer movement, there is a loss in the ability of consumers to share and connect with each other.
- Some individuals thought the Office of Consumer Affairs could do more to support local mini-conferences related to peer support. Some mentioned peer support meetings and trainings at the local level that were unattended by any staff form the Office of Consumer Affairs.
- Some participants thought the certification process should be moved to an independent peer certification board or to a state agency that does certification for other health and human services professionals, which is the model Iowa follows.

Summary and Conclusions

Results of the survey and focus groups provided useful information for peer support certification in Nebraska. Family peer support specialists thought certification would be beneficial for Nebraska. There was not a preference about the type of entity that should administer the certification process: national, state, or private. Many respondents thought certification would lend legitimacy to family peer support and help ensure that specialists are trained and qualified. A certification process should recognize the uniqueness of and be tailored to family peer support.

Many of the focus group participants thought Nebraska had made great strides in its certification process for adult peer support. Adult peer support specialists rated the Nebraska Intentional Peer Support Training (IPS) highly. Participant recommendations for improving the Nebraska IPS training include the following:

- Have more facilitators so more training can be conducted.

- Strengthen the pre-requisites for being trained in Nebraska IPS including in-person WRAP training
- Make sure Nebraska WRAP training is accessible to those in rural areas
- Some participants recommended splitting up the training across multiple weeks to avoid trainer/trainee burnout and to allow for practicing skills between sessions. Participants also recommended having three trainers for the Nebraska IPS training sessions.

Participants generally thought the testing was tough but fair. Some suggested the test be given immediately after the training so they would not have to make a separate trip to take the test.

Many participants thought it was important for the State to develop standards for continuing education units and track individuals who complete those requirements. Participants proposed a number of recommendations for improved continuing training including the following:

- Maintaining a web site with training links and recorded trainings that would count for CEUs
- Pre-determining the amount of CEU credits for particular trainings
- Determining the content of training that needs to be taken to maintain certification (e.g., trauma informed care)

Some participants thought co-supervision meetings should be conducted in person and thought a more interactive format would improve the process. A number of participants recommended greater opportunities for sharing in decision making about certification requirements such as the initial training content, the certification testing process, and continuing education requirements. Participants also expressed the desire to have greater networking mechanisms for peer support specialists.

It is also evident that there are some misperceptions about Nebraska's peer support certification process. Additional information may be helpful in communicating this process to others. A succinct summary of the process is provided by the Nebraska Department of Health and Human Services, Division of Behavioral Health, Office of Consumer Affairs and is as follows:

> *The Office of Consumer Affairs provides a certification as a Peer Support and Wellness Specialist from the Division of Behavioral Health within Nebraska Department of Health and Human Services. Certification includes a written and oral quiz offered to anyone with 40 hours of any peer support training. The written component takes approximately one to two hours to complete and the oral component takes approximately 30 minutes. Usually, a score can be provided on the same day. At this time, two processes are offered to the Certified Peer Support and Wellness Specialist, which are the collection of continuing education hours and participation in co-supervision, neither are required by the participant. Obtaining 6 hours of continuing education is recommended and we record all continuing education credit hours faxed to us that are related to the work of*

peer support. Co-supervision is a 2 hour conference call that is recommended on a quarterly basis. Co-supervision is about two simple questions: what is working well with the 4 tasks and what is not working well with the 4 tasks of Intentional Peer Support. Participants in these calls may simply pass, if they have nothing to share. It is also a place to network with other peer specialists from across the state. We record these hours also. Currently there is no such process in place for Family Peer Specialists or Navigators, but we are open to creating needed supports. We welcome all the feedback in this report and look forward to improving our services from your feedback.

SECTION 6: CONCLUSIONS AND RECOMMENDATIONS

Nebraska has implemented a certification process for adult peer support services similar to processes used in other states. The State developed core competencies using a broad-based participatory process, selected a contractor to train trainers in Nebraska to provide the peer support training based on the competencies and created a certification process to assess the capacity of individuals to provide adult peer support services. This process meets the state's goal in trying to improve the quality of peer support services and ensure the individuals who deliver this service are appropriately trained and qualified. In this assessment of the current certification process, we did not directly observe the testing processes, nor did we statistically analyze the results from certification testing. This assessment was a qualitative review of the certification process. We conclude from our review that the current certification process appears reliable in that it is consistently administered and valid in that it relates to the objectives for which it is designed. There are written procedures for administering the certification process and the testing process appears to be admininstered consistently. Both the written test and the oral quiz appear to be related to the core competencies and thereby further the goals of ensuring adult peer support specialists have the capacity and skills to deliver high-quality services. Participants in the regional discussion groups made a point to note the tremendous progress Nebraska has made in recent years in developing and improving adult peer support services including the certification process. Certainly there are additional processes that could be implemented to more closely assess performance, problem solving, attitudes, and skills (see Bashook, 2005); however, the Nebraska peer support specialist certification process has achieved its goals within the available resources.

There are, however, changes that could potentially improve the current peer support certification process in Nebraska. It is important to ensure the certification process meets best practices in implementing certification standards to protect the State from legal liability and to ensure the best feasible procedures. Implementation of these enhancements must be weighed against the resources required for implementation. The following are recommended modifications to the certification process we believe would improve the process:

1. The Office of Consumer Affairs in partnership with the Nebraska Federation of Families and other stakeholders will undoubtedly contine working on a certification process for family peer support specialists. All parties recogize that family peer support specialists require a special skill set supporting families of children with serious emotional disorders. Often families they serve are involved in the 1) education system and may have an Individual Education Plan, 2) the child welfare system which may include the State as guardian and include foster parents, guardians ad litem and Court Appointed Special Advocates, 3) the juvenile justice system,

which may include probation officers, judicial procedings, law enforcement, local juvenilie detention and Youth Rehabilitation and Treatment Centers and 4) transition service systems including independent living services, supported housing and vocational rehabilitation tailored to the needs of older adolescents and young adults. Family peer support specialists assist parents and other caregivers navigate these myriad systems and may also assist caregivers access services for their own mental health and substance abuse disorders. The skills and competencies required of family peer support specialists may be similar to but somewhat different from those of adult peer support specialists. These similarities and differences will be reflected in the core competencies, the training curricula and certification process for family peer support specialists. Stakeholders have made substantial progress in developing core competencies for family peer support and thinking through issues related to certification. Survey results indicate broad support for a certification process, but there was not a preference regarding whether certfication should be administered by the state, a private agency or a national organization. We recommend the Office of Consumer Affairs continue to participate in and support development of a certificaton process for family peer support. A certification process should recognize national best practices but also be tailored to recognize the unique culture of Nebraska.

2. Some discussion group participants suggested having Wellness Recovery Action Plan (WRAP) training as a prerequisite for the Nebraska Model of Intentional Peer Support (IPS) training. We recommend the Office of Consumer Affairs give serious consideration to this suggestion. The principles of WRAP training would appear to provide a solid foundation for the 40-hour Nebraska Model training. However, implementing this recommendation poses challenges. WRAP training is intended to be facilitated by a trainer rather than self-guided. Expanding WRAP training would require resources to train more WRAP trainers and requiring WRAP would result in additional formal training hours for Peer Support candidates beyond the 40 hours of Nebraska Model training, which could become a burden to candidates and perhaps dissuade some individuals from seeking certification. These factors must be balanced with the added skills and knowledge WRAP training would provide.

3. We recommend consideration be given to increasing the number and accessibility of Nebraska Model IPS training provided. Discussion group participants indicated that more trainings would benefit individuals interested in participating. Expanded training should be more feasible now that another cadre of trainers has been trained under Nebraska's most recent Transformation Transfer Intitiative. We also recommend the Facilitator's Circle and other stakeholders be involved in considering other potential changes to improve the accessibility and quality of the Nebraska IPS

training including holding the training regionally throughout the state to increase access and reduce travel burden for individuals from rural areas, having three facilitators involved in providing each training to give more personal attention to trainees and reduce training fatigue, and splitting up the 40 hour training into multiple sessions to reduce training fatigue and allow trainees to practice skills between sessions.

4. We recommend a formal appeals and complaint process be established and documented in writing. This process would include processes to address an appeal from an individual who did not receive certification, issues raised about the certification and recertification process by individuals who are certified and complaints by individuals who receive peer support services.

5. We recommend establishing a re-certification process including requirements for continuing education credits (CEUs). Because of limited resources, the Office of Consumer Affairs (OCA) has focused on the intitial certification process and provides guidance for continuing education units and co-supervision that is voluntary but not required. This creates a situation in which there is a reasonable certainty that individuals who are recently trained and certified have the skills and competencies necessary to provide high quality peer support services. However, without continuing certification or recertification requirements, individuals, who have Nebraka certification, over time may no longer have these skills and competencies. There should be clearly established standards for the number of continuing education credits required for continuing or re-certification. It may be helpful to have a broad-based participatory process to establish standards for the types of training that count toward CEUs and an objective process for determining how the number of CEUs are determined for particular training. Re-certification may also include requirements for minimum hours of practice/experience and supervision.

6. There were mixed opinions about the value of current quarterly co-supervisionconference calls. This area may be another opportunity to engage peer support specialists in discussions regarding how to structure co-supervision to maximize the benefits to certified individuals. Many of the discussion group participants thought the co-supervision would be more benficial if conducted in person and if they were more interactive than didactic. In addition, related to recommendation #5 above, we recommend co-supervision be established as a requirement for continung certification or re-certification. If the State moves toward a "next generation" certification process through the formal regulatory process, consideration may be given to separating supervision requirements. As part of the current certification process, the Office of Consumer Affairs offers opportunities for

co-supervision to improve peer support competencies. Often as part of formal certification processes, there are requirements for formal individual supervision as a requirement for certification. We suggest that both types of supervisory processes can be combined to help ensure peer support specialists have the skills and capabilities to provide high quality peer support services.

7. We recommend establishing procedures for revoking certification and handling complaints about certified peer support specialists. Peer support specialists should be required to sign a statement to inform certification officials about any conditions that may compromise their ability to perform high-quality peer support and to discontinue claims to certification upon revocation. Conditions for revoking certification should be clearly established in written policy. The State should develop the capacity to track ongoing certification requirements and investigate consumer complaints and situations that may affect the capacity of the certified person to provide peer support services. Procedures should include qualifications of investigative staff, timelines for investigations, procedures for making decisions and communicating results, and procedures for appealing decisions.

8. We recommend ongoing evaluation of the certification process through a continuous quality improvement process. The evaluation should include ongoing analysis of training satisfaction and improvement surveys, monitoring of trainings to ensure consistency and quality, ongoing review and updating of the training curriculum to ensure up-to-date research results and best practices are incorporated, regular input from certified individuals about how the certfication process can be improved, and periodic management audits to assess the degree to which all components of the certification process are working as designed. Modifications to the certification process resulting from the evaluation should be documented. One special note of interest is how well the certification process works for peer support specialists working in the areas of substance abuse and addiction; continuing discussions with stakeholders involved in this area will be benficial.

9. We recommend moving from the current peer support certification process to a next generation certification process through the formal regulations process. This next generation process includes checks and balances including ensuring public input into the certification process, formalizing written standards, and ensuring consistency with Nebraska statutory authority. The move to formal regulatory procedures ensures the certification process has the force of law and allows certification procedures to be enforced. Continued stakeholder input can be formalized through an advisory committee, established through regulations, to oversee the certification process. Moving toward a formalized certification process helps enhance protections of

consumers of peer support services and increases protections for peer support specialists as well. We recognize that a formal certification process will require additional resources to effectively implement compared to the current process.

10. On a longer term basis, the Office of Consumer Affairs should consider separation of the training and certification processes. All certification processes in other states we reviewed are linked to a training curriculum established or adopted by the state. This seems to be a natural starting point for certification development – identifying core competencies, developing a training curriculum that incorporates these competencies, and establishing a certification process that tests knowledge related to the competencies included in the training. State mental health authorities tend to be the entities in the best position to develop all three of these processes. However, once these procedures are established, it may be beneficial to separate these functions as part of the natural evolution of a maturing certification process. Generally, states have an entity responsible for certifying different types of health care professionals. Placing the responsibility of certifying peer support specialists with this entity is likely to elevate the prestige of peer support certification and avoid potential conflicts of interest when an agency has responsibility for both training and certification.

11. Consider how the competencies of peer support specialists fit with and differ from competencies of other mental health and substance abuse professions to ensure quality and harmony across professionals. Scholars have suggested a basic set of competencies across all professionals working with individuals with mental health and substance abuse challenges (e.g., Hoge et.al, 2009) including shared methods to identify and assess competency, competencies to address co-occurring disorders, competencies to work as multidisciplinary team members and as system partners, competencies to focus on preventative and resiliency-focused models of care, and competencies related to cultural and linguistic competence. As Nebraska moves forward with its certification process for peer support specialists, we recommend attending to the larger effort to build cross-professional competencies for behavioral health disciplines and ensure requirements for peer support conform and build upon these broader initiatives. Similarly, we recommend continuously assessing Nebraska's peer support certification process in the context of national peer support program accreditation efforts.

    In addition, we recognize the field of peer support credentialing is evolving. Many states have certification processes, and there are discussions about national certification. As Nebraska moves toward its next generation peer support

certification process, issues about how to recognize peer support certifications from other states and from national credentialing organizations will need to be addressed.

12. Multiple sources currently fund or could fund peer support services. Currently, the DHHS Division of Behavioral Health and Division of Children and Family Services fund peer support in Nebraska. Medicaid and private insurance carriers are examples of entities that could fund peer support in the future. As the Office of Consumer Affairs and other stakeholders address issues surrounding certification of peer support and wellness specialists, these other funders and potential funders should be engaged in the dialogue about standards and core competencies to ensure the needs of each funding system are met and to develop a more comprehensive model of peer support that can be financially sustained.

APPENDIX: REFERENCES

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