DRAFT Action Recommendations
NH Lived Experience Workforce Advancement Blueprint
December 11, 2020

(Public Comment Period Open through December 31, 2020 at tinyurl.com/LEWorkforceBlueprintFeedback)

The Purpose of this document, entitled the New Hampshire Lived Experience Workforce Advancement Blueprint (the "Blueprint"), is to present actionable directions for developing and enhancing the workforce of people with lived experience across New Hampshire's mental health services sector. This workforce development objective is a stated priority in the New Hampshire 10-Year Mental Health Plan and central to several of its larger strategic aims.

The Action Recommendations of the Blueprint are keyed to seven (7) "Challenge Domains" for the lived experience workforce, as identified through research, stakeholder input and key informant interviews:

Lived Experience Workforce Challenge Domains

A) Scope of Practice/Service Model;
B) Provider Culture / Workplace Readiness;
C) Education and Lived Experience;
D) Compensation and Advancement;
E) Career entry, Transition and Attrition;
F) Placement/reporting/supervision
G) Medicaid billing and Documentation

To address these Challenges fourteen (14) Activities/ Action Recommendations) are proposed:

1) Peer Services Orientation for Clinical Providers;
2) Concise "Fundamentals" of Peer Support Training for all New Hires;
3) Peer Practices Co-Learning Community;
4) Education, Equivalency and Training Standards;
5) Peer Specialist Survey;
6) Wage and Compensation Standards;
7) Peer Support Services Survey;
8) Lived Experience Career Tree;
9) Peer Support Mentorship Network;
10) Medicaid Billing Standards Development;
11) Recovery-Informed Documentation and Practices Audit;
12) Recovery-Focused Supervision, Performance Support, and Accommodation Training;
13) Implementation of Activating Hope Systems Change Directions;
14) Lived Experience Services Advisory Council.

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DEFINITIONS, DISTINCTIONS & TERMINOLOGY

Person with Lived Experience/People with Lived Experience (PLE). This term is descriptive of any individual who has experienced a mental health or mental health and substance use challenge and/or recovery. Practically speaking, it applies to those who are willing to disclose this experience. However, not all PLE openly do so, or that all PLE are necessarily interested in using that lived experience to perform a behavioral health-related support role, paid or otherwise.

Peer Specialist: A Peer Specialist is a PLE who provides peer support as a vocation, most often through employment at mental health specialty provider agency or organization. Ordinarily, core skills and knowledge training are expected for a Peer Specialist position. Peer Specialists may perform these roles under a variety of job titles. In many US states, certification through a state or local board process is required for an individual to have the title "Peer Specialist". In New Hampshire, the certification process for peer specialists, administered at the state level, prescribes a foundation in training to be certified and continuing education annually to maintain certification.[1]

LIVED EXPERIENCE WORKFORCE CHALLENGE DOMAINS AND RECOMMENDATIONS

In this section, we visit central themes of the Lived Experience Workforce, as reflected through the Inputs and Insights process for New Hampshire's community. Most of the seven (7) Challenge Domains identified here, thus, are relevant to the discussion of any specialized workforce, including subspecialty professionals. Some general information is included for context because these items may be relevant to Lived Experience workforces everywhere. We examine the specifics of these items as manifested in the NH behavioral health system.

Each Challenge Domain is followed-upon with at least one specific Action Recommendation (Actions). This Blueprint presents three "Multi-Domain" Actions, which are conceived as having impact on multiple challenges. However, it should be recognized that many of those Actions associated with specific Challenge areas could positively affect others and/or the system/community in multiple ways. As Lived Experience workforce successes become 'baked in' to the New Hampshire system, the effects of culture change could be positively seen in multiple areas, including professionalism, program performance, job satisfaction, and service consumer experience.

NH LIVED EXPERIENCE WORKFORCE CHALLENGE DOMAINS
A. Scope of Practice/Service Model
B. Provider Culture and Workplace Readiness
C. Education and Lived Experience
D. Compensation and Advancement
E. Career Entry, Transition and Attrition
F. Placement/Reporting/Supervision
G. Service Billing and Documentation
H. Multi-Domain Actions

A. Scope of Practice/Service Model

Peer support services entail unique modeling based on equality of status and shared experience of ill-health, recovery, and (sometimes) being a service recipient. Peer support relationships aka 'peer relating' are functionally and philosophically different from typical provider-client relating. Boundary issues tend to be quite different as peer specialists strive to find as much mutuality as possible and, most importantly, move away from disparities in power and privilege that might

1 In some places the term "prosumer" has been used to clarify the dual professional and service "consumer" roles

diminish the client/service users sense of empowerment and agency. New Hampshire stakeholders identified this one of the most significant challenge areas.

While peer support values and practices are not universally understood, and training approaches vary, nearly all peer specialists agree that their roles, and even some of their goals, differ from that of other types of mental health specialists. In particular, the possibility of openly sharing their own experience with a service user and a peer specialist's ability to 'model' growth and recovery are distinctive resources that make the practice of peer support unique. These personal resources imbue the lived experience workforce its special contribution to behavioral health. However, the "distinctive competencies" of these in practice emerge from the combination of relevant experience and practical skills training based on the peer support values framework.

Understanding of these competencies in practice is not universal in the field. This can lead to misapprehension of the distinctive roles and service design of peer support programs As reflected throughout our stakeholder feedback process, this can lead to job performance and role confusion concerns, where a marginal understanding occurs. For instance, when a new peer support program is created at a community provider setting, and/or when peer supporters are newly hired into an agency setting, the duties as laid out in their job description may not match expectations based on their training. This can lead to loss of quality in the work and, potentially, conflicts around performance.

One of the ways this disconnect impacts the peer supporter directly is when someone is the first, or among the first, peer hired by an agency. This individual may find themselves in the unenviable position of explaining their distinctive competencies and practices to program staff, colleagues, and supervisors, or 'advocating' to perform their roles in alignment with their training, etc.

Notwithstanding the issues of culture and welcoming at organizations (see next), this problem can be extreme if an individual is employed without prior experience, orientation or training to the competencies of peer support themselves. In this case, without good guidance or supervision, the peer specialist can become disoriented or confused about what and how precisely they should be performing their supportive roles. This can be a barrier even where there exists a general understanding of the work of peer support, but lack of clarity in how it is practiced on the job.

Action Recommendation 1: Peer Services Orientation for Clinical Providers.
All CMHCs or related providers that employ, or plan to employ, peer specialists in their service array are provided with an orientation on the values and practices of peer support.
Action Recommendation 2: Concise "Fundamentals" of Peer Support Training for all New Hires.
Prior to beginning service provision, or within 60 days of beginning such employment, individuals who are new peer specialists and new peer supervisors receive standard online introductory training in the fundamentals of peer support in practice.

B. Provider Culture and Workplace Readiness

Peer support practices differ in many ways from those of other mental health specialty services. The degree to which people who disclose lived experience, providing peer support or otherwise, are welcomed into an agency and service sites can affect both their success and that of the program. Beyond the broader issue of a welcoming environment for peer support providers, expectations related to education, performance, documentation etc. may create unanticipated barriers to success as well.

Nowhere is this more evident than in the area of professional boundaries. Although many of the standards, policies and practices in this domain were originated with a view to protection of client rights and prevention of abuse, some of these conflict with the nature of peer based relationships that are core to how peer specialists perform their work. Furthermore, since peer specialists are likely to have prior relationships with 'clients', guidelines that promote the value of relationship and mutuality of status may be needed that distinguish these from other agency policies. For example, the issue of 'multiple relationships' between peer specialists and peer support recipients (clients) can be overlooked until a problem arises, the results of which can be damaging to the peer specialist, the client, and/or the program as a whole.

Additional complexity of culture in the behavioral health workplace relates to accepting peer support staff as professional/colleagues. Sometimes peer specialists have previously been clients of an agency, such that others/clinicians may have been accustomed to that frame for their relationship. Also, peer specialists, depending on their background, may have less formal education or less education in social services/social science than their colleagues (see next). In a tight job market, this can manifest in sense of protection around expertise and roles, competition or even a question relating to 'earned' status and privilege. A shift in dynamics to ensure that empowerment and respect are upheld all the way around may require some intentional focus.

Peer Support Agencies (PSAs) may be accustomed to multiple relationships and also to managing the complexities of these issues since they employ entirely, or mostly, people who have been service recipients themselves. Education and experience standards may still affect hiring and placement decisions however, creating natural impediments to career development.

Another cultural issue that can create barriers to success relates to what could be sees as a 'culture clash' related to traditional service models and core principles of peer support and consumer empowerment movement, which emerged in contrast to some of these – i.e. as an 'alternative' to the medical model. While most of New Hampshire's system is grounded in 'recovery values,' this may not be sufficient to bridge the values of peer support and the structures and processes of service delivery (such as documentation/billing requirements, etc.) Some people with lived experience may feel that their values and even their training are compromised in the role of 'peer provider.' Similarly, agency intake documents, service notes, etc. may not reflect the strengths-based, collaborative approach to support central to recovery and/or peer specialist work.

Action Recommendation 3: Peer Practices Co-Learning Community
Develop a NH co-learning community related to best practices for peer support services in non-peer service agencies; Include management staff, supervisors, and individuals with lived experience from provider agencies in the learning community that is supported by NH peer services experts.

C. Education and Lived Experience

The distinctive competencies of peer support derive from a combination of skills and lived experience. Similarly, employment in peer support is driven by personal experience, and often the intention to serve and support others on their recovery journey, and a desire to have meaningful employment. The combination of these motivators naturally occurs for people who have interfaced with mental health services over a period of time and who, for one reason or another, are not committed to another career path in life. Often people with lived experience who become peer specialists, for example, have left, or even felt compelled to leave, a prior career path as a result of their condition and recovery.

Although the expansion of lived experience services has led to more training and programs at traditional post-secondary and even high school settings, it is not the norm for people to enter the mental health peer support workforce with advanced degrees in social services/social sciences etc. Also, disability related to behavioral health issues is most prevalent in the 'college years' of life, creating a barrier for many related to their formal education, college degrees etc.

The factor of 'interrupted education,' which impedes financial success and career development for many people impacted by family trauma, poverty, etc. is very frequently a reality for people with lived experience. Those who become interested in the mental health workforce as a result of being or having been a 'client' may not have the degree requirements/expectations of organizations that might employ them. Even given stability in income, family life, etc., completing a college degree as an adult represents challenges, financial and otherwise.

Many community human service agencies hire support service workers with a minimum requirement of a bachelor's degree or less at the 'entry-level'. And peer supporters with a mix of educational backgrounds are already employed throughout New Hampshire's service provider system. However, it is not clear whether, and to what degree, advancement into higher positions/management, etc. would require individuals to meet educational requirements set by organizational policy/expectations. To expand and develop the peer workforce, including promotion to upper management etc. the issue of educational equivalency standards may be highly relevant, as well as continuing education benefits, tuition support for employees, etc.

This ties directly into the issue of New Hampshire standards for peer support specialist certification. Specifically, the 100+ hours of training required for certification eligibility. The investment of time and funds needed to attend the robust array of high-quality trainings is substantial. While New Hampshire's requirements are not extreme or unwarranted, this certification baseline, along with continuing education requirements, represents the high level of professional expectations of peer support providers within the state.

A noted challenge pertaining to peer support specialist certification relates to time and financing for people with lived experience to complete all the pre-requisite training hours. Whether community mental health centers (CMHCs), PSAs, or individuals bear the costs, financial assistance and related supports could ensure that more individuals advance along these more quickly, and, ideally, complete them before beginning their work in peer support services. Progress in this area could amplify the effectiveness of the peer support services, reduce culture problems as above, and ensure that more peer supporters experience job satisfaction, thereby enhancing peer support culture and increasing job retention time.

There are limitations for peer specialist to advance through promotion, title change, and pay/compensation. Peer specialists who complete the training and certification requirements

and peruse further specialty training should be rewarded with a larger range of job and pay opportunities in the broader behavioral health workforce, as a professional in another specialty would expect. One way to advance this objective would be to partner with a local college or university to create a certificate or alternative degree program, which would be accepted, in combination with work experience, as equivalent to traditional academic degrees for purposes of hiring recruitments.

Action Recommendation 4: Education, Equivalency, and Training Standards
Convene a joint education expert and key informant workgroup to examine college degree requirements in the mental health system, peer support specialist certification standards/hours, work and lived experience equivalency parameters, scholarship/tuition support and higher education institution partnership to reduce the barrier to advancement that interrupted education represents for individuals with lived experience.

D. Compensation and Advancement

A recurring theme in reflections from peer specialists was limits on pay and benefits. Several individuals have reflected that they had previously or were planning to leave their peer support positions because wages were so low. Ensuring that peer specialists achieve pay equity and increased compensation to a 'livable wage' across the system seems crucial to growing this workforce. Establishing salary and benefits standards across CMHCs and PSAs could also reduce staff turnover and workforce attrition.

While PSAs employ people with lived experience across the range of positions, CMHCs have limited positions in which peer specialist skills and lived experience credentials are valued job qualifications. By report of the community, only one peer specialist in the state is employed in a supervisory capacity within the CMHC network (i.e. Peer Support Supervisor).

This would indicate that, outside PSAs, all peer specialist positions are entry-level, and therefore opportunities for promotion within or career advancement in peer support beyond specific organizations are minimal. (However, it is possible that individuals with lived experience may find advancement options within their organization in non-peer support identified positions of various sorts: this type of career transition has been observed in many recovery-oriented service provider organizations.

The absence of viable options for advancement, promotion, and wage increase is likely to have a depressing effect on the engagement of any workforce, contributing to 'burn out,' workforce attrition, and loss of institutional/practice knowledge. Finding ways to create/restructure positions to promote staff with lived experience and support career growth could have multiple indirect benefits on the workforce, program and service quality.

Action Recommendation 5: Peer Specialist Survey
Survey peer support workers to collect de-identified data on peer support/lived experience identified workers across New Hampshire. Data points to include demographics, tenure in position, tenure in field, wages, education, location, job satisfaction, career goals and outlook. Construction of the survey questions and process should be guided by people with lived experience.

Action Recommendation 6: Wage and Compensation Standards
Establish a pay scale for peer support services to include minimum hourly and salary rates, benefits and pay differentials based on certification, time in service, job title and rank, etc. Such a resource could serve as an direction and clarification for contract agencies and others, with the intention to ensure that peer specialists are compensated on par with staff in similar position categories.

E. Career Entry, Transition and Attrition

The long-term capacity of the New Hampshire mental health system to meet the demand to employ lived experience workers is unknown. Also unknown is the available workforce not currently employed, seeking employment and/or in transition. Transition /attrition from the workforce, however, has been well observed within both CMHCs and PSAs. The goal of employing peer specialists in every program setting, however, means that even as demand for services expand over time, an increasing number of people with lived experience will need to be engaged, trained, hired and retained. Noting current successes and challenges in New Hampshire, a focus should be brought to: a) *Incentivizing a diverse group of people to join/enter the lived experience workforce, b) creation of positions (or revision of positions to include/promote/accept lived experience qualifications), and c) Expansion of career pathways.*

In combination with a survey of peer specialists themselves (Action Recommendation 5) above, a technical workforce analysis of organizations to examine details on current and planned peer support positions, job titles, compensation, etc. for problem-solving workforce shortfalls, establishing wage parameters, and other items.

Action Recommendation 7: Peer Support Services Survey
Survey all CMHCs, PSAs and related providers on current and planned lived experience positions, job titles, vacancies, education requirements, challenges with recruitment/retention.
Action Recommendation 8: Lived Experience Career Tree
Utilizing data on available and planned lived experience positions across the state, create a 'tree' or ladder indicating pathways to career advancement for people with lived experience, within and/or across mental health system agencies, public and private health, social services and related sectors. Indicators to include requirements for certification, education, etc.

F. Placement, Reporting and Supervision

Peer specialists are often the only identified lived experience workers at a specific program site. In addition, in many of these service settings a peer specialist may report to a supervisor who is not themselves well oriented to the distinctive competencies, values and peer support practices. This same reality may be experienced by people with lived experienced employed in other community organizations, non-profits, etc.

This can contribute to job stress, role confusion, and program/service problems as well. Until more peer specialists are employed across the NH system and more peer supervisor positions are implemented, this is likely to continue. Supervision of peer support staff, can be enhanced by training in multiple ways. (See Action Recommendations 1 and 3). However, this may not be sufficient to support the performance quality and career development of peer specialists isolated by program and/or location. A network of mentors, formal or otherwise, could provide valuable support to peer specialists in early, training and advanced career phases.

Action Recommendation 9: Peer Support Mentorship Network
A statewide network or informal program of 'peer mentors' provides technical and practical support to peer support staff, including career coaching, and general peer support related to employment.

G. Service Billing and Documentation

New Hampshire has taken initial steps towards clarifying options for agencies to bill Medicaid for peer support services. While this is currently available to Medicaid providers in the state, a special billing code has not been incorporated into the state Medicaid Plan to date. A previous consultation with the Center for Social Innovation, through a SAMHSA BRSS TACS grant, examined the issues and directions for change in this domain.

It should be noted that some individuals, PSAs et al, have a concern about the implications of this direction. For instance, that Medicaid documentation standards (emphasizing medical/illness model for example) and not in keeping with the values and ethics of peer support. It is relevant to note that this challenge exists in many US communities with regards to recovery-driven programs and the 'medical necessity' foundations of Medicaid billing (ie. not exclusively peer support services). Given previous priority and work on this challenging area, progress is expected within the short- to medium-term.

Action Recommendation 10: Medicaid Billing Standards Development
Develop a written plan that outlines the interests, commitment, potential options, and timelines for the creation, or modification, of Medicaid options that maintain fidelity of peer support services.
Action Recommendation 11: Recovery-Informed Documentation and Practices Audit
All NH Bureau of Mental Health Services contracted agencies review documents and processes to consider improvements focused on the recovery vision of mental health and pro-active hiring of people with lived experience. Items to be included: job announcements, client/member 'intake' and evaluation forms, service notes/charting, recovery (treatment) plans.

H. Multi-Domain Actions

The following Action Recommendations are abstracted from individual Challenge Domains because they are relevant to and likely to impact multiple domains in different ways. These items correspond with long-term cultural change outcomes as well.

Action Recommendation 12: Recovery-Focused Supervision, Performance Support, and Accommodation Training
Managers and program supervisors at all NH Bureau of Mental Health Services contracted agencies receive initial and annual update trainings to ensure workplace wellness, clarity and program success in employment of people with lived experience (including non-disclosed and non-peer support identified staff).
Action Recommendation 13: Implementation of Activating Hope Systems Change
Stakeholders across state agencies, PSAs, CMHCs and related provider, advocacy, and community groups convene quarterly (ideal) or semi-annually to review the activities, actions, outputs and outcomes of this Blueprint, build alliance and understanding of peer support service integration, problem solve and collaborate on related items.
Action Recommendation 14: Lived Experience Services Advisory Council
Stakeholders across state agencies, PSAs, CMHCs and related provider, advocacy, and community groups convene at least semi-annually to review the activities, actions, outputs and outcomes of this Blueprint, build alliance and understanding of peer support service integration, problem solve and collaborate on related items.