

Pillars of Peer Support: Transforming Mental Health Systems of Care through Peer Support Services

The Pillars of Peer Support Services Summit
The Carter Center
Atlanta, GA
November 17-18, 2009

Recommended Citation: Daniels, A., Grant, E., Filson, B., Powell, I., Fricks, L., Goodale, L. (Ed), Pillars of Peer Support: Transforming Mental Health Systems of Care Through Peer Support Services, www.pillarsofpeersupport.org; January, 2010.

Acknowledgements:

The Pillars of Peer Support Services Summit was supported by: Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Mental Health Services (CMHS), National Association of State Mental Health Program Directors (NASMHPD), Depression and Bipolar Support Alliance (DBSA), Wichita State University Center for Community Support and Research, Appalachian Consulting Group (ACG), Carter Center, OptumHealth, and Georgia Mental Health Consumer Network. Special acknowledgements are also due to Peggy Clark, MSW, MPA, Technical Director Center for Medicaid State Operations at the Center for Medicare and Medicaid Services, and the participants from each of the represented states.

Background

The role of peer support services in mental health services and person centered recovery has been actively developing and evolving in recent years (Davidson, Chinman, Kloos, Weingarten, Stayner & Tebes, 1999). Formal training programs for peer support services have been established, and an emerging Peer Support Specialists (PSS) workforce is providing a range of services that includes but is not limited to: serving on ACT Teams, in peer support programs, in psychiatric inpatient facilities and group and one-on-one settings in mental health systems of care (Fricks, 2005). At the state level the role of peer support has changed since Medicaid (Medicaid, 2007 – also see appendix 1.) designated peer support as a billable service for adults. As this role expands across states and other payer systems, Peer Support Specialists will continue to gain an increased role in systems of care.

In November 2009, the Pillars of Peer Support Services Summit was convened at the Carter Center in Atlanta, GA. The intent of the Summit was to bring together those states that currently provide formal training and certification for peer providers working in mental health systems to examine the multiple levels of state support necessary for a strong and vital peer workforce able to engage in states' efforts at system transformation, including recent innovations in Whole Health. The Pillars of Peer Support Services Summit was supported by the following leaders in peer support development: Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS), National Association of State Mental Health Program Directors (NASMHPD), Depression and Bipolar Support Alliance (DBSA), Wichita State University Center for Community Support and Research, Appalachian Consulting Group (ACG), Carter Center, OptumHealth, and Georgia Mental Health Consumer Network.

The summit collected data on those states that are currently utilizing peer support services under Medicaid reimbursement. Participants were surveyed prior to attendance and summary state reports were provided to all participants. In the survey, participants responded to questions addressing the unique attributes of each state's program.

On the second day of the Pillars of Peer Support Services Summit the state representatives were introduced to three states Transformation Transfer Initiative (TTI) Grants funded in 2009 by SAMHSA to promote Peer Support Whole Health. The presentations of the TTI grants from representatives of Michigan, Georgia and New Jersey shared efforts to offset the average 25-year premature death of consumers served in the public sector by training peer specialists in whole health recovery. The presentations were so well received that Peer Support Whole Health was unanimously added as a national Pillar of Peer Support Services.

States were provided with a rough, informal draft identifying some of the lessons learned or "pillars" based on successes various states have already identified. In the Summit these pillars were reviewed and redefined with the intention of proposing a framework or blueprint for other states interested in developing or expanding their peer support programs. In addition, newly defined pillars of peer support services have been recommended to advance the implementation and ongoing support for peer support services in the mental health field.

This report provides a comprehensive summary of the results and findings of the Pillars of Peer Support Services Summit. The report begins with a review of the relevant literature as it pertains to the evolving policy for mental health services and peer support services. It is followed by a review of existing state level data of peer support services that was collected as part of the Summit. For the purpose of this report and from the content of the summit, the terms Certified

Peer Specialist (CPS) and Peer Support Specialist (PSS) are used interchangeably. A set of twenty five pillars of peer support services were developed in conjunction with this summit. Finally, based upon the results of the summit a series of six recommendations are advanced to promote the role of the pillars in the promulgation of peer support services and the peer support workforce at the state and federal level.

Mental Health System Transformation and the Role of Peer Support Services – A Review of the Literature

The challenges of mental health services and the opportunities for shifting to a recovery based system have been well documented over many years, and in several reports (Institute of Medicine, 2001, 2006; New Freedom Commission on Mental Health, 2003; The President’s Commission on Mental Health, 1978; Surgeon General Report, 1999). Over thirty years ago, President Carter commissioned a comprehensive review of mental health services that generated a series of recommendations (The President’s Commission on Mental Health, 1978). One of the core recommendations identified in the report is the key role of community based supports. In its guidance, the report recommends that: “A major effort be developed in the area of personal and community support which will recognize and strengthen the natural networks to which people belong and depend” (The President’s Commission on Mental Health, 1978 p. 15). “These largely untapped community resources contain a great potential for innovation and creative commitment in maintaining health and providing needed human services (The President’s Commission on Mental Health, 1978 p.15).” This first President’s Commission on Mental Health provided groundbreaking attention and insight into the problems that people face in dealing with mental illnesses and the challenges and limitations that the systems of care encounter in providing care.

The Surgeon General's Report (1999) demonstrated that there are well documented evidence based treatments in mental health, and a range of treatments exist for most mental disorders. The report also presented findings that self-help and mutual support, from which peer support services have evolved, was the fastest growing service for people in recovery. This groundbreaking report fostered a framework for the support and development of resources for people with mental illnesses. The consistent theme from these reports is that mental health is a fundamental component in all aspects of a person's health. The integration of behavioral health and primary care are fundamental to a comprehensive approach to health care (Daniels, Adams, Carroll, Beinecke, 2009). This concept that care must encompass both physical and mental health has increasingly been labeled as a whole health approach. In 2003, The New Freedom Commission report "Achieving the Promise" was released. The report asserted that the current system of care must undergo a fundamental transformation in order to realize "a future when all people with mental illness will recover." A series of recommendations are provided to guide "system transformation" including the specific recommendation for establishing the role of consumers and family members in all levels of policy development and service delivery. Together the Surgeon General and the New Freedom Commission reports establish a framework for linking the science and services for mental health care.

A series of Policy reports from the Institute of Medicine (IOM) also frame the recommendations for improving the American health care system. The Report Crossing the Quality Chasm (2001) establishes that the healthcare system is broken and needs fundamental redesign. It suggests that in order to redesign healthcare a series of six core principles must be adopted. These include the values that healthcare must be safe, effective, efficient, equitable, timely, and patient-centered. In 2006, the IOM presented its report on mental and substance abuse conditions and found that

the Quality Chasm principles are directly applicable to mental health (IOM, 2006). In a specific recommendation the report found that “to promote patient-centered care, all parties involved in health care for mental or substance-use conditions should support the decision-making abilities and preferences for treatment and recovery of persons with mental and substance use problems and illnesses (IOM, 2006). The report affirmed that patient (person) – centered care is directly applicable in mental health care, and all care must be respectful and responsive to those who need it. The notion of person-centered care accounts for the needs of individuals and families in supporting the recipient of care as the “true north” that guides all service decisions (Berwick, 2002).

Peer support has an established history and demonstrated role in the spectrum of mental health services (Grant, 2009). Peer support occurs when people share common concerns or problems and provides emotional support and coping strategies to manage problems and promote personal growth (Davidson, et. al, 1999). In addition to mental health, peer support has demonstrated productive outcomes in the areas of substance abuse, parenting, loss and bereavement, cancer, and chronic illnesses. (Kyrouz, Humpherys & Loomis, 2002; White, 2000).

While President Carter’s Commission on Mental Health (1978) identified the key role of community based supports for people with mental illnesses, the role of Certified Peer Specialists (CPS) is relatively new. In 2001, the services provided by peer support specialist became Medicaid reimbursable (Fricks, 2005).

In order to be eligible for Medicaid reimbursement, training, continuing education, supervision, and care coordination requirements must be established and met. Certification is defined at the state level and is contingent on completing necessary training and the demonstration of core

competencies in supporting others in the recovery process. Continuing education is generally required, and with a few states recommending it strongly. Other requirements for Medicaid reimbursement include: supervision provided by a qualified mental health professional; services must be coordinated in the consumer's individualized treatment plan; and services must focus on identified treatment goals within the parameters of medical necessity. (Smith, Centers for Medicaid and Medicare Services, 2007).

The role of Certified Peer Specialists (CPS) is to work with consumers to assist in regaining balance and control of their lives, and to support recovery (Chinman, Young, Hassel & Davidson, 2006; Sabin & Daniels, 2003; Orwin, Briscoe, Ashton & Burdett, 2003). These positions are important parts of the mental health treatment teams, and settings for care include mental health centers, inpatient and outpatient settings, emergency rooms, and crisis centers (Fricks, 2005).

The role of a CPS is integral to a treatment team, yet it is also distinct from existing traditional mental health services. A key differentiating factor in the CPS role from other mental health positions is that in addition to traditional knowledge and competencies in providing support, the CPS operates out of their lived experience and experiential knowledge (Mead, Hilton & Curtis, 2001). The Peer Specialist works from the context of recovery, frequently utilizing language based upon common experience rather than clinical terminology, and person-centered relationships to foster strength based recovery (Davidson, et. al, 1999). Peer specialists are uniquely qualified to assist individuals in identifying goals and objectives that form the context of the peer support relationship (Chinman, et. al, 2006).

The use of Peer Support Specialist as part of the treatment team has been shown to have a range of favorable results (Davidson et al., 2003; Felton, Stanstny, Shern, Blanch, Donahue, Knight & Brown, 1995; Mead & MacNeil, 2006). Information provided by peers is often seen to be more credible than that provided by mental health professionals (Woodhouse & Vincent, 2006). When peers are part of hospital-based care, the results indicate shortened lengths of stays, decreased frequency of admissions, and a subsequent reduction in overall treatment costs (Chinman, Weingarten, Stayner & Davidson, 2001). Other studies also suggest that the use of peer support can help reduce the overall need and use for mental health services over time (Chinman, et. al, 2001; Klein, Cnaan, & Whitecraft, 1998; Simpson & House, 2002).

There is ample evidence from policy reports that a gap exists in the quality of services available for people with mental illnesses (New Freedom Commission Report, 2006; IOM, 2006) This is intricately linked to the overall quality of health services, and the failure to coordinate care across the spectrum of general and mental health care (IOM, 2006). In addition, a research base has been established that demonstrates that peer support services are an effective component of mental health care (Davidson et. al., 2003; Felton, et. al, 1995; Mead & MacNeil, 2006). These findings support the role of the Peer Support Specialist in person-centered care and the promotion of a whole-health recovery approach. The Center for mental Health Services has also promulgated a set of recovery principles that embrace the role of peer support (SAMHSA, 2004). The combined findings of policy and research reports demonstrate the importance of advancing the Pillars of Peer Support as resources to foster the growth and evolution of the peer support workforce.

Peer Support Findings at the State Level

As a part of the participation in the Pillars of Peer Support Services Summit each state was asked to complete a survey on the scope of peer support services in their state. Twenty-two of the twenty-three participating states completed the survey. Yet, not all states completed all of the questions. The results of this survey provide a comprehensive accounting for how states are effectively using peers, their roles, and the opportunities and challenges they face. The specific areas of review for the participating states examined their demographics, experiences with the role, challenges, and reimbursement of Peer Support Specialists in their states. This is the first comprehensive review to examine the status of peer support services for state level mental health systems of care. This material is a useful assessment and illustration of the current status of peer support services in state level mental health system.

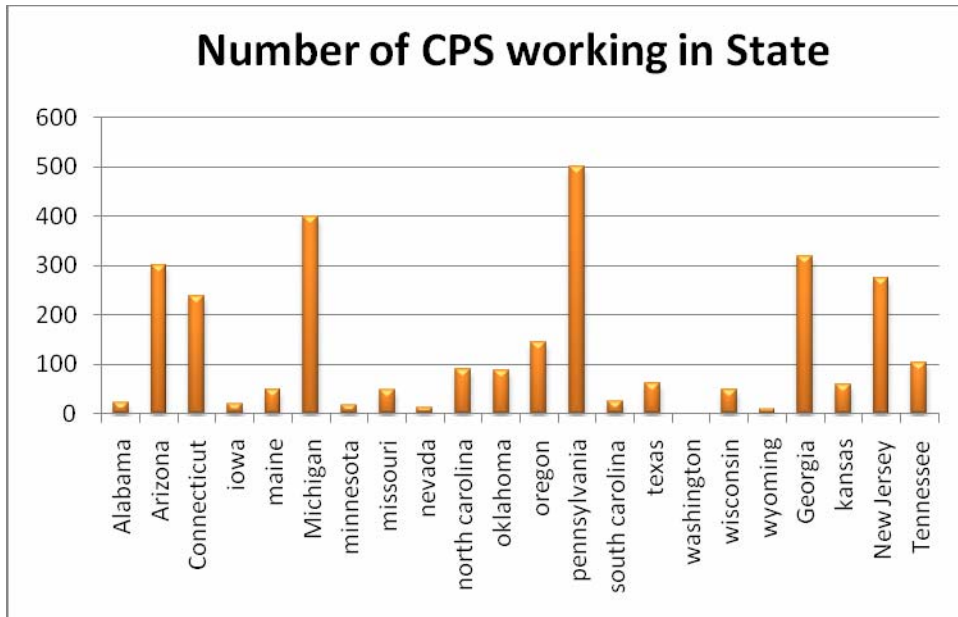
Peer Specialists Employed in State Systems

The findings of this study support the diverse role of Peer Support Specialists in state mental health systems. The range of consumers employed in the states varied widely from a high of 500 in Pennsylvania to a low of 9 in Wyoming (see Figure 1). Of the twenty-one respondents ten states are currently employing at least 50 consumer peer support specialists (Arizona, Connecticut, Georgia, Maine, Missouri, North Carolina, Oklahoma, Oregon, Pennsylvania, Texas, and Wisconsin). Of the seventeen states that responded to the question “Does your state have a distinct CPS service that is Medicaid billable”, five do not currently have distinct Medicaid billable programs (Alabama, Maine, Nevada, North Carolina and Texas) (see Figure 2).

Figure 1.

Approximately how many consumers are employed as peer specialist in your state?

N = 21. The range was from 9 to 500.



Rates of Medicaid Reimbursement

The rates of reimbursement for Medicaid peer support services were tracked for the participating states. The states that indicated they do not have a billable program are Alabama, Maine, Nevada, North Carolina and Texas (see Figure 2). The most common reporting increment was in fifteen minute increments. For comparison, hourly rates were divided into a fifteen-minute rate. The range for reimbursements was between \$3 and \$19 per billable fifteen-minute increment (see Figure 3). The average rate of reimbursement was \$10/fifteen-minute unit of service. One state (Iowa) reported reimbursement on a monthly basis of \$150. Tracking billable services is also an important aspect of billing for peer support services. The states that answered indicated that they track by billing codes and one reported using service logs.

Figure 2.

Do you have a distinct service called peer support that is Medicaid billable?

N = 17

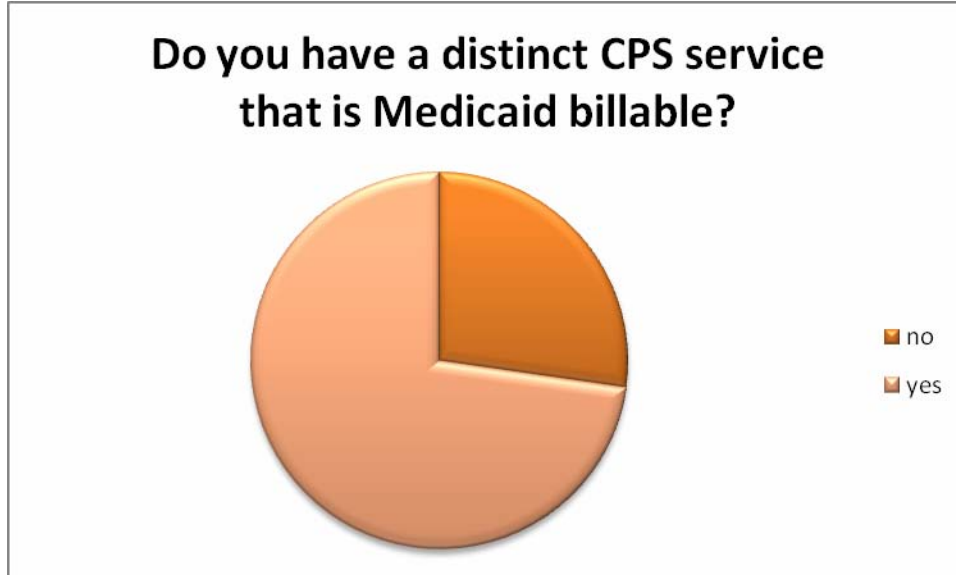


Figure 3.

What is your state's Medicaid reimbursement rate for peer support?

N = 13



Training Peer Support Specialists

Training is an essential component of peer support services. Most states have a minimum number of training hours required for certification. However, six of the seventeen states who responded to the question regarding training (Maine, Nevada, Oregon, Texas, Wyoming, and Wisconsin) have requirements to complete a module-based training (see Figure 4). Of the states requiring a minimum number of training hours, the range is from a high of eighty to a low of forty. Of the remaining eleven states that require a minimum number of training hours, six states (Arizona, Missouri, Oklahoma, South Carolina, and Washington, and Kansas) set the standard at forty hours.

Figure 4.

Required Hours of Training

N = 17



Certification of Peer Support Specialists

Certification is a key component of state workforce programs for peer support services. All but two of the seventeen states who responded to the question regarding certification indicated that

they had certification processes (see Figure 5). The most common certifying agent is the state department of mental health, and some states use other entities including advocacy groups and academic institutions (see Figure 6). One state reported that they were in the process of defining the certification process.

Figure 5.

State Certification

N = 17

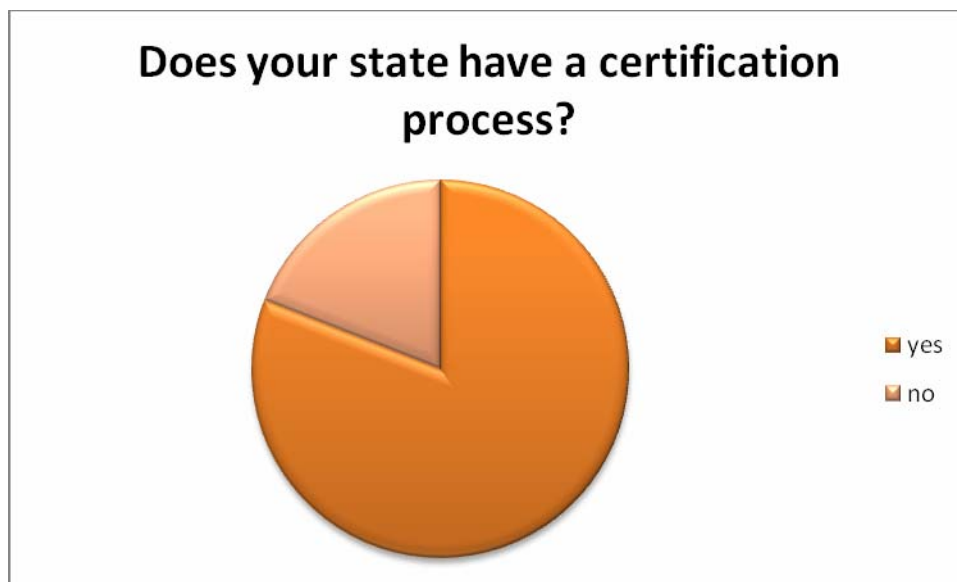
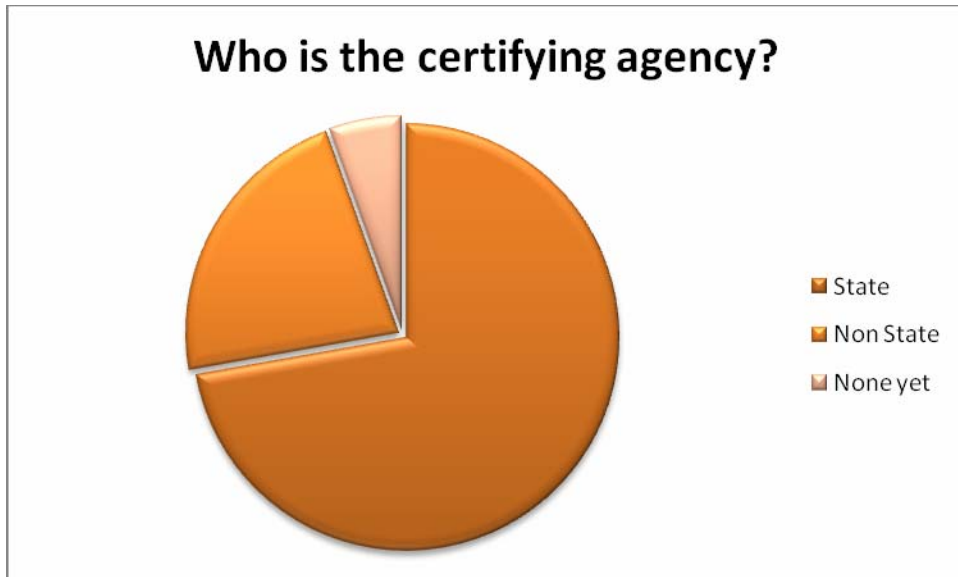


Figure 6.

State Certification of CPS

N=17



Barriers to Implementation of Peer Support Services at the State Level

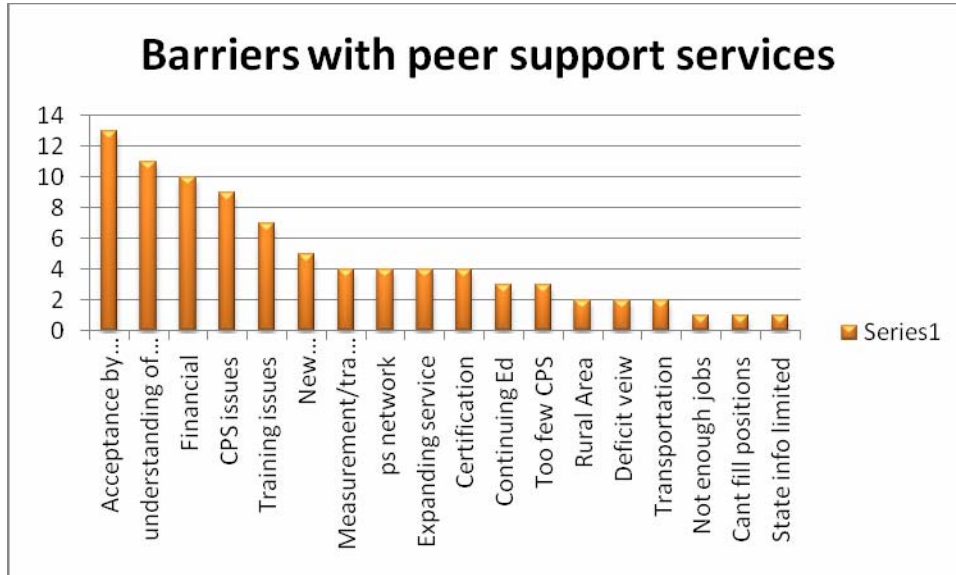
Twenty two states reported a range of barriers to implementing peer support services.

Additionally, each state reported a number of barriers and concerns. The most common findings were the acceptance of PSS at mental health centers, financial issues, overall understanding of the PSS role, and common CPS issues (See Figure 7). The range of common CPS issues include: dual role stress; lose disability benefits due to income; afraid to ask for help; fear of job loss; lack of anonymity; misunderstanding own role; and burn out and turn over.

Figure 7.

Barriers to Implementing Peer Support Services

N = 22



Unique Attributes of Peer Support in State Systems of Care

A series of three qualitative questions were also posed to each state. Detailed reports of these findings are included in Appendix 2. The questions posed to each state include:

- 1. What do you think are the strengths, unique qualities or innovations of your program?**
- 2. What infrastructure do you believe must be in place at the state level to run a successful peer support program?**
- 3. What recommendations would you make to states attempting to set up this kind of program for the first time?**

The input from these questions supports the need for a set of common principles for the strategic development, implementation, promotion, and maintenance of peer support services in state systems of care. While each state has adopted a range of implementation strategies, there have

been some common design elements across states. These include consultation for the development of Medicaid reimbursement waivers, technical assistance for program start up, and curriculum development and training programs for peer support. There is also a need for ongoing support and resources to sustain peer support services in existing states, and a commitment to grow peer support in states that do not currently have these services.

Based upon the findings from the survey, extensive work from Appalachian Consulting Group (ACG), and the summit planning committee, a set of key principals were developed. These “Pillars of Peer Support Services” were created as a framework for the summit to consider and modify based upon their experience.

Pillars of Peer Support

One of the principal goals of the summit was to examine the role of peer support programs in various states and to use this information to foster a set of “Pillars” or guidelines for developing and implementing new programs. The review of how the participating states are using peer support yields a range of strategies as described above. While there are ongoing challenges, it is clear that the participating states have been successful in the use of peers in their workforces and overall systems of care.

The Pillars of Peer Support are intended to be a resource for existing states in their work with the PSS workforce, as well as a tool for states that are beginning or expanding their programs. In the Summit work groups reviewed an initial set of Pillars and examined them from their state based experience. Proposed changes were then assimilated by the summit work group and a new list was created. There was broad consensus for the list and support for their adoption. The summit

participants also used the Pillars of Peer Support Services to develop a set of recommendations for their implementation.

The Pillars of Peer Support Services

Created by State Representatives at the Carter Center: Pillars of Peer Support Services Summit
November, 2009

A state's Peer Specialist Certification Program is strengthened when...

1...there are **Clear Job and Service Descriptions** that define specific duties that allow Certified Peer Specialists to use their recovery and wellness experience to help others recover.

2 ...there are **Job-Related Competencies** that relate directly to the job description and include knowledge about the prevalence and impact of trauma in the lives of service recipients as well as trauma's demonstrated link to overall health in later life.

3...there is a **Skills-Based Recovery and Whole Health Training Program** which articulates the values, philosophies, and standards of peer support services and provides the competencies, including cultural competencies and Trauma Informed Care, for peer specialist duties.

4...there is a **Competencies-Based Testing Process** that accurately measures the degree to which participants have mastered the competencies outlined in the job description.

5...there is **Employment-Related Certification** that is recognized by the key state mental health system stakeholders, and certification leads directly to employment opportunities that are open only to people who have the certification.

6...there is **Ongoing Continuing Education**, including specialty certifications, that exposes the peer specialists to the most recent research and innovations in mental health, Trauma Informed Care and whole health wellness, while expanding their skills and providing opportunities to share successes, mentor and learn from each other.

7...there are **Professional Advancement Opportunities** that enable Certified Peer Specialists to move beyond part-time and entry level positions to livable wage salaries with benefits.

8...there are **Expanded Employment Opportunities** that enable certified peer specialists to be employed in a variety of positions that take into account their own strengths and desires.

9...there is a **Strong Consumer Movement** that also provides state-level support, training, networking and advocacy that transcends the local employment opportunities and keeps Certified Peer Specialists related to grassroots consumer issues.

10...there are **Unifying Symbols and Celebrations** that give Certified Peer Specialists a sense of identity, significance and belonging to an emerging profession or network of workers.

11...there are ongoing mechanisms for **Networking and Information Exchange** so that Certified Peer Specialists stay connected to each other, share their concerns, learn from one another's experiences, and stay informed about upcoming events and activities.

12...there is **Media and Technology Access** that connects Certified Peer Specialists with the basic and innovative information technology methods needed to do their work effectively and efficiently.

13...there is a **Program Support Team** that oversees and assists with state training, testing certification, continuing education, research, and evaluation.

14...there is a **Research and Evaluation Component** that continuously measures the program's effectiveness, strengths and weaknesses and makes recommendations on how to improve the overall program.

15...there are opportunities for **Peer Workforce Development** that help identify and prepare candidates for participation in the training and certification process.

16... there is a **Comprehensive Stakeholders Training Program** that communicates the role and responsibilities of Certified Peer Specialists and the concepts of recovery and whole health wellness to traditional, non-peer staff (peer specialist supervisors, administration, management and direct care staff) with whom the Certified Peer Specialists are working.

17...there are **Consumer-Run Organizations** that operate alongside government and not-for-profit mental health centers that intricately involve consumers in all aspects of service development and delivery and provide value-added support to the peer workforce.

18...there are regularly-scheduled **Multiple Training Sessions** that demonstrates the state's long-range commitment to training and hiring Certified Peer Specialists to work in the system.

19...there is a **Train-the-Trainer Program** for Certified Peer Specialists that demonstrates the State's commitment to developing its in-state faculty for the on-going training.

20...there is **Sustainable Funding** that demonstrates the State's commitment to the long-term success and growth of the program.

21...there is **Multi-Level Support** across all levels of the government, with champions at all levels, that demonstrates the State's commitment to the program and continually promotes the valuable role of Certified Peer Specialists in the system

22...there is a **Peer Specialist Code of Ethics/Code of Conduct** that guides peer support service delivery.

23...there is a **Culturally Diverse Peer Workforce** that reflects and honors the cultures of the communities served.

24...there is **Competency-Based Training for Supervisors** of Certified Peer Specialists which reinforces fidelity to the principles of peer support and emphasizes the role of peer specialists in building culturally competent and trauma informed systems of care that take into account the overall health and wellbeing of persons served.

25...there is opportunity for Certified Peer Specialists to receive training in and deliver **Peer Support Whole Health Services** to promote consumer recovery and resiliency.

These Pillars of Peer Support are intended as a set of guiding principles for the development of state based programs. They are also directly applicable to other organizations and roles that utilize the resources of Peer Support Specialists. As a result of the development of the Pillars, the summit was also able to develop a set of recommendations for their use and implementation.

Recommendations for the Implementation of the Pillars of Peer Support

The participants in the summit built upon the development of the Pillars with a set of recommendations for their implementation. This set of recommendations is a compilation of

three summit work groups who proposed next action steps. In general these divided into a set of guidelines for various stakeholders. The framework for these recommendations includes an identified stakeholder, a proposed set of actions, and a time line for implementation. Due to the framework and goals of the summit, these recommendations are specifically tied to state-based mental health systems of care and Medicaid-funded services. They are however, broadly applicable to other systems of care including the Veterans Administration, managed care organizations, and other service delivery systems.

These six recommendations were developed from the summit and should be tracked for progress and implementation over the period outlined in each. There was also a consensus from the summit that this group should continue as a working group to monitor and track progress, if sustainable funding can be generated.

1. NASMHPD should adopt and endorse the Pillars of Peer Support and use their resources to disseminate and promote them both within their organization and with their stakeholder groups within the next year.
2. SAMHSA/CMHS should adopt and endorse the Pillars of Peer Support and use their resources to disseminate and promote them both within their organization and with their stakeholder groups within the next year.
3. SAMHSA should create a National Center of Excellence for Peer Support, endorse the Pillars of Peer Support as a best practice for peer support implementation, and identify funding to assist all states on implementing peer support in two years.

4. NASMHPD, SAMHSA/CMHS, and CMS should issue a letter to State Medicaid Directors in support of the Pillars of Peer Support and recommendations for their implementation by 6/1/10.
5. NASMHPD/NRI and SAMHSA/CMHS should convene a task force to develop common data standards and service codes for peer support that are based upon the Pillars of Peer support, and incorporate them into the NOMS and other data collected from all states for the 2010 data year.
6. Managed care entities that operate state mental health contracts should adopt and endorse the Pillars of Peer Support and use their resources to disseminate and promote them both within their organization and with their stakeholder groups within the next year.

Conclusion and next Steps

The Pillars of Peer Support Services Summit was convened in November, 2009 with support from: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), National Association of State Mental Health Program Directors (NASMHPD), Depression and Bipolar Support Alliance (DBSA), Wichita State University Center for Community Support and Research, Appalachian Consulting Group (ACG), Carter Center, OptumHealth, and Georgia Mental Health Consumer Network. This group helped to convene leaders from states that currently have peer support programs that are billing Medicaid for these services. The result was an active and lively review of the state of peer support in state based mental health systems of care.

As a part of the summit, data was collected and reported on the current status of peer support services in state based systems. To date this is the most comprehensive review of PSS in

these systems. Hopefully this data can be useful in a variety of settings to endorse and expand the level of peer support services across diverse systems of care.

Based upon the summit findings a set of “Pillars of Peer Support Services” were developed and endorsed. These are intended to be both guidelines and resources for the implementation of peer support services. The participants in the summit pledged their existing tools and resources for others to use in the development and expansion of peer support. At the present time a formal mechanism for this sharing and mutual technical assistance does not exist, but may grow out of the summit if there is a sustainable infrastructure.

A set of six recommendations have been developed by the summit participants. Hopefully, each of the named stakeholders will engage in a process to review and implement the recommendations. While the summit does not have identified next steps, the organizing committee and sponsors remain available to help support the implementation of the pillars.

The findings of this report demonstrate that peer support has gained an important and effective role in state systems of mental health care. The goals and principles of peer support are consistent with contemporary policy reports including the New Freedom Commission, the Institute of Medicine, and others. The Pillars of Peer Support that are outlined in this report provide a framework for future services to be built upon. They have been adopted by a consensus group and can serve as tools to help move the field forward. Recognition is due to the forward thinking states that participated in this summit to foster the evolving transformation of mental health services and strength based recovery.

References

- Berwick, D.M. (2002) A user's guide for the IOM's quality chasm report. *Health Affairs (Millwood)* 21 (3) 80 – 90.
- Center for Medicare and Medicaid Services (2007), Letter to state Medicaid directors, <http://www.cms.hhs.gov/SMDL/downloads/SMD081507A.pdf> (accessed 1/2010).
- Chinman, M.J., Weingarten, R., Stayner, D., and Davidson, L. (2001) Chronicity reconsidered: Improving person-environment fit through a consumer run service. *Community Mental Health Journal*. 37 (3) 215-229.
- Chinman, M., Young, A.S., Hassell, J., Davidson, L. (2006) Toward the implementation of mental health consumer provider services. *Journal of Behavioral Health Services & Research*. 33 (2) 176-195.
- Daniels, A., Adams, N., Carroll, C., Beinecke, R. (2009) A conceptual model for behavioral health and primary care integration: emerging challenges and strategies for improving international mental health services. *International Journal of Mental Health*. Vol. 38 no. 1, 101 – 113, Spring.
- Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., and Tebes, J.K. (1999) Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*. 6 (2) 165-187.
- Fricks, L. (2005). Building a Foundation for Recovery: A Community Education Guide on Establishing Medicaid-Funded Peer Support Services and a Trained Peer Workforce. DHHS Pub. No. (SMA) 05-8089. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.
- Grant, E. (2009) An examination of the integration of certified peer specialists into community mental health centers. Unpublished manuscript. Wichita State University, Wichita.
- Grant, E.A., Swink, N., Reinhart, C., and Wituk, S. (In Press) The development and implementation of a statewide certified peer specialist program. Brown, L.D. & Wituk, S. (Eds.). *Mental health self-help: Consumer and family initiatives*. New York: Springer.
- Institute of Medicine (IOM), 2006. Improving the quality of health care services for mental and substance abuse conditions: quality chasm series. Washington, DC: National Academies Press.
- Institute of Medicine (IOM), 2001. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academies Press.
- Klien, A.R., Cnaan, R.A., and Whitecraft, J. (1998). Significance of peer social support with dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice* 8 (5) 529-551.

- Kyrouz, E.M., Humphreys, K., and Loomis, C. (2002). A review of research on the effectiveness of self-help mutual aid groups. In B.J. White and E.J. Madara (Eds.), *American self–help clearinghouse self-help group source book* (7 ed., pp 71-85). Cedar Knolls, NJ; American Self-Help Group Clearing House.
- New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD.
- Orwin, D., Briscoe, J., Ashton, L., and Burdett, J. (2003) Reflections on a pilot peer support service. The mind and body research and development team. 1-9.
- Report to the President from The President’s Commission on Mental Health. (1978) Volume One. U.S. Government Printing Office, Washington, DC.
- Sabin, J.E. and Daniels, N. (2003) Strengthening the consumer voice in managed care: VII the Georgia peer specialist program. *Psychiatric Services*. 54, 4 497-498
- SAMHSA (2004) National consensus statement on mental health recovery. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; Center for Mental Health Services, www.samhsa.gov.
- Simpson, E. L. and House, A.O. (2002) Involving users in the delivery and evaluation of mental health services: systematic review. *British Medical Journal*. 325, 1-5.
- U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- U.S. Department of Health and Human Services (2003). *Emerging New Practices in Organized Peer Support*: National Technical Assistance Center.
- White, W. (2000) The history of recovered people as wounded healers: from native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly*. 18 (1) 1-22.
- Woodhouse, A. and Vincent, A. (2006) Mental health delivery plan—development of peer specialist roles: A literature scoping exercise. Scottish Recovery Network and the Scottish Development Centre for Mental Health, Edinburgh.

Appendix 1.

Appendix 2.

State Medicaid Director letter – Peer Support Services

<http://www.cms.hhs.gov/SMDL/downloads/SMD081507A.pdf>

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



Center for Medicaid and State Operations

SMDL #07-011

August 15, 2007

Dear State Medicaid Director:

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

Background on Policy Issue

States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services. The following policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers.

As States develop behavioral health models of care under the Medicaid program, they have the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system. When electing to provide peer support services for Medicaid beneficiaries, State Medicaid agencies may choose to collaborate with State Mental Health Departments. We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service.

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

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

Delivery of Peer Support Services

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

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

1) Supervision

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

2) Care-Coordination

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

Page 3 – State Medicaid Director

3) Training and Credentialing

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

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

Sincerely,
/s/
Dennis G. Smith
Director

cc:

CMS Regional Administrators

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

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

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

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

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

Debra Miller
Director for Health Policy
Council of State Governments

Appendix 2

A qualitative Review of State by State Implementation of Peer Support Services

1. What do you think are the strengths, unique qualities or innovations of your program?

This question had a large variety of answers with little overlap. All 22 responding states answered this question.

| State/Respondent | Response/findings |
|-------------------------|---|
| ALABAMA | We have had three certification trainings and have a long waiting list of consumers who want to take the training. Our first peer specialist was hired in 1994 at one of our state hospitals, she is still on the job today. We have established a state peer specialist association--the Alabama Peer Specialist Association. We have one peer specialist working with deaf and hard of hearing consumers. |
| ARIZONA | In Arizona, we celebrate the diversity and self-determination of our Consumer Run Agencies and their grassroots origins to serve their own community. For example, RIAZ provides wellness and vocational rehab programs; REN emphasizes self-advocacy and empowerment; Our Place clubhouse runs one of the most successful restaurants in Tucson, and The Pinal Hispanic Council serves the Latino community in Eastern Arizona. |
| CONNECTICUT | Blending the role of peer support and relational skills with practical, competency based knowledge of the mental health system. |
| GEORGIA | Strong Partnership with the GA Mental Health Consumer Network. A strong, inclusive and culturally diverse workforce, including three CPSs who are living with legal blindness and several who are multi-lingual. The Peer Support Whole Health Initiative. A new policy that began in 2009 so that peers who have been certified in other states can obtain their GA certification. |
| IOWA | ACG has shared with us some of the best practices from other states, and we think we meet some of those. We use a train-the-trainer program, continuing education efforts, efforts to add substance abuse training into our curriculum, strong connections to our statewide consumer membership organization, Iowa Advocates for Mental Health Recovery, and the Peer Support Roundtable offered by Magellan, which brings together folks from all over the state on a monthly basis, and there is a new initiative within our Dept. of Corrections, to consider utilizing peer support in our prison system. Also, as of July 1, 2010, our Magellan contract will expand to serve about an additional 25,000 individuals on Medicaid who are over 65. Peer Support is provided increasingly within the usual places of care, and this permits excellent collaboration within provider organizations, around development of peer support. |
| KANSAS | The State of Kansas has 27 Community Mental Health Centers (CMHC's) across the state, 26 are providing Peer Support services to varying degrees. Currently there are 60 FTE Peer Support staff across the State. The CMHC's in Kansas are striving to seek out qualified individuals and utilize the unique skills they bring to the Peer Support Program. Peer Support staff are available for crisis support, support with activities of daily living, support to achieve individualized goals and develop strategies necessary to move forward in recovery. CMHC's are beginning to utilize Peer Support staff to assist with transition from the hospitalization back to the community as an effort to provide support and decrease readmission. |
| MAINE | The CIPSS (Certified Intentional Peer Support) training program creates a solid foundation in the philosophies and values of intentional peer support. On-going support for participants is created through quarterly co-supervision meetings and continuing education classes. Intentional Peer Support is a philosophy based on four tasks used to develop and maintain relationships. Through relationships we think about help in a new way. Rather than |

| | |
|-----------|---|
| | <p>focusing on problem solving and what we don't want in our lives, we instead challenge one another to discover our hopes and dreams. Together we learn and grow and move towards what we want. Another strength of the peer support program in Maine is the impact on traditional services, both in philosophy and in practice. Some innovative programs include peer support in emergency departments and peer crisis respite.</p> |
| MICHIGAN | <p>Michigan has developed a strong training program in partnership with Lansing Community College (LCC) and the Appalachian Consulting Group. Individuals who meet all requirements for certification receive 3 elective credit hours from LCC. Michigan Certified Peer Support Specialists work as consultants contracted by MDCH to provide training and continuing education. Continuing education requirements mirrored after national social work standards are currently under development. Peer whole health is a strong focus with over 100 CPSS trained in the Evidence based Stanford Chronic Disease Self Management Program (CDSMP) titled Personal Action Toward Health (PATH) in Michigan. Peer trainings are conducted at retreat centers encouraging connections and friendships developed during both day and evening activities. CPSS have developed a facebook group and a newly formed statewide association. Each PIHP and community mental health agency in the state has a designated liaison. Bimonthly meetings with liaisons are held to discuss strengths, barriers and outcomes of the peer trained workforce. During the initial peer training multiple continuing education events occur simultaneously providing networking, support opportunities, and mentoring. Peer services are a 1915 b (3) waiver coverage therefore CPSS as a covered service are required in every area of the state. In June 2009 the first annual statewide peer support specialist conference occurred with over 400 individuals attending. MDCH has specific requirements for the role of CPSS in areas of evidenced based practices. Each team providing DBT have a CPSS as a required and integral component. CPSS are employed in areas implementing supported employment. In addition, CPSS are involved in a variety of services within the Integrated Dual Disorder Treatment teams. Several peer initiatives in Michigan are currently part of research projects at the state and national level</p> |
| MINNESOTA | <p>The Minnesota Certified Peer Specialist program is in its first phase of implementation. At this stage we are designing policy/program guidance and establishing systems to track certifications. The strengths of our current effort include: our partnership with the Mental Health Consumer/Survivor Network of Minnesota (a free-standing, nonprofit primary consumer operated agency with a state-wide presence), our focus on ensuring employment for individuals who become certified and creating a career ladder to promote retention in the field.</p> |
| MISSOURI | <p>The Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services State Advisory Council members researched and chose a Peer Specialist training and certification model. Based on the Council recommendations, the Division has adopted the Appalachian Consulting Group "Georgia Model" for Peer Specialist training. The Division and the Office of Transformation are committed to following through on the Council recommendations to move the mental health system to a wellness model that empowers individuals to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. One primary strategy in transforming the system is to recognize the power of consumer as providers. Recognizing consumers as providers is taking root in the mental health system. Emerging evidence strongly supports the need for peer support services as a cost-effective and complementary adjunct to professional mental health services and supports. Peer support services can move the system to focus less on illness and disability and more on wellness. To accomplish this goal, Missouri has provided equal weight to expertise gained through the "lived experience" as is done with other credentials or knowledge base. A Peer</p> |

| | |
|------------|--|
| | <p>Specialist can share lived experiences of recovery, share and support the use of recovery tools and model successful recovery behaviors. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. Additionally, Peer Specialists can help consumers connect with other consumers and with their community at large.</p> <p>With the oversight of the State Advisory Council, three Peer Specialist Basic Trainings have been conducted in 2008-2009. The week-long training has been conducted by Randy Johnson an Appalachian Consulting Group trained consumer and an employee of Mental Health America of the Heartland. He has trained three additional Missouri Peer Specialist Trainers, two of which are Council members. To date 90 individuals have been trained and 48 have reached the goal of Certified Missouri Peer Specialist status. Twenty community mental health centers have sent individuals to the training and 12 have certified peer specialists working in their agencies. Six Consumer Operated Services Program Drop-In Centers and Warm Lines sent individuals to the training. Additionally, the Veteran’s Administration, residential providers, Services for Independent Living, and a substance abuse treatment agency have sent individuals to the training. Two Peer Specialist Supervisor Trainings were conducted. In 2009-2010, three additional Peer Specialist Basic Trainings and three Supervisors trainings will be planned. Additionally, there are plans for a more cohesive network to be formed with regular conference calls of the trained individuals to provide ongoing support and consultation.</p> |
| NEVADA | focus on recovery and peer counseling |
| NEW JERSEY | <p>One of the greatest innovations of this project was the early engagement of Focus Groups consisting of: consumers, families, consumer providers, and professionals to inform the delivery, design and evaluation of the peer wellness coaching project. A major strength of our program is that DMHS used information that was gathered from our Transformation Stakeholder Input Process to drive the design of the peer wellness coaching project.</p> <p>Clearly “coaching” as a peer-delivered service was articulated by our consumer stakeholders as a preferred model of service delivery for our system of care. In addition, the curriculum incorporates a holistic approach to health and wellness which was also articulated by our consumer stakeholders. The curriculum includes and modules on fear of services, nutrition, oral health exercise/movement and motivation. UMDNJ-SHRP works collaboratively with its School of Alternative and Complementary Medicine to provide expert lectures on these important topics. Yet, what was most impressive and unique about this program was the integrity and commitment of the newly trained peer wellness coaches, who at the commencement, each spoke to the profound life transformation that they had experienced as a result of their pursuit of the life coach credential.</p> <p>A major strength of our peer support service is our close collaboration with the University of Medicine & Dentistry of New Jersey's School of Health-Related Professions and the nationally renowned Institute for Wellness and Recovery Initiatives out of Collaborative Support Programs of NJ. Each of these organizations has provided national leadership in proactively addressing the early mortality and medical co-occurring morbidity of persons with psychiatric disabilities through SAMHSA's 10 by 10 Campaign. Key members of their faculty have published extensively on issues related to the promotion of health and wellness of mental health consumers. A key advantage of the program is that students enrolled in the curriculum have the opportunity to translate their newly acquired knowledge and skills on the job as the course is structured to be in the</p> |

| | |
|-----------------------|--|
| | <p>form of a practicum. Finally, students who successfully complete the 16-day curriculum and the examinations will earn 6 undergraduate academic credits.</p> |
| <p>NORTH CAROLINA</p> | <p>One of the most important strengths is that the NC State Leadership at the Division of MH/DD/SAS and Division of Medical Assistance understands, supports, and includes in policy a recovery based service delivery system and peer services. This has allowed for growth of peer services in the delivery system. Since 2006, ACT and CST have offered opportunity for employment of Certified Peer Support Specialists.</p> <p>The state has a process to certify consumers as Peer Support Specialists and a process to approve PSS training curriculum that meet specific training standards. Another strength in North Carolina is the consumers and provider network, which has demonstrated creative and innovative methods for developing and funding Peer Services. Some of the Providers and programs are:</p> <ul style="list-style-type: none"> • Recovery Innovations – <ul style="list-style-type: none"> o Community Building - A recovery-centered program to help individuals obtain and remain in housing of their choice and become a contributing member of their community. o Restart program – A recovery-centered program committed to helping individuals who have experienced mental health challenges wishing to "start over". Participants are offered short-term housing in an independent apartment setting with peers and professionals assisting participants to achieve the goals they have identified as central to "restarting" their lives. o The Recovery Response Center - Staffed with a team that includes physicians, nurses, mental health professionals and peer support specialists, the Recovery Response Center offers a "Living Room" crisis alternative recovery environment that supports the values of hope, choice and empowerment from the onset of a person's entry into the program. o Wellness City - A community made up of individuals embarking on or expanding their recovery journey. A staff of well-trained peers who have experienced their own recovery challenges and successes will share what they have learned and will work alongside practitioners and educators who are committed to the founding principles of the recovery community. • Meridian Behavioral Health Services – <ul style="list-style-type: none"> o The Recovery Education Program provides a supportive and empowering environment that facilitates wellness and skill-building through an educational model. The program facilitates a culture of self-determination and empowerment by offering classes, courses and seminars in various Wellness Management approaches and Wellness Toolbox topics. • Mecklenburg's Promise – <ul style="list-style-type: none"> o Peer Bridger - serve as mentors, providing support, encouragement, information and above all, hope. Mecklenburg's PROMISE Peer Bridger program works with people transitioning from an inpatient setting into the community, as well as those who are already in the community and are looking for an advocate, role model, and mentor. o Peer Support Services Warm Line - a peer run, confidential, non-crisis telephone support service available to all individuals in Mecklenburg County with mental health challenges. Our trained peers are available to listen to your concerns, provide supportive confidential conversation, and information on community resources. o The Giving Tree Drop-In Center - a place individuals involved with Mental Health services in Mecklenburg County can go to "hang out," get involved, pursue an interest or just meet other people with similar interests. The Drop-In Center offers daily workshops such as: Poetry Groups, Music Classes, Coffee Houses, GED classes, Computer Lab, Painting, WRAP (Wellness Recovery Action |

| | |
|----------------|---|
| | Planning), as well as peer support groups. |
| OKLAHOMA | We have been doing this for almost 5 years now. We have been making strides to teach not only the people we serve but providers about recovery, peer services etc as an idea for wellness. We have recently teamed up with our local NAMI affiliate to help coordinate the trainings. We have a variety of trainers from different communities and walks of life come in to provide training modules. Generally speaking in the public provider sector we have a strong belief in recovery and a general acceptance that peer support services are a necessary component of recovery. |
| OREGON | Oregon has developed a strong peer delivered services movement. We are taking a broad approach from Recovery Mentors in the Addictions system, Peer Bridger program at the Oregon State Hospital, Family Navigators in the Children's Mental Health System, consumer/survivor help run help lines, and a strong adult mental health consumer/survivor network of services and supports. We are actively supporting the development of a training program for young adults (transition age youth). Peer support and peer directed programs are scattered throughout the state, and offer numerous opportunities for training and education on mental health systems change, advocacy, and job opportunities to enter the workforce. Oregon is taking a broad policy approach to peer delivered services that includes the child and adult mental health system and the addictions system. It has been identified as one of the key policy initiatives for the Addictions and Mental Health Division. |
| PENNSYLVANIA | <p>--- PA took the time to prepare our environment for a new way of doing business. We offered technical assistance, presentations and lots of personal stories all over PA, so stakeholders would see peer support as more than a service/program but a fundamental shift in how the mental health system operates.</p> <p>--- PA is unique in that Certified Peer Specialist supervisors also go through a two-day supervisory training (mandatory).</p> <p>--- Because our state leaders are strong backers of the peer support service, we added a component to our state-plan amendment that basically states- The peer support service is an in-plan services and there must be choice. In other words, every county must provide the service and there must be a choice of two providers.</p> <p>--- As a Medicaid billable service, we added an option where free-standing peer support services could also bill.</p> <p>--- PA has an approved Medicaid billable peer support service as one source of funding. We have partnered with the criminal justice system and have peers doing in-reach and outreach in our jails. We created a civil service classification so peer support specialists can work in our state hospitals and walk with people as they go from hospital to community.</p> <p>--- The certified peer specialist initiative has created unity amongst peers throughout PA. With over 1000 certified peer specialists we have seen the need to create local and regional peer support professional networking meetings across the state. We also have a PA Peer Coalition to assist us (peers) to unify for success in the workplace.</p> |
| SOUTH CAROLINA | In addition to the initial certification program, HHS requires and we provide, continuing education opportunities for our certified peer support specialists, we have reached an agreement with the states A&D, the Depart. of Alcohol and Other Drug Abuse Services, and our local Veterans Hospitals, William Jennings Bryant Dorn in Columbia and Ralph H. Johnson VA Medical Center to provide basic core training for their peer specialist as well. We offer peer training to interested parties out-of state, Central Ala. VA Hospital. We have developed a recertification procedure, ethics training and a code of conduct, a readiness self assessment and training on role transformation. We partner with our states client run organization as well as DAODAS in the certification training. We have a low client to cps ratio of 1 to 8 increasing intensive skill building opportunities. We also do a basic services evaluation each year. We also developed a powerpoint to explain the service to other staff and handbook for supervisors. |

| | |
|------------|--|
| TENNESSEE | <p>Tennessee’s statewide system of 46 Peer Support Centers staffed solely by consumers shines as a unique innovation. The peer support provided through the BRIDGES psychoeducational courses as well as the BRIDGES support groups stand as a significant strength in our state. The state certification program for Tennessee Certified Peer Specialists was developed by a workgroup of peers and is managed by a Certified Peer Specialist.</p> <p>The list of possible trainings required for a Certified Peer Specialist encompass quality trainings, such as WRAP, IMR, and BRIDGES.</p> |
| TEXAS | <p>understand the unique strengths and challenges of our system and how it works, enabling them to help other consumers work through the system to find resources. Lead support groups in the community.</p> <p>communicate with their peers on a substantially more practical level than the very best trained psychiatrist, nurse, caseworker or psychotherapist. They have knowledge that cannot be learned from a book or achieved by getting a clinical license. They do not use professional “jargon.” Have strong engagement skills and a stronger connection with the consumers.</p> <p>provide hope for recovery to other consumers by talking about their own experiences and how they have overcome barriers. They help the consumers feel “normal” and provide them with encouragement.</p> <p>provide perspective and insight to other mental health staff members about the challenges of having a mental illness, which provides the staff members with a new level of respect for the people they serve. Have greater insight as to how consumers perceive treatment. Have a true desire to give back to their peers who are experiencing what they have experienced. Provide feedback to administration and service directors regarding the best way to configure the system and reduce problems with access and treatment.</p> |
| WASHINGTON | <p>We reduce barriers to attendance by providing lodging and meals throughout the state sponsored training. We allow our regional mental health entities the opportunity to provide the trainings themselves in order to help increase the number of trainings offered each year. These entities must use the mandated curriculum, however they can add to it and some have been able to partner with community colleges to provide college credit.</p> <p>The majority of our trainers are either consumers or certified peer counselors or both and many of them come out of the trainings.</p> <p>The definition of consumer in Washington includes the parents of children receiving mental health services and this allows us to include them in the peer support program. Lastly, our process for reviewing and approving peer counselor application is based on the value of trying to include as many applicants as meet the minimum requirements. Before denying any application, we call the applicant and discuss their qualifications with them in order to allow an additional opportunity to capture information that might allow their application to be approved.</p> |
| WISCONSIN | <p>Although Peer Specialists throughout the state have been trained in a variety of different curriculum, we have developed a set of competencies that each of these curriculum must address. This will prepare them for the certification process which is currently being adopted. Currently, Peer Specialists and peer supports are being utilized in a variety of settings: community mental health, in patient units, crisis, warm lines and consumer recovery centers. The Medicaid infrastructure is in place for Peer Specialists and is currently being utilized. Two of our Independent Living Centers hire peer specialists and provide services directly or under contract with county agencies. Consumers are involved in the mental health council and various other advisory groups.</p> |
| WYOMING | <p>Base funding from state appropriations</p> <p>History—about 6 years experience with this project</p> <p>History in rural settings (very small towns with populations of less than 5,000) as well as in our largest community (population of about 60,000)</p> <p>The greatest strength is in the ongoing, positive commitment from those employed</p> |

| | |
|--|--|
| | <p>as peer specialists. The following two comments were provided by peer specialists: I believe in the power of peer support and I think is unique and unlike anything out there. I believe that our program here at Northern Wyoming Mental Health Center is focused on family voice and choice. We are family strength driven and are focused on the unique strengths of the peer specialist as well. Every guest that walks in the door for the first time interacts with the peer specialist prior to seeing a clinician. Our community supports the efforts of the peer specialist as well. The Peer Specialist is available to clients for a wide variety of services including WRAP, transportation, Emergency assistance. At our facility we provide technical assistance to clients including, computer skills training, low-cost computer sales and refurbishing, and help acquiring and using cell phones. Sharing of peer recovery stories with clients occurs in both the clinical setting and when working side-by-side in our Washakie Works program.</p> |
|--|--|

2. What infrastructure do you believe must be in place at the state level to run a successful peer support?

| State/Respondent | Response/findings |
|-------------------------|--|
| ALABAMA | A process for evaluating peer services. Training for providers on peer support, a continuing education program and expansion to a full Medicaid billable program |
| ARIZONA | The state agency must create their own peer run program with clear working goals and plans of actions. At AZDBHS, we have The Office of Individual and Family Affairs run by peers and family members. We are part of the Executive Team and report directly to the Director. We oversee all of the CSAs in the state and their contracts and services, and provide technical assistance to develop new programs and educational tools. |
| CONNECTICUT | Access to training, a professional development "ladder", appropriate supervision and understanding of the role, and adequate funding and penetration in the system to avoid tokenism and co-option of peer values. In consumer operated organizations funding must be sufficient to support a professional organization i.e. HR director, director of development, fiscal officer, compliance officer etc. Often the CEO has to wear all these hats even if they do not possess the background or skills to perform these functions. |
| GEORGIA | Filling of 4 vacant positions in the Consumer Relations and Recovery Section, increase in the number staff of the CPS Project itself to more than one person, CPSs at each regional office to provide extremely accessible technical assistance to CPSs in the field, continuing to build on the momentum toward resiliency built by the work done in GA with the Relaxation Response |
| IOWA | Within the programs that Magellan funds through community reinvestment, Medicaid is about 40-60% of the population that is served by the agencies using the community reinvestment dollars. In the long term, we have to figure out how to expand peer support into the non-Medicaid population. Staff time that is able to be devoted to the training, the maintenance of a certification process if/when we develop one, the need to do quality assurance at all levels, and just adequate funding and time to do with work of supporting the ongoing training, the train-the trainers, the many ongoing needs of graduates for support and employment |

| | |
|----------------|--|
| | related assistance, and continuing education needs and such things as maintenance of a website and contact lists with newsletters and other means for graduates to have access to each other and to quality information to support their needs going forward. |
| KANSAS | In August 2007 Centers for Medicare and Medicaid Services (CMS) sent a letter to State Medicaid Directors recognizing a greater emphasis on recovery from serious mental illness. Recovery is possible when individuals have access to supportive services in their communities. Along with recognition came the interest of States in providing peer support services and seeking to have the Peer Support staff identified as providers eligible to serve Medicaid eligible adults who experience mental illness or substance use disorders. The State of Kansas expanded their rehabilitative services model to include peer support services. Peer support services are respected as an evidence-based mental health care model. Peer Support providers receive training, credentialing, and ongoing supervision. Peer support services can be included as part of a comprehensive individualized treatment plan to assist the individual in recovery. |
| MAINE | A certification and oversight process, funding and funding mechanisms, standards of practice, competencies and leadership that supports and promotes integration of peer support. |
| MICHIGAN | Structural reimbursement mechanism for coverages approved and supported by Center for Medicare and Medicaid Services. Strong leadership, and commitment by central office staff. Recovery as a principle and practice embedded in state policy, Mental Health Code and contractual requirements. Well developed relationships and communication with consumer run programs and consumer networks. Strong core training program with expert trainers and clear certification requirements. |
| MINNESOTA | The State of Minnesota is partnering with the Mental Health Consumer/Survivor Network of Minnesota to implement the Certified Peer Specialist program. In doing so, the State is creating systems to guide program/curriculum standards, tracking and accountability for certified individuals. As we partner with the Mental Health Consumer/Survivor Network of Minnesota we hope to build their role as the leaders of this effort in Minnesota while maintaining the required oversight and monitoring role to assure compliance with federal Medicaid regulations. States must create infrastructure that supports the development of Certified Peer Specialist support as a mental health consumer led effort. |
| MISSOURI | The State level needs leadership committed to the belief that recovery is possible and that peer support is a crucial component in this process. The infrastructure needs a Peer Specialist Champion in the State system to continually work on the integration and enhancement of Peer Specialists into the services provided. The infrastructure also needs to include a web-based system for information, training registration and testing. Wichita State University has done an excellent job of providing these support services for Missouri. The web site is www.peerspecialist.org . |
| NEVADA | consumer focus |
| NEW JERSEY | We are seeking support in the area of a program development specialist to assist us in identifying best and promising practices in the area of peer support service models throughout the country and beyond. Resources for ongoing training and education of peers is widely needed and requested. The evaluation and refinement of standards, policies, and procedures that control and support credentialing of consumers in positions within the service delivery system to promote career ladders for consumer providers in our system would also be helpful |
| NORTH CAROLINA | |

| | |
|----------------|--|
| OKLAHOMA | Support, funding, and a demonstration that people in recovery can and do exist. I also believe that we need to have positions in leadership that are held by people in recovery and not just in the "Offices of Consumer Affairs". |
| OREGON | Funding is a needed ingredient to the development and sustainability of a peer support program. At present, small grants are in place to support peer directed programs. The state is exploring this issue with Medicaid and other funding sources. In addition to resources, onsite and remote technical assistance, networking opportunities, appropriate research and outcome measures, and information technology are all needed at the state level. In Oregon, we have numerous state-level leaders, including the Director of Addictions and Mental Health, who are knowledgeable and supportive of a peer support program. These leaders have access to state-of-the-art information and bring sophistication to the table as well as a general understanding of peer direction and services. Furthermore, Oregon's state-level leadership is empowered to draw upon external leaders to refine the program. Developing additional leadership from the community is necessary to ensuring expansion of this program. |
| PENNSYLVANIA | PA was blessed to have state leaders, who bought into the peer support service from the beginning and our timing was right. We had just put out our PA Call for Change document outlining our call to transform PA's mental health service delivery system and we were in the midst of closing the state hospital in our state's capital. Peers were part of the leadership team for both. This demonstrated the need for peers at all levels in our mental health system. We interlocked peer support as a necessary part of system's transformation. During the closure of Harrisburg State Hospital, we developed self-directed community support plans to replace the standard discharge plans. Peer support was offered to every individual going from hospital to community. The voice of people making this transition spoke up for peer support. |
| SOUTH CAROLINA | A recognized certification training program, a continuing education/recertification program, partnerships with other agencies with peer services, designated position descriptions, service descriptions, an evaluation program, trained trainers, code of conduct. Agency support supervisory training |
| TENNESSEE | Specific training for the mental health clinicians who will be supervising Peer Specialists. The person or persons running the peer support program from the state level should be Certified Peer Specialists themselves. |
| TEXAS | Structured initial and ongoing train the trainer training on peer support for the specialists in the field. Consumers should be involved in the curriculum development and the training process. Some areas of needed training are stated below: core competencies, on the job training, how to transition from peer to staff how to run a support group, listening skills, engagement, Having enough funding available to support the program. To allow peer support services encounters to count towards the centers' performance measures. To have the peers participate in the decision-making going on at the state-level. To have guidelines and policies that takes into consideration the differences between rural and urban areas. To have a person at the state-level to provide support for peer services, increase public knowledge, and to keep up to date on the evidence based practices for peer support services. To create a peer organization so they have a voice, can offer their perspective to other programs, can share ideas, and information can be disseminated to them. The implementation of structural (how services are provided in the setting) and process (values, beliefs and style of provider such as personal accountability, choice in decisions, etc) standards |
| WASHINGTON | It is helpful if the state provides oversight of the training program in order to ensure quality, as well as education and technical assistance to the mental health providers so that they can make good use of the workforce that's being created. The state should consider requiring their mental health providers hire peer specialists as some |

| | |
|-----------|--|
| | agencies may need this push in order to update their practices. Infrastructure should be developed with an idea that as the program grows, the level of funding for the program also needs to grow. |
| WISCONSIN | The infrastructure must have a leadership that commits more than words to the promise of the peer specialist position. Leadership comes from the people on both sides of the partnership between persons who are in recovery and professionals. Funding of individual consumers to actively participate in local and state conferences, training, and committees is essential to develop capacity and reduce stigma. Employment opportunities for Peer Specialists must be available and developed. Requiring the availability of the peer specialist service as a part of the Medicaid psychosocial rehabilitation programs would speed up the development of a successful peer support program. |
| WYOMING | Consistent and adequate funding for base services (especially in small towns) A mechanism for ongoing support and training that is peer lead and meaningful/useful to the peer specialists—in a small state, learning needs to be tailored to a small group with very diverse learning needs. Networking with other entities to broaden the leadership, knowledge level, and professional esteem for peer specialists. There are still challenge around the language/concepts of the recovery model versus the medical model. Peer specialists said the following: 1) Permanent funding; 2) Increased number of peer specialists throughout the state; 3) Peer run centers for those interested in recovery; 4) More education about what peer specialist is and the benefits of the program; 5) Buy in from state officials; 6) The state level staff needs to both care and understand the principles involved with how peers can and do provide aid in client recovery. |

3. What recommendations would you make to states attempting to set up this kind of program for the first time?

All 22 responding states answered this question. Due to the variety of responses and lack of overlap, the answers are displayed below.

| State/Respondent | Response/findings |
|------------------|---|
| ALABAMA | Involve consumers from the beginning of the planning process. Develop a plan, involve all stakeholders. Educate consumers on peer services and your certification process before acceptance into your certification training. Extensive training for providers on peer support and recovery. |
| ARIZONA | Cultivate and celebrate grassroots groups and their own cultural diversities. Provide the basic tools, technical support, and sources of funding. Discourage sameness and cookie cutter programs. Encourage independence and self-determination from the system itself. Include advocacy education tools to help improve the system at a local, state, and national level, and to fight stigma and end discrimination |
| CONNECTICUT | Strong steering committee of people in recovery willing to engage various stakeholder viewpoints and participation in the planning and execution of the initiative. Top level leadership needs to be active, visible, and strong champions committed to its success. |
| GEORGIA | Patience, creativity and experimentation, a strong training and certification program, an annual enforced requirement of a set number of Continuing Education Credits, strong technical assistance for those working in the field |
| IOWA | Begin developing consensus within consumer/family organizations throughout the |

| | |
|-----------|---|
| | <p>state early in the process. Bring on support from the Mental Health Planning Council. Try to get provider support in place at or near the beginning of the process if possible. We did not start with provider support for the development of our Academy, and it has, in some ways, caused growth to happen slower than it might have. We started with buy in from our MHPC, and we knew that we were “kick starting” the dialogue in our state by funding the Academy before there were any providers asking for it. On the other hand, if we had waited until providers were asking for it, we probably wouldn’t be nearly as far along in the process by now. Another idea would try to bring in the hospitals at the beginning of the process also, in order to make opportunities for peer support more available in those settings, as well as through CMHC’s.</p> |
| KANSAS | <p>Ongoing education and support for the CHMC’s across the State regarding the benefits of utilizing Peer Support staff is necessary to expand peer support services. CHMC’s will be encouraged to utilize Peer Support staff as part of a comprehensive discharge plan. Peer Support staff may be able to bridge the gap between hospitalizations and “re-entry “into Community Mental Health services. Education can also address the stigma and concerns related to hiring current or former consumers of mental health services. Hiring and training can create some financial burdens for the Community Mental Health Centers on the front end, but may reduce expense later on. Therefore, KHS is recommending this service be more fully utilized and outreach to the entire provider network needs to be done in order to accomplish this mission. Newsletters, articles and presentations are recommended as part of the attempt to reach out and education the providers in Kansas with the goal of decreasing readmission rates, decreasing utilization of crisis services, and successful, supportive transitions to the community.</p> |
| MAINE | <p>Think about what good peer support likes like from the beginning with both peers, providers and administrators. Get at least some "champion" providers on board to begin with to work out fears and create a clear, collective vision with peers, providers and administrators. Understand the difference between peer support and individuals who have experienced mental health issues working as case managers or in other traditional roles. Ongoing requirements in the certification process provides on-going support of learning and growing and helps maintain fidelity to peer support values.</p> |
| MICHIGAN | <p>Assure that peers support specialists are a Medicaid covered service and available to all individuals served. Develop and support consumer direction, involvement and decision making throughout the process. Reach out to other states that have a strong program and adopt what has already worked. Provide certification at the state level and assure that a strong training program is in place and applied consistently. Develop and maintain a support model once individuals are certified. Involve executive leadership at the agency and program level</p> |
| MINNESOTA | <p>States should consider this a system transformation effort toward mental health recovery and engage resources related to facilitating organizational change. Such resources may include the creation of a steering committee of stakeholders, forums for interagency discussion and technical support for organizations as a whole. Assuring that leadership of provider organizations understand the role of peer specialists and will support /encourage this new provider group is crucial to successfully incorporating peer specialists into the organization. The incorporation of Certified Peer Specialists into existing mental health service delivery systems challenges some organizations and/or professionals to reconsider their assumptions about certain professional norms, such as the capacity of peers to sustain appropriate boundaries while also intentionally using self-disclosure as part of their service approach. Therefore, the incorporation Medicaid-billable peer support can raise</p> |

| | |
|----------------|---|
| | <p>many questions amongst providers at the initial stages of implementation. These questions subside as peers join the workforce and the peer support service approach is demonstrated within agencies. States should be prepared to address the concerns of professionals and practitioners who are not familiar with the concepts of peer support as part of their plan for program implementation.</p> |
| MISSOURI | Don't reinvent the wheel. The training curriculum and technical support are already available. |
| NEVADA | set goals, short term and long term planning |
| NEW JERSEY | Have sufficient time and input from stakeholders to develop a rich curriculum. Have sufficient time and exposure to market the program properly and delivery it with enough time for practical application. Also, get agency administrators and supervisors "on board" and committed to project from the outset. Also, have the time and opportunity to research what is going on/what is working in other states before you begin. |
| NORTH CAROLINA | Ensure that State Leadership, including members of the General Assembly have an understanding and support the concept of peer services. Buy-in from the community and the service providers is essential for successful peer services. Have a vision of the direction to take to implement peer services and ensure that funding is viable to support peer services. It is very important to have a standardized training curriculum or strong training standards for consumers to become Peer Support Specialist. The certification process must be low cost and have the infrastructure to support the processing of the certification applications and re-certification. |
| OKLAHOMA | Doing research in the programs that work. I believe that having leadership who strongly believe and demonstrate that belief in recovery. It is important that you have a good strong base of people in recovery who are willing to advocate for this and have the ownership in the program. Have a willingness to hear "no" but to keep fighting anyway. |
| OREGON | <p>States should make appropriate predictions about the scope of this program. This is to say that states should budget accordingly and be flexible to alternative funding sources to sustain the program. Funding sources beyond the usual governmental sources should be identified over the course of the program. States should hire or contract with people who have experience using the system of services and supports (family members of youth, young adults, individuals in recovery, and adult consumer/survivors) to lead the state's program. This involvement from the highest level of government should be a high priority. Additionally, states should look beyond "peer support specialists" and encourage the development of grassroots peer directed programs in addition to the establishment of peer specialist roles. Alternative, non-medical services must be part of the continuum of care to allow for choice and a full compliment of options. States should draw upon the inherent leadership skills within the addictions community, consumer/survivor movement, young adults, and transition age youth. These are the state experts that will propel a program to excellence. Finally, states must work in partnership with all stakeholders including funding sources to develop meaningful outcome measures and research programs to identify successes and improvement areas for this program. Appropriate attention to "what works" and "lessons learned" should be measured by states so this program can flourish.</p> |
| PENNSYLVANIA | <p>Assist stakeholders to understand this is more than a program, but also fundamental in the way mental health services do business.</p> <p>Have lots and lots of people sharing their story...it brings the conceptual</p> |

| | |
|----------------|--|
| | <p>knowledge and complex ideas to 'life' in an easy to understand form. Storytelling can stimulate people to think actively about change and project themselves into visions of the future goal.</p> <p>Don't re-invent the wheel- do your homework! Research what other states are doing including lessons they have learned along the way. Ask the 'how' and 'why' questions. How did you do this? Why did you choose to do it this way? Prepare the environment- providing information and technical assistance minimizes fear and assists stakeholders to envision their part in a new service. Make sure you create 'buy-in' from the very beginning by getting peer and provider associations to the table...let stakeholders be part of creating the service.</p> |
| SOUTH CAROLINA | Ask other states for support - copy what works for their state - pilot the program in a few key but small area to "work out the kinks" |
| TENNESSEE | <ul style="list-style-type: none"> • Visit another state that is already running a successful program. • Solicit a significant amount of peer input and have peers design the program. • Begin with specific trainings for the mental health clinicians who will be supervising the Peer Specialists. • Develop a standardized training (that includes testing) for the consumers who want to become Certified Peer Specialists. • Educate providers about Peer Specialists and help them to understand how hiring Peer Specialists will benefit their bottom line. • Formalize the announcement of the program and roll it out with as much fanfare as possible. • Include annual awards and recognition. |
| TEXAS | <p>To involve consumer stakeholders and providers in the development from the very beginning of the process. This will assist with getting consumer and provider buy-in for peer support services.</p> <p>To not reinvent the wheel. There are policies and procedures, curriculum, and training that already exists that can be used.</p> |
| WASHINGTON | We would suggest that new programs may not need to reinvent the wheel, but rather look at what other states are doing as there are a lot of good ideas out there. Recognize that your program will likely grow and you should plan your funding accordingly. Prior to creating a workforce, it is helpful to work with the provider agencies that will be hiring in order to ensure they adopt recovery principles into their work culture. Be available to provide technical assistance to the provider agencies. Consider ways to fund and/or support opportunities for peer specialists to network on the local level- peer specialists benefit from having the collegial support of other peer specialists. Address issues of confidentiality in your application process at the front end of program development. Consider making a requirement that your mental health providers hire peer specialists. The Georgia program's web site is a great example of how to help your workforce find jobs. |
| WISCONSIN | Ensure that a leader with authority champions the development of Peer Specialists and participates with others of differing views in the defining the details of the state vision. Develop a structure to ensure employment opportunities prior to training peer specialists. Have a developed set of competencies for Peer Specialist training and employer training and provide these trainings within a similar time frame. |
| WYOMING | <p>Don't sweat the small stuff—you will learn as you go</p> <p>Get to know the state data system. If you can have opportunities to utilize it, it will be helpful.</p> <p>Leadership is built by having leadership experience. Peer specialists can teach and lead within your state's recovery/consumer communities and with one-another.</p> <p>Peer specialists said the following: 1) Contact states who have a peer program to find out what is working and what isn't; 2) Require any agencies who employ a peer specialist to treat them with respect and include the peer specialist in ALL aspects of the agency's operation; 3) Make sure that any person selected to be a</p> |

| | |
|--|--|
| | peer specialist is well-grounded in his/her recovery; 4) Remember how important peer support is for those of us in recovery. 5) Take a chance on something great. Believe in the program and train the peer specialists well. Offer continued support. |
|--|--|

Appendix 3

Pillars Of Peer Support Summit Attendees

| Name & Email | Title & Organization |
|-------------------------|--|
| Allen S Daniels | Executive Vice President and Director of Scientific Affairs Depression and Bipolar Support Alliance |
| Amber Dawn Guerrero | Coordinator of Recovery Support Services OK Dept. of Mental Health and Substance Abuse Services |
| Arnaldo Maldonado | Liaison Division of Behavioral Health Services - Office of Individual and Family Affairs |
| Barbara L Qualls | Statewide P.I./Planning Director State of Nevada MHDS |
| Benjamin G Druss | Rosalynn Carter Chair in Mental Health Rollins School of Public Health at Emory University |
| Beth Filson | Peer Educator Center for Community Support & Research |
| Bill Bouska | Manager, Child and Adolescent Mental Health System Oregon Addictions and Mental Health Division |
| Charlene Cronier Powell | Nurse Consultant Appalachian Consulting Group, Inc. |

| | |
|------------------------|---|
| Charles Bernard Willis | Director Statewide Peer Wellness Initiative Georgia Mental Health Consumer Network |
| Cynthia Godin | Mental Health Administrator State of Minnesota |
| David W Miller | Project Director NASMHPD |
| Debbie Ann Webster | Mental Health Program Manager NC Division of MH/DD/SAS |
| Emily A Grant | Research Associate Wichita State University Center for Community Support & Research |
| Frank E Shelp | Commissioner Georgia Department of Behavioral Health and Developmental Disabilities |
| Gina Kaye Calhoun | Certified Peer Specialist Trainer PA Office of Mental Health and Substance Abuse Services |
| Ike Garber Powell | Director of Training Appalachian Consulting Group, Inc. |
| Janet Jares | Advocacy Coordinator Mental Health & Substance Abuse Services Division, Wyoming Dept of Health |

| | |
|----------------------------|--|
| John Fryer | Certified Peer Support Specialist Justice In Mental Health Organization |
| Justin Harding | Policy Associate NASMHPD |
| Kara Panek | Mental Health Program Administrator Division of Behavioral Health and Recovery |
| Katherine Michelle Roberts | Office of Client Affairs Director SC Depat. of Mental Health |
| Larry Fricks | Director, Appalachian Consulting Group and Vice President of Peer Services, Depression and Bipolar Support Alliance Appalachian Consulting Group and Depression and Bipolar Support Alliance |
| Lauren Lacefield Lewis | Mental Health Services Program Manager Tx Dep of State Health Services |
| Leticia Huttman | Director, Office of Consumer Affairs Maine DHHS Office of Adult Mental Health Services |
| Lila PM Starr | Adult Mental Health Specialist, LBSW Iowa Department of Human Services |
| Lisa Goodale | Vice President, Training DBSA |

| | |
|-------------------------|--|
| Lisa Ragan | Director of Employment and Peer Support Services Tennessee Department of Mental Health and Developmental Disabilities |
| Lynn Amyx | Program Developer/Discharge Planner team lead Kansas Health Solutions |
| Margaret Molnar | Special Assistance for Consumer Affairs Department of Human Services, Division of Mental Health Services |
| Mary Shuman | Supported Employment and Housing Specialist Georgia DMHDDAD |
| Michael Benjamin Autrey | Director, Consumer Relations Alabama Dept. of Mental Health |
| Morgan Groves | Program and Planning Analyst Bureau of Prevention Treatment and Recovery |
| Pamela Werner | Specialist Michigan Department of Community Health |
| Peggy A Clark | Technical Director Center for Medicaid and State Operations - CMS |
| Randy Glenn Johnson | Sr. Director Mental Health America of the Heartland |
| Rick Hendy | Adult Program Administrator Utah Division of Substance Abuse & Mental Health |

| | |
|-----------------------|--|
| Robert Ross Patterson | Project Director GA Certified Peer Specialist Project |
| Rosie Anderson-Harper | Training Coordinator Missouri Department of Mental Health |
| Sherry Jenkins Tucker | Executive Director Georgia Mental Health Consumer Network |
| Steven M Fry | Director of Recovery Community Affairs CT Dept of Mental Health and Addiction Services |
| Susan Bergeson | Vice President Optumhealth |
| Thomas H Bornemann | Director Carter Center Mental Health Program |
| Tim P Tunner | Project Coordinator NASMHPD |
| Wendy Tiegreen | Program Director Division of Mental Health, Developmental Disabilities and Addictive Diseases |
| William Boyer | Section Chief, Program Development PA Office of Mental Health & Substance Abuse Services |