



National Model Standards

for Peer Support Certification

SAMHSA
Substance Abuse and Mental Health
Services Administration

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I. PREFACE

On March 1, 2022, President Biden announced his administration’s [strategy to address our nation’s mental health crisis](#) as outlined in the 2022 Presidential Unity Agenda. This national mental health strategy seeks to strengthen system capacity, connect more Americans to care, and create a continuum of support –transforming our health and social services infrastructure to address mental health holistically and equitably. A primary goal outlined within this strategy is accelerating the universal adoption, recognition, and integration of the peer mental health workforce across all elements of the healthcare system. This included the development and implementation of a national certification program for mental health peer specialists¹. To meet this goal, SAMHSA collaborated with federal, state, tribal, territorial, and local partners including peer specialists to develop the National Model Standards for Peer Support Certification, inclusive of substance use, mental health, and family peer certifications. These National Model Standards closely align with the needs of the behavioral health (peer) workforce, and subsequently, the over-arching goal of the national mental health strategy.

SAMHSA acknowledges the nuances across the peer workforce and the communities being served, as states often reflect needs that are unique to their community within a certification. Further, SAMHSA’s National Model Standards for Peer Support Certification are not intended as a substitute for any state certifications but instead have been developed as guidance for states, territories, tribes, and others, to promote quality and encourage alignment and reciprocity across often disparate state peer support certifications. Since the 2015 release of the SAMHSA’s [Core Competencies for Peer Workers in Behavioral Health Services](#)², the peer workforce has flourished, resulting in the implementation of state-endorsed or state-run peer certification programs across 49 out of 50 states³. The National Model Standards are designed to accelerate universal adoption, recognition, and integration of the peer workforce, and strengthen the foundation set by the peer workforce, reinforced by the Core Competencies, and implemented by our state, local, and tribal partners.

II. TERMINOLOGY

Overview

SAMHSA’s Core Competencies for Peer Workers in Behavioral Health Services describes peer support as “offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations.” For the purposes of this document, the terms ‘peer supporter’, ‘peer worker’, and ‘peer specialist’ are interchangeably used to describe a person with lived/living* experience, either directly or through a current/former dependent, involving a problematic mental health and/or substance use condition(s), and who supports other people experiencing similar challenges in a wide range of non-clinical activities including advocacy, navigation and linkage to resources, sharing of experience, social support, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. Across the United States, various other terms such as recovery coach, mentor, peer provider, or peer navigator are used to describe peer workers. In the context of this document, both the terms ‘peer’ and ‘peer worker’ will be used to

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interchangeably describe someone working in a mental health, substance use, and/or family peer support role (both certified and non-certified, unless specifically noted as below).

- A peer worker who is in the process of seeking certification will be referred to as a 'prospective certified peer worker'.
- A peer worker who has completed certification or credentialing will be referred to as a 'certified peer worker'.
- An organization that is tasked with/approved to oversee all or part of the peer certification process for a state will be referred to as a 'state certification entity'. Please note that many states work or contract with multiple organizations/entities on certification. For example, some states may incorporate trainings/examinations through one entity, while actual certification is issued by a state government entity. Examples of entity types include but are not limited to state agencies, state certification boards, and third parties (including private/nonprofit agencies).

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

What is peer support certification and why does it matter?

For the purposes of this document, peer support certification refers to "the process required to obtain an official document which attests that an individual has the skills and knowledge required for the peer support services profession". The document is issued by an authorized body which is recognized by the state, district, tribal, or territorial behavioral health authority where an individual may provide substance use or mental health peer support services³." Certification processes for peer workers offer a range of benefits to the peer workforce, their employers, and the individuals being served. Employers and the public may feel more confident in the services being provided by certified peer workers, and certification often assists peer workers with finding paid positions, and in some cases allows employing organizations to bill Medicaid, private insurers, and third-party payors for services that are provided by a certified peer worker. Furthermore, studies suggest that training and certification may enhance adult recovery outcomes for both certified peer workers and the people being served, and 60% of respondents in one study reported transitioning off or reducing public assistance while working as a certified peer worker⁴. Certifications are generally based on standards that clarify and set requirements for training, experience, and other requisite qualifications.

What are the different types of certifications?

Peer certifications are typically developed and implemented based upon the lived experiences of the peer worker and the people they serve. Throughout this document, nuances between and similarities across three (3) general types of peer certification are recognized. These include:

Mental Health Peer Certifications

- For peer workers with lived experience involving a mental health condition.

Substance Use Peer Certifications

- For peer workers with lived experience involving a substance use condition.

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Family Peer Certifications

- For peer workers with lived experience as the primary caregiver of a current/former dependent with a mental health and/or substance use condition.

It is also important to note that some states and their corresponding certification entities may effectively utilize the same certification process for more than one type of certification. Often combining mental health and substance use lived experiences, these certifications are typically referred to as 'integrated'. While the national model standards emphasize similarities across the certification types noted above, there may be instances where key distinctions are made between them. By and large, family peer certifications are designed for the parents/caregivers of a child, young adult, or adult with direct lived experience related to a mental health/substance use condition. However, SAMHSA recognizes the crucial role that other family members play as peers, including children, siblings, spouses, and domestic partners of a person experiencing these same challenges. Thus, while this document defines family peer workers as primary caregivers, SAMHSA highly recommends that state certification entities consider the development or addition of specialized pathways to certification for these other critical family members and loved ones.

As noted above, varying subtypes of specialized peer workers with unique lived experiences are also integral constituents of the peer workforce. For example, the role of transitional age youth peer workers is quickly expanding across the country, and some states offer transitional age youth aged 18 to 30 a choice between obtaining a specialized certification for their age group or an adult mental health/substance use certification⁵. Some other examples may include but are not limited to justice-involved, older adults, unhoused populations, veterans, and people living with a physical health condition or disability. While the National Model Standards only distinguish between mental health, substance use, and family peer certifications and workers, the various subtypes may benefit from the recommendations outlined in this document. SAMHSA's National Model Standards for Peer Support Certification should be used as a guiding framework for developing or revising all types of peer certification, and it is recommended that state certification entities overseeing mental health, substance use, and family peer certifications specifically consider uniform adoption to achieve consistency across the nation.

**Please note that all references to mental health and substance use peer certification pertain to adult-only (over the age of 18) services.*

For additional resources and information on mental health and substance use peer support, please visit the [SAMHSA BRSS TACS](#) main webpage. For additional resources and information on parent/family peer support, please visit the [SAMHSA BRSS TACS Parent and Families](#) webpage.

What is a 'National Model Standard'?

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

1. Promotes quality of and consistency across peer services
2. Limits barriers to expanding the peer workforce
3. Is based upon guidance from the peer workforce

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4. Is based upon existing practices utilized by state certification entities*

*Applies to both state and territorial certification entities

III. PROCESS

How were the National Model Standards Developed?

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

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

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

1. **Identify a Domain:** domains that are *critical* to the peer workforce and *common* across mental health, substance use, and family peer support certifications were identified. A domain was determined as **critical to the peer workforce** via discussion with local, state, and federal expert partners, and **common across multiple certifications** via analysis of resources, including the Comparative Analysis of State requirements and various state certifications for peer workers. Only domains categorized as both critical and common were included for consideration. An example of an identified domain meeting these requirements is the general significance of *lived experience* to the peer workforce and across peer certifications.
2. **Develop a Model Standard:** for each identified domain, a distinct criterion (or set of criteria) was developed that is based on existing (certification) requirements and has been identified

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through a collaborative process as being widely accepted, effective, and adaptable across state peer support certifications. Each standard was written based upon the needs of *a) the peer workforce* and *b) the people that the peer workforce serves*. Over the course of several days, the TEP identified key considerations for each domain through a series of activities and discussions. These key considerations, along with various other resources, were then utilized to draft each standard. A recommendation that certified peer workers have lived experience specifically aligning with the needs of the population they serve (e.g., mental health, substance use, family) is a broader example of this.

IV. APPLICATIONS

How will the National Model Standards benefit the peer workforce?

As noted in the preface section, the National Model Standards for Peer Support Certification were created to accelerate universal adoption, recognition, and integration of the peer workforce across all elements of the healthcare system. In discussions with the TEP, specific and measurable key objectives were identified to help guide both their development and use. As state certification entities intentionally align their corresponding peer certifications with the national model standards, several benefits can be expected. Adoption of or alignment with SAMHSA's National Model Standards for Peer Support Certification will:

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

V. NATIONAL MODEL STANDARDS

Model Standard #1: Authenticity and Lived Experience

“People with lived experience must be front and center in the creation, development, and adoption of (peer certification) standards - at federal, state, and local level.”

“Nothing about us without us—centering the lived experience of peers.”

-TEP Members on maintaining authenticity in peer support

OVERVIEW

The term lived experience is defined as “personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people¹⁰.” In the context of this document, *lived experience* specifically refers to those directly affected by the social, health, public health, or other issues associated with a mental health and/or substance use condition, including family members, and whom have experience with strategies that aim to address associated challenges^{11,12}. The term *lived experience* implies a past connotation involving challenges related to a mental health and/or substance use condition, while the term *living experience* often refers to current related challenges. However, issues related to a mental health and/or substance use condition may resurface throughout one’s life, and some individuals may better relate to the term living experience while identifying as being in recovery. In the context of this document, *lived experience* will refer to both current and former challenges related to mental health/substance use unless specifically noted.

SAMHSA, in discussions with the TEP, confirmed that lived experience is an essential component of the peer role, and should be addressed in all mental health, substance use, and family peer certifications. Furthermore, SAMHSA determined that people with lived experience, including those in the peer workforce, should be reflective of the community they serve and be meaningfully involved in the development, adoption, and revision of national, state, and local peer certifications. SAMHSA also acknowledges the existence of multiple pathways of recovery* and the crucial role that people with living experience may play in the peer workforce when embedded in the appropriate setting, role, or organization (e.g., harm reduction organizations). Through collaboration with our expert partners and analysis of various resources, and in keeping with SAMHSA’s working definition of recovery* as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential”, the following National Model Standard on Authenticity and Lived Experience was developed.

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RECOMMENDED STANDARD

SAMHSA's National Model Standard on Authenticity and Lived Experience** recommends that:

- State certification entities include a self-attestation requirement (e.g., a written narrative, questions, check box) that promotes the following statements of authenticity across the peer workforce:

Mental Health and Substance Use Peer Certifications

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

Family Peer Certifications

- A prospective certified family peer worker should be able to describe their lived experience as a primary caregiver of an individual with a mental health and/or substance use condition, and describe strategies utilized to address associated challenges.

Promoting Authenticity Through Self-Attestation

- Describe any strategies that you used to overcome challenges related to (yours or a child/dependents) mental health and/or substance use condition. What strategies do you still use today?
- Describe how you utilize your lived experience in assisting others.
- Describe your lived experience and/or your self-defined recovery or resiliency.
- Describe how your lived experience qualifies you as a certified (mental health/substance use/family) peer worker.
- Share your vision of helping others who are experiencing similar challenges.

*For additional information on recovery pathways, please see Standard #8: Recovery'.

**While the Model Standard on Authenticity and Lived Experience is intended as a guiding framework for mental health, substance use, and family peer certification, other specialized lived experiences such as youth, justice-involved, veteran, older adults, and other family members (e.g., parents of loss and siblings, spouses, and children of people experiencing a mental health/substance use condition) exist across the peer workforce. Therefore, SAMHSA recommends that state certification entities consider the development of specialized pathways to certification for these other valuable lived experiences.

Model Standard #2: Training

OVERVIEW

Training is critical to the development of high-quality peer services and a common requirement across peer certifications. In discussions with expert partners, several parameters for defining a model standard on training were identified. These include 1) *the quantity of training (hours)* and 2) *content within the training(s)*. Training parameters should promote quality while attempting to limit barriers that prospective certified peers may encounter when seeking certification. It was also recommended that state certification entities contract with peer and family run organizations and people with lived experience in the development and provision of any required training(s), and that

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trainings be facilitated by experienced, certified peer workers. While a wide variation in the quantity of training currently exists (ranging from <25 to 480 hours), there is some commonality across certifications. Most state certifications require between 40 and 46 hours of training for individuals seeking certification and include a wide variety of topics that are integral to providing peer services. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Training was developed.

RECOMMENDED STANDARD

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

Quantity (hours)

- Training requirements range from 40 to 60 hours for mental health, substance use, and family peer certifications.

Content and Facilitation

- Incorporate accommodations outlined in Model Standard #8 (Diversity, Equity, Inclusion, and Accessibility).
- Ensure that certified peer workers with relevant lived experience play a leading role in the design, application, and revision of peer certification trainings and state certification entities utilize a clear and transparent process for procuring new training organizations.
- Include principles outlined in SAMHSA's [Core Competencies for Peer Workers in Behavioral Health Services](#) (for mental health and/or substance use peer certifications).
- Include principles and core competencies outlined by family-run organizations (for family peer certifications)**.
- Address the following cross-cutting core content areas for mental health, substance use, and family peer certification trainings, identified in conjunction with expert partners with lived and professional experience, include:

Core Content Areas

- Role, scope, and purpose of the peer (mental health, substance use, integrated, or family)
- Values and principles of peer support, recovery, and resiliency
- History of recovery movements in mental health, substance use, and families
- Recovery and resiliency resources and tools*** (e.g., recovery planning)
- Self-help/mutual support groups
- Community resources (e.g., social, prevention, education, employment)
- Legal systems and resources
- Diversity, Equity, Inclusion, and Accessibility (DEIA)****
- Computer and digital health literacy (e.g., computer skills, virtual peer support)
- Ethics
- Harm reduction (including suicide and overdose prevention)
- Communication, language, and group skills (e.g., peer-to-peer engagement, storytelling)

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- Advocacy (self and system) and reducing prejudice/discrimination (e.g., stigma)
- Crisis response
- Trauma-responsive approaches
- Understanding and identifying mental health, substance use, and co-occurring conditions
- Self-care and wellness (e.g., physical, mental, etc.)
- Self-determination, choice, and shared decision-making

- Include information on child serving systems and social services, parenting skills, building resiliency in family peer support, and family relationship building (for family peer certifications).

**Breadth, length, and content may differ depending on the setting, assigned duties, and type of peer certification. For example, a mental health peer certification may include more extensive content on mental health conditions and associated services compared to substance use. Similarly, a family certification may incorporate additional topics or content related to child welfare and social services, but still include a broader focus on harm reduction services. Cross-cutting content areas such as the scope, role, and purpose of the peer may differ across mental health, substance use, integrated, and family peer certifications. Please also note that this list is intended as guiding framework, other important content areas for training may exist, and the content areas above may not be exhaustive.*

***Examples of family-run organization core competencies may be found in the References and Resources section of this document.*

****Please see SAMHSA's [Core Competencies for Peer Workers in Behavioral Health Services](#) and [SAMHSA's 8 Dimensions of Wellness](#) for more information on mental health and substance use peer support.*

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

Model Standard #3: Examinations

OVERVIEW

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

RECOMMENDED STANDARD

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

Content (of Examinations)

- Relates directly to and is appropriately based on the peer role (mental health, substance use, or family).
- Only reflects information explicitly covered in trainings.
- Includes a general focus on the competencies of peer support.
- Is incorporated into a study guide or similar resource(s) that is provided between training and examination.

Development and Revision (of Examinations)

- Is led by certified peer workers to promote fidelity and reliability.

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- Involve collaboration with other state certification entities to encourage alignment and reciprocity.

Structure, Format, and Accommodations (of Examinations)

- Include alternative testing methods such as vignettes, case studies, and scenario/role-playing based questions to encourage content application.
- Provides multiple testing locations and virtual testing for individuals with limited transportation and individuals in rural communities.
- Incorporate all accommodations outlined in Model Standard #8 (Diversity, Equity, Inclusion, and Accessibility).
- Offers multiple dates/times to take an examination throughout the year.
- Allows individuals to re-take an examination up to three (3) times before they may be required to re-take certification training**.

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

***Some costs may be associated with retaking an exam. For more information on costs/fees, please see standard #10.*

Model Standard #4: Formal Education

OVERVIEW

In this document, the term 'formal education' refers to structured teachings that occur through an academic institution and follow an official curriculum, not inclusive of training(s) that a prospective certified peer worker may complete as part of their certification. Attainment of a high school diploma or passage of a General Educational Development (GED) exam are examples of common formal educational requirements, and many state Medicaid programs integrate these prerequisites for billing/reimbursement purposes. It is important to note however that not all state certification entities require a formal education, and these were identified as common barriers for the peer workforce and the organizations seeking to hire certified peer workers (and subsequently bill for services provided by them). While formal education requirements promote literacy and fluency, such mandates were identified as having a limited positive impact on the peer workforce by the TEP, and alternative pathways to meet literacy and fluency needs were identified as critical to expanding the peer workforce. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Formal Education was developed.

RECOMMENDED STANDARD

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

- In lieu of any formal educational requirements, prospective certified peer workers should be able to demonstrate literacy and fluency in the language in which they will be providing services, either through required examinations or other application requirements.

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- If a prospective certified peer is unable to demonstrate the literacy and/or fluency** needed to complete the certification process, it is recommended that state certification entities provide a list of formal educational trainings/opportunities that may help them achieve certification.

**States should consider revisiting policies that require formal education of certified peer workers for reimbursement (e.g., third-party payors) and seek to incorporate parity across reimbursement standards and requirements for mental health, substance use, and family peers.*

*** For more information on accessibility laws and requirements, please see Model Standard #5 and Model Standard #8.*

Model Standard #5: Supervised Work Experience

OVERVIEW

In the context of this document, 'supervised work experience' refers to hours worked, in a paid or volunteer capacity, within an organization/setting that provides peer support services. Supervised work experience was identified as a requirement across 22 out of the 55 state peer certifications via the Comparative Analysis of State Requirements.

- **Four (4)** state certifications require less than 200 hours.
- **Eleven (11)** state certifications require 500 hours.
- **Three (3)** state certifications require 2000 hours.
- **Thirty-one (31)** state certifications do not require any supervised work experience.

In discussions with expert partners, supervised work experience requirements were described as a potential barrier that can inhibit the growth of the peer workforce. Conversely, supervised work experience may also promote competency through practical experience for peer workers who may be beginning their career. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Supervised Work Experience was developed.

RECOMMENDED STANDARD

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

- For state certification entities that currently institute a supervised work experience requirement, a maximum of 120 hours of supervised work experience should be required.
- For state certification entities that institute a minimum requirement, any combination of paid, volunteer, virtual, and out-of-state hours should be accepted.
- In cases where state certification entities do require supervised work experience, prospective certified peers should be provided with a list of vetted mental health, substance use, and/or family organizations that:
 - Offer opportunities for paid and/or volunteer supervised work experience, and,
 - Are able and prepared to provide reasonable accommodations according to the American with Disabilities Act (ADA) and Title 6 of Civil Rights Act of 1964^{17, 18}.

***State certification entities receiving federal financial assistance are required, by law, to provide reasonable accommodations (e.g., American Sign Language Interpreters) that enables protected classes to complete certification^{19,21}. For more information on accessibility, please see Model Standard #8.*

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Model Standard #6: Background Checks

OVERVIEW

Some people with a mental health and/or substance use condition may become involved in the criminal justice system (e.g., probation, incarceration, diversion courts, parole). While these are often thought of as the main consequences following arrest and conviction, justice-involvement may result in other lasting effects on the individual—including ramifications stemming from permanent convictions such as difficulty finding employment and housing. With the current mental health and substance use crisis facing the nation, it is important to note that an estimated [44% of those in jail and 37% of those in prison](#) have a mental illness²³, while [63% of people in jail and 58% in prison](#) have a substance use disorder²⁴. Peer support plays a critical role in promoting recovery and reducing recidivism across these populations²⁵.

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

RECOMMENDED STANDARD

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

- Background checks be the responsibility of hiring organizations rather than part of the certification process.
- In instances where a state certification entity chooses to obtain criminal background information on prospective certified peers, it is recommended that they:
 1. Clearly outline potentially disqualifying offenses* and include guidelines for time after which such offenses will no longer be considered.
 2. Limit potentially disqualifying offenses to those that pose a risk to the people being served, and preclude or avoid mention of, investigation into, or required disclosure of misdemeanors, drug and alcohol related crimes, non-violent felonies, and similar offenses.

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3. Utilize an initial process of self-disclosure that solely focuses on the identification of potentially disqualifying offenses.
4. Conduct background checks for confirmation purposes or where additional information is needed.
5. Review applications flagged for potentially disqualifying offenses on a case-by-case basis within 90 days of submission.
6. Incorporate a process that allows prospective certified peers to appeal disqualifications due to criminal offenses.

**Examples of offenses that may pose a risk include but are not necessarily limited to crimes involving sexual violence and other forcible felonies.*

Model Standard #7: Recovery

OVERVIEW

As noted in Standard #1 (*Authenticity and Lived Experience*), recovery associated with a mental health and/or substance use condition is a common and critical component of lived experience across the peer workforce. The term ‘abstinence’ or ‘abstinence-based recovery’ describes a historical view on substance use recovery relating to a process of change that includes refraining from the use of all mood or mind-altering substances. This has been interpreted by some to also include some medications used in the treatment of mental health and substance use conditions. While abstinence may be a pathway for some, SAMHSA recognizes and supports the value of medications used in addiction treatment, the existence of multiple pathways of recovery, and the need for a peer workforce that reflects the varying requirements and diverse makeup of the populations being served. In discussions with our expert partners, recovery pathway-specific requirements for peer certification were identified as a barrier to expanding and strengthening the peer workforce, and only two (2) state certifications were identified as having explicit abstinence-specific requirements for prospective certified peers³. Through collaboration with our expert partners and analysis of various resources and staying consistent with SAMHSA’s working definition of recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential”, the following National Model Standard on Recovery was developed.

RECOMMENDED STANDARD

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

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

**Please note that SAMHSA’s National Model Standard on Recovery only applies to substance use/mental health peer certifications. SAMHSA acknowledges the existence of multiple pathways of recovery and recognizes that people with both lived and living experience, including those receiving harm reduction services, are critical components of the peer workforce when embedded in the appropriate setting or organization. To learn more about SAMHSA’s harm reduction work, please visit <https://www.samhsa.gov/find-help/harm-reduction>.*

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

OVERVIEW

Strategies and principles for incorporating diversity, equity, inclusion, and accessibility (DEIA) into peer support certification have been identified as a critical need of the peer workforce. DEIA is a cross-cutting standard that can be incorporated across peer certification requirements (e.g., training and examinations), general strategies utilized by state certification entities, and practice competencies used by individual peers. With a primary focus on serving and addressing the needs of under-resourced and under-represented populations through behavioral health equity strategies, some key populations that benefit from DEIA include but are not limited to Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious groups; members of cultural and linguistic minorities; lesbian, gay, bisexual, transgender, queer/questioning and intersex (LGBTQI+) persons; justice-involved persons; veterans; persons with disabilities such as deaf and hard of hearing persons; older adults; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on DEIA was developed.

RECOMMENDED STANDARD

SAMHSA's National Model Standard on DEIA recommends the following strategies for incorporating DEIA across peer certifications.

Training and Examination (*accessibility*)

- Incorporate captioning, signed video materials, braille materials, interpreters, and other accommodations for people with disabilities.
- Include alternative methods such as vignettes, video, and scenario/role play components.
- Offer multiple formats and languages.
- Provide at multiple locations and include remote/virtual options to promote equitable access and certification.
- Offer multiple dates/times to take accessible trainings/examinations throughout the year.
- Allow for individuals to choose a different training entity if the original choice does not meet their accessibility needs or cannot do so.
- Provide reasonable accommodations according to the ADA and Title 6 of Civil Rights Act of 1964^{17, 18}.

Training and Examination (*content*)

- Address anti-racism, discrimination, privilege, implicit bias, and structural barriers.
- Are designed and facilitated by individuals from diverse and under-represented populations.
- Incorporate accessibility-specific trainings for peers who may work with protected populations.
- Include content on cultural and structural competency and DEIA practice and implementation.
- Include content on barriers to service access for marginalized groups.

General Strategies

- Recognize tribal sovereignty by establishing reciprocity where tribal nations may exist across state lines.
- Target recruitment and promote pathways to certification for diverse and under-represented populations.
- Hire or contract with consultants and trainers from diverse and under-represented populations.

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- Offer scholarship programs in instances where certification cost (including testing and examinations) is a barrier.
- Offer funding and scholarships where the cost of Communication Access Realtime Translation (CART), American Sign Language (ASL) interpretation, and other language accessibility solutions are a barrier to certification.

Model Standard #9: Ethics

OVERVIEW

Ethical standards elevate the quality of services and the well-being of the people being served by the peer workforce. Often in the form of a Code of Ethics or Code of Ethical Conduct, these guidelines are a common component of national and state peer certifications, with prospective certified peers frequently being required to review, sign, and adhere to a Code of Ethics to obtain and maintain their certification. Some examples of ethical guidelines/codes of ethics across national and state certification entities are noted in the reference/resource section of this document. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Ethics was developed.

RECOMMENDED STANDARD

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

- State certification entities utilize an ethics committee made up of certified peer workers to develop a Code of Ethics or revise an existing one to ensure that the ethical guidelines are applicable to the peer role and are non-clinical in nature.
- Prospective certified peers be required to read, sign, and adhere to a Peer Worker Code of Ethics.
- State certification entities implement a publicly available, anonymous process for reporting an alleged breach of ethics by certified peer workers and hiring organizations.
- State certification entities employ an impartial committee or board, made up of certified peer workers and unaffiliated with the certification entity, to review breaches of ethics and take appropriate action when necessary.
- State certification entities provide continuing education on ethical standards annually.
- Codes of Ethics include, but are not necessarily limited to, ethical standards that require agreement/attestation to:
 - The defined role, scope, and responsibilities of the peer
 - Maintaining personal and professional boundaries
 - Preventing conflicts of interest
 - Confidentiality
 - Mandated reporting

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

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Model Standard #10: Costs and Fees

OVERVIEW

Fees associated with application, trainings, examinations, and recertification have been identified as significant barriers to the certification of the peer workforce. The Comparative Analysis of State Requirements identified 20 state certifications that offer free peer support training, 20 state certifications that include costs that vary depending on the training provider utilized, and 10 states with costs ranging from \$99 to \$900. Approximately one-half of the certification entities that were analyzed also included initial application fees ranging from <\$100 to \$299, with an average cost of \$130. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Costs and Fees was developed.

RECOMMENDED STANDARD

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

- State certification entities work with their state to find resources to subsidize all costs or fees for both certification and re-certification.
 - Potential sources of funds might include but not be limited to state general revenues, SAMHSA's block grants (SUBG/MHBG), other allowable formula or discretionary grant funding programs, other public and/or private sources.
- State certification entities work with their state to find resources to subsidize all costs or fees associated with reasonable accommodations (e.g., CART, ASL interpretation and other disability or language access accommodations).
- If costs are associated with a certification, state certification entities offer scholarships* to any individuals that are unable to pay for their certification.
- In cases where the above is not possible, or where revisions associated with these changes are in progress, state certification entities clearly outline the exact costs or fees associated with each of the following, if applicable:
 - General application fee
 - Trainings
 - Examinations
 - Total cost of certification
 - Total cost of re-certification, including costs associated with any Continuing Education Units (if applicable)

**Examples of scholarship programs being offered by state certification entities can be found in Exhibit B: References and Resources. Please note that SAMHSA does not endorse any specific state certification entity, and these are only being provided as examples of how state certification entities may structure scholarship programs.*

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Model Standard #11: Peer Supervision

OVERVIEW

Supervision is a professional and collaborative activity between a supervisor and a worker in which the supervisor provides feedback and guidance to support a worker's performance and growth. This promotes competent and ethical delivery of services and the continued development and growth of a worker's abilities, knowledge, skills, and values³⁶. During the TEP, peer supervision was also identified as being vital to the fidelity of peer support services and an important operating standard for the peer workforce. In 2014, the Pillars of Peer Support Supervision were developed, with five pillars emerging from an ongoing series between SAMHSA, the National Association of State Mental Health Program Directors, and other expert partners. It was determined that those taking on supervision tasks should have a deep understanding of the nature of peer practice, knowledge of the peer worker's role and of the principles and philosophy of recovery (for substance use/mental health peer workers) or resiliency (for family peer workers), and familiarity with the code of ethics for peer workers in the state³⁸. Through collaboration with our expert partners and analysis of various resources, the following National Model Standard on Peer Supervision was developed.

RECOMMENDED STANDARD

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

- State certification entities consider the development and implementation of a certification process for peer supervisors that includes the following characteristics:
 - State certification entities require that prospective certified peer supervisors have direct experience as a peer worker, relevant lived experience**, and a deep understanding of the skills, values, and principles of the peer role.
 - *Substance Use and Mental Health Peer Supervisor Certifications*
 - State certification entities incorporate the core elements outlined in the 5 (five) Pillars of Peer Support Supervision into certification requirements.
 - *Family Peer Supervisor Certifications*
 - State certification entities incorporate the core elements associated with resilience into certification requirements.
 - State certification entities require certified peer supervisors to receive training that includes, at minimum, the recommendations outlined in Model Standard #2 (Training).
 - State certification entities incorporate the recommendations outlined in Model Standard #4 (Formal Education) into peer supervisor certifications.
 - State certification entities incorporate, at minimum, the strategies outlined in Model Standard #8 (Diversity, Equity, Inclusion, and Accessibility) into peer supervisor certifications.

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- State certification entities require certified peer supervisors to adhere to a code of ethics that includes, at minimum, the recommendations outlined in Model Standard #9 (Ethics).
- State certification entities partner with hiring organizations and peer and family-run entities to develop and implement supervisor-specific career pathways for certified peer workers.

**SAMHSA's National Model Standard on Supervision has been specifically written for, and only applies to, peer supervisor certifications. Resources to help supervisors understand the role of peer workers and how to supervise peer workers in the behavioral health settings are available at SAMHSA's webpage [Bringing Recovery Supports to Scale Technical Assistance Strategy's Spotlight for Supervision of Peers](#) and [Family, Parent and Caregiver Peer Support in Behavioral Health](#).*

***While not a model approach, it is recognized that some organizations may already employ peer supervisors without lived experience and/or experience as a peer worker. For these cases, and when a peer worker is seeking supervisory certification hours within such organizations, SAMHSA recommends that state certification entities incorporate special provisions or allowances that meet the needs of both peer worker, peer supervisor, and hiring organization.*

VI. REVISIONS AND RECIPROCITY

Every state certification brings a unique set of strengths and challenges, and SAMHSA is confident that the (certification) processes being utilized across the nation are developing strong, committed, and knowledgeable certified peer workers. It is for this reason that SAMHSA is recommending that state certification entities strengthen collaboration efforts and implement additional processes for expanding reciprocity, and strongly encourages state certification entities to utilize this document to revise, strengthen, and align their peer support certifications with other states. A few potential strategies for supporting and expanding the peer workforce were identified and are outlined in Exhibit A. A set of guiding questions were also developed for state certification entities to consider during revisions and when exploring strategies for increasing reciprocity and expanding the peer workforce and are outlined in Exhibit B.

VII. CONCLUSION

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

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EXHIBIT A— Strategies for Supporting and Expanding the Peer Workforce

1. Establish a reciprocity board or committee made up of certified peer workers.
2. Create an interstate compact or other binding document that can be used to establish reciprocity between states.
3. Connect with a national reciprocity organization to discuss strategies for implementing reciprocity.
4. Develop a simple certification process for peer workers that are certified in another state. An example of this could be requiring a peer worker to submit documentation showing out-of-state certification, and then granting provisional certification or allowing that peer worker to immediately sit for their examination, if required.
5. Form state consortiums to raise awareness, establish resources, and encourage adoption of the model standards outlined in this document.
6. Partner with universities and community colleges to expand career pathways and educational opportunities for certified peer workers.
7. Collaborate with local, state, and federal partners to identify strategies for promoting living wages for the certified peer workforce.
8. Develop and conduct trainings that aim to increase awareness of providers and others on the value and role of peer workers.

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EXHIBIT B— Guiding Questions for Revising Peer Certifications

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

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EXHIBIT C—SAMHSA’s Technical Expert Panel on Peer Support Certification

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

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

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SAMHSA's mission is to lead the public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

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