Certification of Paraprofessionals

Issues and Models From Other States

Certification of Peer Support Specialists, Addiction Counselors and other Psychiatric Rehabilitation Professionals has been recommended by the Governor's Regional Substance Abuse Task Forces to expand the mental health work force in West Virginia. I asked for models and opinions on LinkedIn, Facebook, other professional networks and several professional Web sites. Almost every state has its own curriculum, credentialing process and code of ethics.

Curriculum: Wisconsin[i] uses training in social work and psychology, including active listening, group facilitation and strengths-based planning. Oregon[ii] trains people in all aspects of wellness. The University of North Carolina contracts with the state to provide a registry. The National Association of Peer Specialists (NAPS) has developed an evidence-based curriculum called Recovery To Practice (RTP). The United States Psychiatric Rehabilitation Association (USPRA) offers Web-based training and a national examination to become a Certified Psychiatric Rehabilitation Practitioner (CPRP). In West Virginia, the Community Behavioral Health Technology Program, the Prestera Center and the Veterans Administration are working together to develop a joint statewide curriculum, and we are the first state to offer college credit. According to the National Mental Health Consumers Self-Help Clearinghouse, the following states also offer training: Michigan (8 days), New Hampshire (5 days to 2 weeks), New Jersey (102 hours), North Carolina (80+ hours), Pennsylvania (75+ hours), Hawaii (72 hours), Arizona (70 hours), Illinois and South Carolina (30 hours), Georgia and Iowa (26 hours).

Credentialing*:* In New Jersey, an incorporated nonprofit called The Certification Board, Inc. certifies Peer Specialists in its Addiction Professionals Division. According to its web site, a peer specialist fills "an entry level position that operates under the supervision of an appropriately credentialed counseling modality." It also certifies : Clinical Supervisors (CCS), Prevention Specialists (CPS), Co-Occurring Disorder Professionals (CCDP), Tobacco Treatment Specialists (CTTS), Criminal Justice Counselors (CJC), Criminal Justice Professionals (CCJP), Chemical Dependency Associates (CDA), Community Mental Health Associates (CMHA), Disaster Response Crisis Counselors (DRCC), Addiction Disability Specialists (ADS) and Woman's Treatment Specialist (WTS). It also does credentialing for other states, such as Hawaii.

The Florida Certification Board is a single statewide agency for all mental health and addiction professionals It has at least three types of certification:

Certified Recovery Peer Specialist – A - "provides peer mentoring and support … must be a true peer; this means that the peer specialist is also a consumer of public or private mental health services."

Certified Recovery Peer Specialist – F - "provides peer mentoring and support to families ... The peer specialist must be a first-degree relative or primary caregiver of a child diagnosed with a mental illness."

Certified Recovery Peer Specialist - "for those persons who possess competency in both family and adult peer mentoring," combining the other two credentials.

The Georgia Mental Health Consumer Network has a Certified Peer Specialist (CPS) Project, which offers several statewide examinations per year, about one month after the training. People with out-of-state certifications must take the same test.

The New Jersey model has the most reciprocity, but is also the most specific, requiring additional credentials and fees to cross disciplines or work above the entry level. The Florida model has higher expectations, including life experience requirements and different credentials for adults and family members, but it uses a single statewide board and may be difficult to replicate. The Georgia model uses an examination by the training authority, which also collects the fees. NAPS offers a national curriculum, but does not certify professionals, leaving certification up to the states. USPRA does certify psychiatric rehabilitation professionals, and the CPRP credential is widely accepted.

Codes of Ethics: The Georgia Code of Ethics upholds the principles of self-determination, role modeling, sharing experience, education, respect, self-advocacy, privacy, and community integration. It forbids personal and substance abuse, discrimination, conflicts of interest, intimacy and significant personal gifts.

The Pennsylvania Code of Ethics is developed by the Institute for Recovery and Community Integration. “The following principles will **guide** Certified Peer Specialists (CPSs) in their professional roles and relationships.” (MHASP Session 9 Module 2). Like the Georgia Code, it encourages self-determination, self-advocacy, community integration, role modeling, privacy and education, and it forbids the same things. Unlike the Georgia Code, it does not directly encourage respect and sharing experience. It adds 8 core ethical principles and five decision making principles. The ethical principles are “Do the Most Good, Do No Harm, Focus on the Individual, Be Fair and Just, Tell the Truth (Honesty), Informed Consent, Privacy and Confidentiality, Continuing Education.” The decision making principles are “Primary Benefit, Ethical Action, Expectation, Resources, Satisfaction.”

The New Jersey Code of Ethics is based on the following principles: compliance with professional standards, responsibility, cultural sensitivity, empathy, advocacy, education, self-care, role modeling, scientific objectivity, constructive supervision, honest documentation, confidentiality, disclosure and informed consent. It forbids dual relationships, diagnosing and discrimination, but not abuse. It speaks of people who receive services as clients or sometimes as consumers. It does not refer to them as peers, but it gives PEER as a job title. Most of the rules reflect this mind set. In general, it is a clinical code of ethics with minor variations.

The Florida Code of Ethics is the same for all mental health professionals, including compliance with professional standards, staying inside their field, nondiscrimination, confidentiality, not practicing while suspended, reporting arrests (whether guilty or innocent), sexual misconduct, fraud and exploitation.

In section 5.1, its description of “exploitation of consumers” assumes that, “Ethical problems are often raised when a certified professional blends his or her professional relationship with a consumer with another kind of behavior. Behavior is unethical when it reflects a lack of awareness or concern about the impact of the behavior on the consumers. Certified professionals who engage in more than one role with consumers may be trying to meet their own financial, social or emotional needs.” (1993, Corey G., Corey M., and Callanan P.)[iii] Under sexual misconduct, it states, “Consumers can be influenced consciously and subconsciously by the unequal distribution of power inherent in such relationships.” Both standards assume that the relationship is not between peers, where equal distribution of power and meeting each others needs are operating principles.

The North Carolina Code of Ethics is based on several values: dignity; human rights; respect; self-directed recovery; sharing experiences; mutuality; hope; living full lives; making choices; community-based and natural supports. The Code also encourages personal responsibility, honesty - “keeping it real,” mutual learning, empowerment, honoring commitments, open dialogue, listening, equal relationships, confidentiality, person-centered and accessible records, education and community resources. It discourages power struggles; abuse, either active or passive; loaning, borrowing and gifts; dual relationships; taking people home (charity) and diagnosing.

The Georgia Code of Ethics is the most widely accepted but the least comprehensive. The Pennsylvania Code of Ethics is based on Georgia's, uses guidelines rather than rules, adds core values and decision making principles. The New Jersey Code of Ethics is clinical in its assumptions. The Florida Code of Ethics applies a consistent professional standard, but assumes unequal relationships. The North Carolina Code of Ethics is the clearest and the least professional. All four codes condemn discrimination, abuse and exploitation; most of them encourage self-determination, mutuality, sharing, respect and inclusion.

Peer specialists are currently discussing a national code of ethics[iv] on LinkedIn. Among the principles are active recovery; honesty and truth; respect and dignity; mutual support; shared experience; listening and learning from each other; self-care; equality; acceptance; trustworthiness; individuality; systems advocacy; role modeling; personhood; education and personal responsibility. These principles have not been assembled in a single document, so the list will probably be shortened if a national credential is developed.

Conclusions: The states I examined had different strengths and weaknesses. Florida has the highest standards for peer support, but because it has a single Certification Board, its Code of Ethics does not reflect them. Georgia has the most peer-based certification process, and its Code of Ethics sets a national standard, but other codes are more developed. New Jersey's Certification Board is a nonprofit organization with reciprocity in other states, but its standards are very rigid and its Code of Ethics is clinical. Pennsylvania has a highly principled code of ethics, but peer specialists are certified regionally, so even statewide reciprocity is problematic. North Carolina has a university-based registry and an intuitive Code of Ethics, but it lacks a way to enforce standards and it is not as peer-based as Georgia.

Nationally, NAPS and USPRA have evidence-based training programs, but neither one certifies peer specialists. USPRA certifies Psychiatric Rehabilitation Professionals (CPRPs) and The Certification Board, Inc. certifies most other mental health and addiction professionals across state lines. A national Code of Ethics for peer support is being discussed, but there is no credentialing organization to develop it.

I think that the Georgia model is best. It links credentials to tests and training, and since we are already developing college-level courses, we could incorporate RTP into the curriculum. It is consumer operated out of a statewide network. After adopting the Georgia Code of Ethics, we can develop our own.

If we recognize the CPRP standard in psychiatric rehabilitation and apply the Georgia model to peer support certification, we can expand the work force for mental health and addiction services; take an evidence-based approach to both disciplines; build a stronger consumer network and decentralize the mental health system.

i Mental Health Networking group on LinkedIn, “Susan Inman: How peer workers can hurt people with mental illness.”

ii Mental Health Networking group on LinkedIn, “Does anyone want to start a peer wellness association?”

iii The reference is in the original document, which did not have a bibliography.

iv Mental Health Networking group on LinkedIn, “If you could write the Scope of Practice and Code of Ethics for Peer Support Specialist what are some of the things you would include?”, “Does anyone want to start a peer wellness association?” and “Susan Inman: How peer workers can hurt people with mental illness.”
Peer to Peer Network group on LinkedIn, “There is national dialogue on the development and push for a national certification for our peer workforce. Where do you sit on the fence about it?”