NEW HAMPSHIRE
PEER WORKFORCE ADVANCEMENT PLAN

Draft Report Issued: March 12, 2021
By the New Hampshire Department of Health and Human Services,
Bureau of Mental Health Services

New Hampshire Peer Workforce Advancement Plan

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EXECUTIVE SUMMARY

In January 2019, the Department of Health and Human Services (DHHS) published the State's 10-Year Mental Health Plan, which set a vision for the future of New Hampshire's mental health system.

The Plan was informed by a statewide stakeholder process that included input from hundreds of interested parties who took a critical look at the existing system. It addresses the needs of individuals and families across the continuum of care, and provides innovative models to meet the evolving landscape and increasing complexity of New Hampshire's mental health system.

The 10-Year Mental Health Plan prioritized 14 recommendations to implement within its first two years. These foundational recommendations are intended to strengthen the system's infrastructure and position New Hampshire to successfully expand and sustain a robust mental health system.

The New Hampshire Peer Workforce Development plan is the result of the 10-Year Plan's Recommendation #7, which seeks to expand the availability of peers in practice settings and to integrate people with lived experience into various parts of the mental health system. This requires concerted efforts in several areas such as training, recruitment, workforce retention, integration, compensation, benefits, and workplace culture. Some areas are relative to most workforce development strategies, while other factors are specific to the roles, challenges, and opportunities of people with lived experience in the role of a peer support specialist.

The purpose of this document, the New Hampshire Peer Workforce Advancement Plan (Advancement Plan) is to present actionable recommendations for developing and enhancing the workforce of people with lived experience across New Hampshire's mental health services sector.

Preparation of the Advancement Plan included stakeholder input at three (3) public conference/feedback sessions presented virtually and via written feedback on draft versions. This process was coordinated by the NH Department of Health and Human Services, Bureau of Mental Health Services (BMHS), National Alliance on Mental Illness of New Hampshire (NAMI-NH) and Humannovations. Participating stakeholders included individuals representing peer support agencies (PSA), community mental health centers (CMHCs), community and system advocates, and many individuals with lived experience.

Recommendations of the Advancement Plan focus on seven (7) "Challenge Areas" for the lived experience workforce, as identified through research, stakeholder input and key informant interviews:

Lived Experience Workforce Challenge Areas

1. Scope of practice/service model	5. Career entry, transition and attrition
2. Provider culture and workplace readiness	6. Placement/reporting/supervision
3. Education and lived experience	7. Service billing and documentation
4. Compensation and advancement	8. Multi-area recommendations

To address these Challenge Areas, we propose the following 13 Recommendations:

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 employer survey;
8) Lived experience career ladder/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) Peer Advancement Advisory Council.

We would like to express our sincere appreciation to Hummanovations and NAMI-NH for their support and hard work in coordinating the public stakeholder process. The work of Eduardo Vega from Hummanovations was instrumental in this process and the development of the Advancement Plan. We also wish to thank the many key informants, inclusive of individuals with lived experience, staff and leaders from CMHCs, PSAs, and advocates, whose input was central to the discussion and recommendations throughout this document. All of those who contributed valuable time and insight are gratefully acknowledged for their dedication to the wellness and mental health of the citizens of New Hampshire.

SECTION ONE:
VISION, BACKGROUND, AND DEFINITIONS

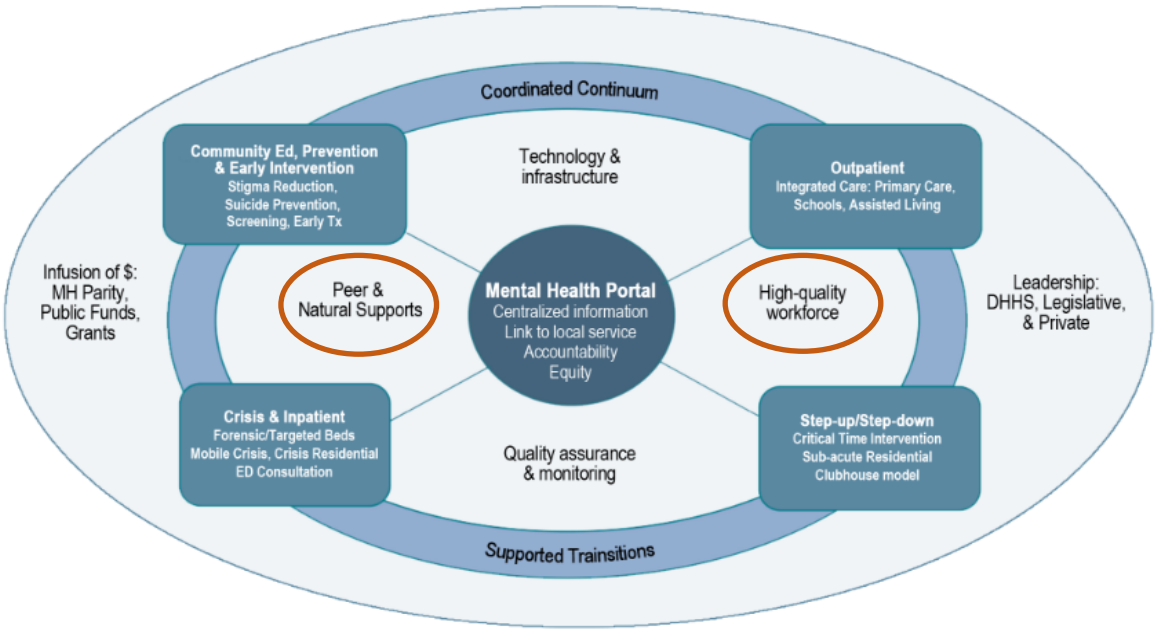
VISION

"Peer supports should be fully integrated throughout the care continuum, where they can serve as powerful advocates and public educators, provide recovery-oriented outpatient care, and support individuals as they transition into and out of EDs and psychiatric hospitals."
New Hampshire 10-Year Mental Health Plan

The New Hampshire 10-Year Mental Health Plan envisions a statewide mental health services continuum. It articulates the vision of a system "that provides access to a full continuum of care for all populations – community education, prevention and early intervention, outpatient supports, step-up and step-down options, and crisis and inpatient services – across the state … [including the] infusion of peer supports throughout the system."

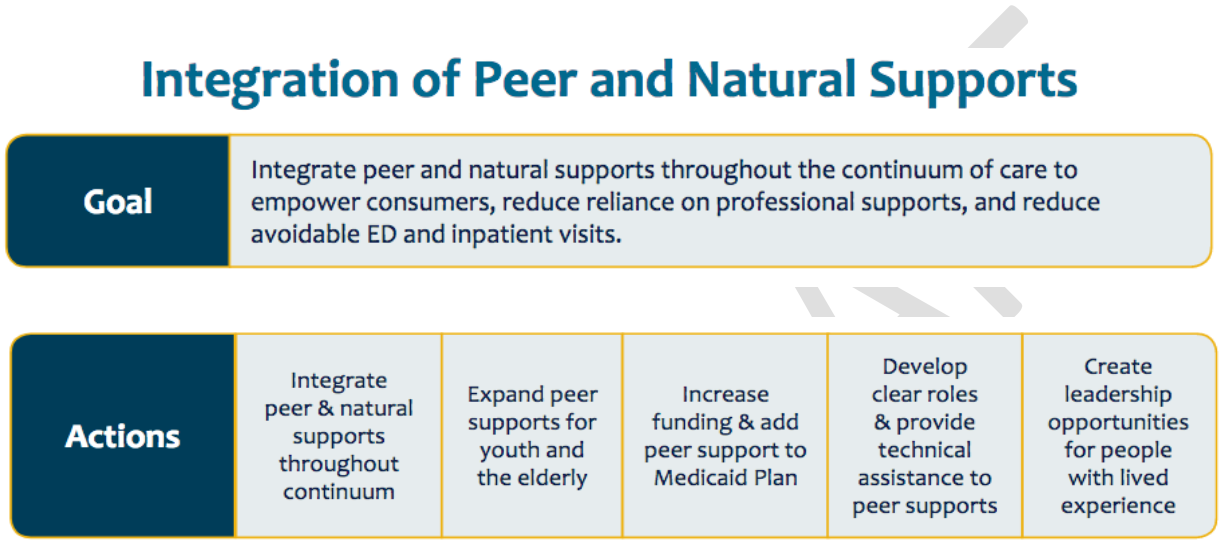
New Hampshire's mental health community promotes mental health and wellness, and provides services that align with the 'Recovery Model' of mental health. Foundational New Hampshire values, such as independence and self-determination, are also closely linked to this model. The values and principles identified in the 10-Year Mental Health Plan include person-centered services and supports, a whole person focus, and empowerment of people, families & communities.

The values and practices of peer support, including the state's primary models for peer support specialist training are tightly aligned with these principles. Similarly, peer support services provided by a skilled workforce of individuals with lived experience are excellent resources for addressing social determinants of health.



As seen in the 10-Year Mental Health Plan's framework (above), the two focal human resource elements in this vision include 1) peer and natural supports, and 2) high-quality workforce. A robust, effective, and empowered peer workforce is essential to creating the mental health system of New Hampshire's envisioned future.

The 10-Year Mental Health Plan's Recommendation to Infuse Peer Supports throughout the Mental Health System clarifies that *"Successful peer support requires clear role/job descriptions along with training, education, and coaching for peer and professional staff alike."*



The actions identified in the 10-Year Mental Health Plan are concrete, vital, and also broad. Progress on these actions has already occurred in several ways, and this Advancement Plan serves to provide an outline for targeted recommendations and actions to continue building the peer support system in New Hampshire.

BACKGROUND AND PROCESS

New Hampshire's Peer Workforce Advancement Plan (Advancement Plan) was commissioned by DHHS/BMHS through a contract with NAMI-NH and a subcontract to the consultant, Mr. Eduardo Vega at Hummanovations. Mr. Vega is an internationally recognized expert in mental health systems, community engagement, and peer support services. The goal of the Advancement Plan is to create clear directions for accomplishing NH's 10-Year Mental Health Plan objective of *Infuse Peer Supports Throughout the Mental Health System.* In advance of creating the Advancement Plan document, the project team presented an introductory outline to stakeholders through a virtual conference (webinar) conducted on September 30, 2020. Based on participation at this event, NAMI-NH also convened a listening session to optimize stakeholder input opportunities, co-led by a third-party professional facilitation group on October 20, 2020. Public feedback and personal commentary in these events were substantial and essential in ensuring that the final Advancement Plan's content was useful and deeply informed by local expertise.

DEFINITIONS, DISTINCTIONS & TERMINOLOGY

For the purposes of this project, it is essential to distinguish among certain descriptions, roles, and terms with respect to the lived experience workforce. In the behavioral health field as a whole, many different terms exist, leading to ambiguity and confusion.

Further, as a result of the origins of mental health peer support in the social movements of consumer empowerment, self-help, and systems change advocacy, the many diverse ways that people with lived experience identify themselves and their relationship to mental health services, is important.

Recognizing the significance of individuals claiming their own identities and roles, this document should not be seen to challenge or undermine any chosen identity. Nor is it to be interpreted as advocating for individuals with lived experience to disclose, change the way they disclose and/or identify, or reevaluate their relationship to their work.

The definitions provided below are intended to provide clarification for the discussion in this document and related planning efforts.

Person/People with Lived Experience (PLE): This term is descriptive of any individual who has experienced a mental health and/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, and not every PLE is necessarily interested in using their lived experience to perform a behavioral health-related support role, paid or otherwise.

Peer(s): Peers are people who self-identify their lived experience in recovery. Peers have life experiences similar to those of the people they support. Their shared experience affords them the unique capacity to help those they serve reach their identified goals while promoting a sense of hope and belonging within their communities.

The New Hampshire state rule He-M 402.02(g) defines Peer as "any individual, 18 years of age or older, who self identifies as having lived experience as a former recipient, or as at significant risk of becoming a recipient of publicly funded mental health services."

Throughout this Advancement Plan, the term "peer workforce" is used to refer to peers who engage in activities such as advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting and more as their vocation.

Peer Support Services: Peer support services in mental health are based on a PLE supporting another through their own behavioral health challenges. New Hampshire State rule He-M 402.02(i)(1-4) defines Peer Support Services as those "provided for peers by peers, are designed to assist peers in their recovery, include an educational environment in which people have the opportunity to learn wellness strategies while developing mutually beneficial relationships, and include other educational, vocational or housing opportunities".

Peer Support Specialist: A peer support 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 support specialist position. Peer support specialist may perform these roles under a variety of job titles.

In many other states, peer support specialists are considered a distinct segment of the mental health workforce, with relevant expectations regarding training, certification, performance, and documentation. In New Hampshire, the certification process for peer support specialists, administered at the state level and defined in State rule He-M 426.13 (d)(4), prescribes foundational training requirements, completion and passing of the Certified Peer Support Specialist exam, and continuing education to maintain certification.

Peer Support Agency (PSA): These are independent, non-profit, community-based 'peer-run' organizations in New Hampshire that provide a range of peer support programs focused on people with mental health and co-occurring conditions, principally through state and local contracts. New Hampshire State rule He-M 402.02(h) defines a Peer Support Agency as "an organization whose primary purpose is to provide culturally competent peer support to peers 18 years of age or older." At the federal level, these programs have historically been called "Consumer-Operated Service Programs" (COSPs).[1]

Recovery Community Organization (RCO): Recovery Community Organizations are typically private addiction recovery programs providing a range of services related to substance use challenges. In New Hampshire, as elsewhere, a significant portion of the substance use peer support services involve Recovery Coaches and Certified Recovery Support Workers (CRSW).

Recovery Coach: Most often, although not always, recovery coaches are PLE who focus on supporting people with their substance use/addiction recovery. In New Hampshire, recovery coaches are typically employed by Recovery Community Organizations (RCOs), private or public addiction recovery programs, and serve under a variety of job titles.[2]

[1] https://store.samhsa.gov/sites/default/files/d7/priv/sma11-4633-theevidence-cosp.pdf

2 In some communities in the US "Recovery Coaching" is an alternative term for mental health peer support services and training. In addition, peer specialists are sometimes called recovery coaches unofficially or by title in provider organizations.

SECTION TWO: STATE OF THE STATE

New Hampshire's broader mental health system employs many people with lived experience in multiple settings. The majority of these positions are within the program array of Community Mental Health Centers (CMHCs) and Peer Service Agencies (PSAs).

Peer Support Specialist Profile: New Hampshire's peer workforce is distributed across multiple agencies and diverse service settings with wide-ranging policies. Contracted providers and community non-profits do not normally disseminate employee demographic details with regards to race, gender, education, etc. except as required by funders or law. As such, it is difficult to define the characteristics and diversity of the peer workforce or to typify a New Hampshire peer workforce for purposes of this discussion. While a detailed workforce data source might include such details for purposes of targeted intervention in areas of development/recruitment, etc., demographic review is not within the scope of this plan. (See Recommendation #5 and #7)

Employment of Peers in CMHCs

New Hampshire's ten designated Community Mental Health Centers (CMHCs) provide comprehensive community-based mental health prevention, treatment, and recovery services for children, adults, families, and older adults. As of October 2020, all of New Hampshire's CMHCs employed at least one peer support specialist, with several of these agencies employing many. In addition to the most prevalent program, the Community Support Program (CSP), peer support specialists are currently working in the following programs: Assertive Community Treatment (ACT), Crisis Treatment Center (CTC), (Psychiatric) Emergency Services (ES), Integrated Treatment Team (ITT), Rapid Response and Mobile Crisis Response Teams (MCRT).

At least forty-three (43) peer support specialists were reported to be employed in CMHCs as of December 2020. Nineteen (19) of these peer support specialists were certified peer support specialists, while twenty-four (24) had yet to complete training and/or other certification requirements. Ten out of eleven (10 out of 11) peer support specialists on ACT teams were certified peer support specialists at the time of this review. Most CMHCs employed some peer support specialists who had not yet completed certification, and some included a mix of both certified peer support specialists and non-certified peer staff. Under current BMHS guidelines and State rule, peer support specialists have up to twelve months after being hired to complete all training and exams to become a New Hampshire certified peer support specialist.

Key Observation 1

A significant number of peers employed by CMHCs, regardless of title or position, are not certified peer support specialists in New Hampshire. This disparity can create gaps in understanding, performance, and service quality in several ways. State guidance allows for individuals to complete training requirements of certification within one year of employment. However, the availability of training sessions varies, while fees, and time away from work required for individuals to participate in all modalities could be substantial.

Although substantial in depth and quality, certification training requirements are potentially burdensome to peer staff and employers, and could present

challenges to service users (clients) as well – for example, peer staff may not always be available if they are participating in training. On the other hand, lack of training in the fundamentals and practices of peer support can undermine an individual's ability to provide quality support, their confidence in the work they do, and limit successful integration of peer support services.

This represents a systemic challenge to integration of the peer workforce, job satisfaction and optimal quality of peer support services.

Employment of People with Lived Experience in Peer Support Agencies

Roughly 68% of the known peer workforce in New Hampshire are employed at Peer Support Agencies (PSAs), which as a group reportedly employ at least ninety-one (91) peers. Each of the PSAs serves at least one designated mental health region, with some providing services at multiple locations within the region, for a total of fourteen (14) peer-run mental health peer support programs across the state. Given the size of New Hampshire, this is a robust deployment of peer-run services compared to other states.

The prevailing assumption of PSA staffing is that all, or substantially most, employees are people disclosed with lived experience. About 70% of PSA personnel are individuals with lived experience, some of whom are certified peer support specialists. Employment at PSAs is likely to be experienced differently than more traditional clinical service provider settings due to the intrinsic emphasis of PSAs on recovery, empowerment, and peer support values.

Due to the diversity of PSAs around the state, it is not justified to make broad-scale assertions about the culture, hiring practices, etc., of these agencies or the employee experience. However, it is clear from public and key informant comments that several of the challenges that affect peer support staff in CMHCs are also realities of work at PSAs; such as wage and compensation limitations, opportunities for advancement, etc. are systemic issues that can vary, but are not isolated to any specific provider or type of organization.

Employment of People with Lived Experience in other Community Organizations/Settings

Entities such as advocacy organizations, clubs, housing providers, hospitals, and non-profits that serve communities outside of, or intersecting with, mental health services, employ people with lived experience in various ways – as peer support specialists, speaker/trainers, program staff, or volunteers. NAMI-NH, for instance, provides stipend-based payments to individuals through their Peer-to-Peer education program, and employs peers on a part-time basis. Currently, this portion of the peer workforce in New Hampshire is small.

Individuals with lived experience of mental health conditions also provide support services as Recovery Coaches in substance use-focused Recovery Community Organizations, residential treatment/recovery houses, etc. While the training, expectations and workforce issues of this subspecialty are somewhat distinct, crossover lived experience is highly relevant. The prospect of multiple and cross-over peer specialist services is an area of some debate and great potential benefit as well.

The options for lived experience career mobility related to both of these specialties is potentially significant, however, and an important factor in the landscape of opportunity within the field.

Key Observation 2

People with lived experience employed in peer support roles throughout New Hampshire value the work they do and they are deeply committed to it in several ways. Many have said that working in peer support is profoundly important and personally gratifying.

The low wage and salary provided for peer positions, however, has put some in the difficult position of having to hold other or multiple jobs to manage the cost of living. One peer support specialist said that they were working for less than half the pay they had earned outside the sector.

As a result of this financial stress, some peer support specialists leave their positions, or the peer workforce altogether, because they ”could not afford to keep doing it” even while affirming that they loved the job and loved helping peers in their recovery. The causes of compensation challenges in the field may be complex, but achieving a ‘livable’ wage for the peer workforce is key to its sustainability over time.

Stakeholder Insight and Feedback

Public input was central to creating, revising, and prioritizing every aspect, recommendation, finding, and discussion of the content of the Advancement Plan. Three stakeholder participation forums were held virtually in the process of developing this Advancement Plan. In each of these, a combination of presentation, dialogue, and focal questions fostered attendee input, including remarks captured in live chat.

Discussions in the first two sessions, held in September and October, related to a range of issues, including the Advancement Plan purpose and approach, priorities for change, the relationship of PSAs to state agencies and CMHCs, challenges experienced by peers in CMHC settings, and questions about the process itself. The last session, held in December, presented the draft Advancement Plan, Challenge Areas and Recommendations for specific input on their value and language. Public comment was also invited by direct link to a Google document file provided and promoted by NAMI-NH throughout. The direct feedback link was posted on the BMHS website and highlighted on the DHHS website to provide opportunity for statewide community input.

Public Forum 1: On September 30, 2020, the project team (NAMI-NH, BMHS and Humannovations) conducted a virtual public forum to present the background, initial approach of the Advancement Plan and timeline for project completion. Fifty-six (56) individuals attended at least part of this session, providing insight and response to the Advancement Plan introduction through the chat function, direct voice address and through response to planned polls. Participants responded to a draft outline and key questions and polls, designed to align the content of the Advancement Plan with the priorities of the community. The principal key poll question presented at public forum was: *“Please select the 3 most important workforce challenges to address for success of the lived experience workforce in your view.”* (Multiple selections available)

The top 5 items chosen from selections:

#Votes	Workforce Challenge Areas
19	Scope of practice/service model
17	Employer/workplace readiness/recovery culture and/ or workplace culture readiness and professional tensions
15	Placement/reporting/supervision- multiple roles, professional standards and consideration
14	Pay and compensation
12	Training, education/experience and interrupted education
	Provider culture and workplace readiness
	Career entry, transition and attrition
	Service billing and documentation

Public Forum 2: Based on feedback at the first event and the expressed desire for more dialogue, a community listening session was held on October 20, 2020 to create more space for open discussion. A trained community mediator from New Futures facilitated this listening session, with a focus on the following questions.

Question 1: "What needs to happen for peers to be seen as valued members of the team, and for their roles to be understood within their organizations?"

"I feel like I have to be telling my supervisors what I should be doing. This makes it really frustrating and… I get so burned out I want to quit."
A New Hampshire peer support specialist

Many stakeholders agreed there is a strong need to provide education to agencies and organizations that employ peers on the topics of peer support, peer roles and responsibilities. Peers who work in the field expressed that they often felt isolated, misunderstood and misinterpreted within the system of care, and even within their own organizations. Participants made suggestions around training and cross-training that were strongly supported. There was an emphasis on the need to develop system-wide training on additional topics such as peer culture, language, trauma informed care, and stigma reduction. Training was also suggested for leadership, supervisory, administrative, clinical, and non-clinical staff. Creating equity in an individual's lived experience and not limiting career mobility based on lack of formal or academic achievement was also an important topic.

Question 2: "How do we attain enough workforce diversity to meet the complexity of needs?

There was recognition of a need to expand the diversity of the peer workforce and seek out unrepresented individuals. This question generated primarily conversation around the need to actively recruit peer support specialists who identify as black, indigenous, and people of color (BIPOC);lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ+) communities; and those who can support individuals who are deaf or hard of hearing or have visual impairments. The group also suggested training in the areas of diversity and cultural awareness.

Stakeholders also acknowledged the diversity of roles that peer support specialists fulfill in various settings, such as PSAs, CMHCs, hospitals, and advocacy organizations. There was a strong desire to unite peers who work throughout the system to ensure that they are able to fulfill their job responsibilities while being rooted in core principles of peer support. There was recognition that peer support specialists have varying skill sets and can hold extremely diverse jobs. For example, the analogy was made to social workers who have standard foundational training and core values but work in a multitude of environments. There is a need to build the peer workforce to be able to meet the diversity of job opportunities that are arising throughout New Hampshire's mental health system. The system will require different specialists such as positions within PSAs, hospitals, housing programs and on crisis response teams and Assertive Community Teams. There was recognition of the need to develop both core and specialty training opportunities to support the diversity of jobs that peer support specialists will hold.

Question 3: "How do we best support peers working in different environments? What would help you feel like you want to stay in the peer support field?"

"If I go to a training I'm still required to meet "productivity" and if I don't have a productivity expectations I would be paid significantly less."

"…the most important issues in the advancement of New Hampshire's lived experience/peer workforce is the creation of a tiered compensation structure and opportunity for continued education leading to career advancement."

~ New Hampshire peer support specialists.

Sustainable wages and pay equity were common themes in feedback to these questions. Similar to previous questions, stakeholders feel that, despite their passion for peer support, the pay is unsustainable especially for those with families. Stakeholders expressed that, along with pay equity, there also needs to be an emphasis on creating opportunities for career mobility and advancement for peer support specialists. Individuals strongly expressed the need for recognition of life experience to be seen as a unique qualification, similar to how other types of job experience are recognized and contribute to pay rates and compensation.

Several stakeholders mentioned trauma informed work environments and the need to feel safe in a work environment. This reaffirms the need for increased training in trauma informed care. Trauma informed care training benefits quality of services provided to individuals through programming as well as the internal work culture and understanding among colleagues of their potential life experiences.

The need to be recognized as a professional working as a valued member of a team was cited as a significant need. Stakeholders cited a lack of education about the role and unique expertise peer support specialists bring to a team. In order to feel supported, there needs to be recognition of the importance of integrating peers throughout the system of care and not hiring a "token peer" who then feels isolated and often misunderstood. Suggestions to provide broad training across the system and specifically to those who supervise peer support specialists was cited as one potential solution. Participants also suggested forming peer groups and co-reflection cohorts for peer support specialists who work in similar work environments, which would allow peers to gain mutual support and feel more confident as an advocate within their work environment.

Key Observation 3

Many people with lived experience working in CMHC programs report being the only peer support specialist in the service or program. Sometimes they are in the position of having to create and/or clarify their role as a peer support specialist for purpose of the local team, program design and/or management. In some cases, these individuals begin their employment lacking training or experience that would empower them to do this and contribute most effectively to the work. Several individuals reported feeling that their job title, job description, duties and assignments did not align with their understanding of their role as peers. Some peer staff reported feeling that they had to educate their supervisor to achieve a good fit understanding for purposes of work at the program, performance assessment, etc.

On December 4, 2020 a draft of the Advancement Plan, the Challenge Areas, and Recommendations were presented at a public forum of twenty-eight (28) attendees. Based on this focused workgroup-style session, revisions, additions and changes to Recommendations were incorporated in the public draft document that was posted on December 14, 2020.

LIVED EXPERIENCE WORKFORCE CHALLENGE AREAS AND RECOMMENDATIONS:

In this section, we identify central themes of the peer workforce, as reflected through the inputs and insights gained from the public input process from New Hampshire's community stakeholders. Most of the eight Challenge Areas identified here, thus, are relevant to the discussion of any specialized workforce, including the peer workforce.

Each challenge area is followed by at least one specific Recommendation. This document presents three "multi-area" recommendations, which are considered to intersect with more than one challenge area. Of note, many recommendations associated with specific challenge areas could positively affect others and/or the system/community in multiple ways. As peer workforce successes become integrated into the New Hampshire system, the positive effects of culture change could be seen in multiple areas, including professionalism, program performance, job satisfaction, and service recipient experience.

NH Lived Experience Workforce Areas
1. Scope of practice/service model
2. Provider culture and workplace readiness
3. Education and lived experience
4. Compensation and advancement
5. Career entry, transition and attrition
6. Placement/reporting/supervision
7. Service billing and documentation
8. Multi-area recommendations

1. Scope of Practice/Service Model

Peer support services feature unique connections based on equality of status and shared experience of mental illness, recovery, and (usually) being a service recipient (client). Peer support relationships are functionally and philosophically different from typical provider-client relationships. Boundary issues tend to be quite different as peer support specialists strive to find as much mutuality as possible and, most importantly, move away from disparities in power and privilege that might diminish the traditional medical model client/service users' sense of empowerment. New Hampshire stakeholders identified the challenge of this in the context of mental health service provision as an area of significant misunderstanding. Peer support values and practices are not universal, and training approaches vary. Nearly all peer support 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 peer support specialists openly sharing their own experience with a service recipient enhances their ability to 'model' growth and recovery, and makes peer support unique. Such personal qualities in the lived experience workforce emphasize peers' 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 and principles.

The way peer support competencies translate into practice varies widely in the mental health field, which may lead to misunderstanding of the distinctive roles and service design of peer support

programs. As reflected through stakeholder feedback, job performance and role confusion concerns can result. For instance, when a new peer support program is created at a community agency or organization, or when peers are newly hired into an agency setting, the duties in their job description may not align with the model and philosophy of peer services they were trained on. This can lead to loss of quality in the work and, potentially, conflicts around performance. One of the ways this disconnect impacts people with lived experience directly is when they are the only, or one of the first, peers hired by an agency. These peers may find themselves in the undesired position of explaining their distinctive competencies and practices to program staff, colleagues, and supervisors, or 'advocating' to perform duties in alignment with their training and values.

Notwithstanding the issues of culture and welcoming at organizations (see Challenge Area 2), this problem can be amplified if an individual is employed without prior experience, orientation or training in the competencies of peer support. In this case, without good guidance or supervision, peer specialists can become confused about what their role is and how precisely they should be practicing 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 as to its function in the job or program setting.

Recommendation 1: Peer Services Orientation for Clinical Providers.
Provide all CMHCs or related providers that employ, or plan to employ, peers in their service array with an orientation on the values and practices of peer support.
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 support specialists and new peer supervisors receive standard online introductory training in the fundamentals of peer support in practice.

2. 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 disclose their personal lived experience, with others in their work environment, varies greatly and can affect the extent to which they are, or are not, welcomed into a work environment. Disclosure is an intentional component of peer support services but the approach is not always understood or shared by other mental health providers. Beyond the broader issue of a welcoming environment for peer support specialists, expectations related to education, performance, documentation etc. may also create unanticipated barriers to success.

Nowhere is this more evident than in the area of professional boundaries. Although many of the standards, policies and practices in this area were originated with a view to the 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 support specialists perform their work. Although mutuality is generally an important value in peer support, implementation of mutual support represents a challenge in the mental health service model, where one person is paid to support a service recipient and the costs of this are publicly funded. Furthermore, since peer support specialists may have prior

relationships with service recipients, guidelines that promote the value of relationship and mutuality of status may be needed that distinguish these from clinical agency policies. For example, the issue of 'multiple relationships' among peer support specialists and peer support recipients (clients) should be overlooked until a problem arises, which can be damaging to the peer support specialist, the client, or the program as a whole.

Additional complexity of culture in the behavioral health workplace relates to accepting lived experience employees as professional colleagues. Sometimes peer support specialists are former service recipients (clients) of an agency, such that others may have been accustomed to that frame for their relationship. Further, peer support specialists, depending on their background, may have less formal education including less education in human services/social sciences than their colleagues. In a tight job market, this can manifest in sense of competition between professionals, protection around expertise and roles, or even doubts as the legitimacy of peer support services. A shift in dynamics to ensure that empowerment and respect are upheld all the way around may require some intentional focus on policy, practice and culture change.

Another cultural issue that may create barriers to success is the potential 'culture clash' between traditional service models and the principles of peer support and consumer empowerment that emerged 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 and billing requirements). 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 that is central to recovery and/or peer support specialist work. (See Challenge Area 7.)

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 service experts.

3. Education and Lived Experience

The distinctive competencies of peer support are derived 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, as well as 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. People with lived experience who become peer support specialists have left, or felt compelled to leave, a prior career path as a result of their condition and recovery.

Although the expansion of peer services has led to more training and programs at traditional post-secondary and even in some high school settings, it is not the norm for people to enter the mental

health peer workforce with advanced degrees in human services or social sciences. Also, disability related to behavioral health issues is most prevalent in the college years, which can create a barrier for many related to their formal education.

This concept of interrupted education, can impede financial success and career development, and 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 service recipient may not meet the educational requirements of organizations that might employ them. Even with stability in income, family life, etc., completing a college degree as an adult represents challenges, financial and otherwise.

Many human service agencies hire peer support workers with a minimum requirement of a bachelor's degree or less at the entry level. Peer support specialists with a mix of educational backgrounds are already employed throughout New Hampshire's mental health system. However, it is not clear whether and to what degree, career advancement would require individuals to meet educational requirements set by organizations. To expand the growth horizon of the lived experience workforce, including promotion to management or executive positions, the issue of educational equivalency standards may be highly relevant, including possible continuing education benefits, and tuition supports for career advancement.

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 time needed to attend the complete set of high-quality trainings is substantial. While New Hampshire's requirements are not extreme or unwarranted, this certification baseline, along with continuing education requirements, sets a high level of expectation for peer support specialists within the state.

There are limitations for peer support specialists to advance through promotion, title change, and pay/compensation. Peer support specialists who complete the training and certification requirements and pursue further specialty training should be rewarded with a wider 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 is 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 an equivalent to traditional academic degrees for purposes of hiring, recruitment, wage differentials and promotion. Progress in this area could amplify the effectiveness of the peer support services, reduce culture issues, and ensure that more peer support specialists experience job satisfaction, thereby enhancing peer support culture and increasing job retention.

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. Develop peer support specialist certification standards/hours, work and lived experience equivalency parameters, scholarship/tuition support,

and create higher education institution partnerships to reduce the career barriers that interrupted education represents for individuals with lived experience.

4. Compensation and Advancement

Limitations on pay and benefits emerged as a recurring theme in reflections by peer support specialists. Several individuals expressed that they had previously left or were planning to leave their peer support positions because wages were so low. Ensuring that peer support specialists achieve pay equity and increased compensation to a livable wage across the system is 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 support specialist in the state is employed in a supervisory capacity within the CMHC network, as a peer support specialist supervisor.

This would indicate that, outside PSAs, most peer positions are entry-level, and therefore opportunities for promotion and career advancement in peer support are marginal. However, individuals with lived experience may find advancement options within their organization in non-peer-identified positions of various sorts. This type of career transition has been observed in many community service provider organizations.

The absence of viable options for advancement, promotion, and increased earning is likely to have a depressing effect on the engagement of any workforce, contributing to burnout, workforce attrition, and loss of institutional or 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.

Recommendation 5: Peer Support Specialist Survey
Conduct a survey of peer support workers across New Hampshire, to collect de-identified data on employees who identified as being an individual with lived experience. Data points should include demographics, tenure in position, tenure in field, wages, education, location, job satisfaction, career goals and outlook. Construction of the survey questions and review process should be guided by people with lived experience.
Recommendation 6: Wage and Compensation Standards
Establish a pay scale for peer support specialists to include minimum hourly and salary rates, benefits and pay differentials based on certification, time in service, job title and rank, etc. This resource could serve as a direction and clarification for contract agencies and others, with the intention to ensure that peer specialists receive a livable wage and are compensated on par with staff in similar position categories.

5. 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 and the availability of potential peer support specialists is unknown. The goal of employing peer support specialists in every program setting means that as demand for services expands 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 enter the lived experience workforce, b) creating more lived experience positions (or revision of positions to include/promote/accept lived experience qualifications), and c) expanding career pathways within the field.

In combination with a survey of peer support specialists themselves (Recommendation 5 above), a technical workforce analysis of organizations should be conducted 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.

Recommendation 7: Peer Support Employer Survey
Survey all CMHCs, PSAs and related community organizations on current and planned lived experience positions, job titles, vacancies, education requirements, challenges with recruitment/retention.
Recommendation 8: Lived Experience Career Ladder/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 should include requirements for certification, education, and experience or equivalency expectations.

6. Placement, Reporting and Supervision

Peer support specialists are often the only identified lived experience workers at a specific program site. (See Key Observation 3). In many of these service settings a peer support specialist may report to a supervisor who is not well oriented to the distinctive competencies, values, and peer support practices.

Until more peer support specialists are employed across the NH system and more peer supervisory positions are implemented, this is likely to continue. Training can enhance supervision of peer support specialists in multiple ways. (See Recommendations 1 and 3). However, this may not be sufficient to reduce job stress and may not support the career development of individuals isolated by program and/or location. A network of mentors, formal or otherwise, could provide a valuable resource to peer support specialists in early, training and advanced career phases.

Recommendation 9: Peer Support Mentorship Network

Develop 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.

7. Service Billing and Documentation

DHHS has taken initial steps toward clarifying options for agencies to bill New Hampshire Medicaid for peer support services. While this is currently available to Medicaid providers in the state, a special billing code has not yet been incorporated into the state Medicaid Plan to date. A previous consultation with the Center for Social Innovation, through a SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center Strategy grant, examined the issues and direction for change in this area.

It should be noted that some individuals, PSAs et al, are concerned about the implications of this direction. For instance, that Medicaid documentation standards emphasizing medical/illness model are not in keeping with the values and ethics of peer support. Additionally, stated by a stakeholder, "documentation does not have to compromise the values of peer support and can be utilized effectively," this indicates there is space for discussion and compromise. It is relevant to note that this challenge exists in many US communities with regard to recovery-driven programs and the 'medical necessity' foundations of Medicaid billing (i.e. not exclusively peer support services). Given previous priority and work in this challenging area, progress is expected to continue.

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.
Recommendation 11: Recovery-Informed Documentation and Practices Audit
All NH DHHS, BMHS contracted agencies should review their 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 and member intake and evaluation forms, service notes/charting, recovery and treatment plans.

8. Multi-Domain Area Recommendations

The following Recommendations were pulled from individual Challenge Areas because they are relevant to and likely intersect with multiple areas in different ways. These items correspond with long-term cultural change outcomes as well.

Recommendation 12: Recovery-Focused Supervision, Performance Support, and Accommodation Training
Provide initial and annual trainings for managers and program supervisors at all DHHS, BMHS contracted agencies to ensure workplace wellness, clarity and program success in employment of people with lived experience (including non-disclosed and non-peer support identified staff).
Recommendation 13: Peer Advancement Advisory Council
Create a Peer Advancement Advisory Council, comprised of stakeholders across state agencies, PSAs, CMHCs and related provider, advocacy, and community groups to review the activities, actions, outputs and outcomes of this plan, build alliance and understanding of peer support service integration, problem solve and collaborate on related items. The Peer Advancement Advisory Council should meet quarterly, and would be responsible for driving the implementation of system change.

CONCLUDING STATEMENT:

The vision of integrating people with lived experience throughout all elements of New Hampshire's mental health workforce reflects enduring appreciation of the resource of lived experience, and a shift in culture to inclusion of peer support that has been building for many years.

In development of this Advancement Plan, New Hampshire's commitment to broad-scale implementation of these directions is affirmed and clarified. The Advancement Plan's Recommendations contain concrete items for positive impact in all of the major challenge areas associated with its current peer workforce, and items relevant to ongoing evaluation.

Inclusion of peer support specialists, mental health providers, peer support agencies (PSAs), advocates, and others, has been a key part of the creation of the Advancement Plan. The insights provided by all community stakeholders was crucial in the planning efforts that affect them, and will be essential to the ultimate success of implementing our solutions.

New Hampshire is one of very few states to bring substantial resources, planning, and focus to expanding its lived experience workforce across systems and sectors. In doing so, with respect to all of those who care for this work, and for New Hampshire's mental health in general, the state is a leader in the nation. This leadership, in active partnership among agencies, state government, community organizations, peer support agencies and lived experience stakeholders, promises much in terms of better wellness for thousands of New Hampshire citizens.

APPENDIX A:

PEER ADVANCEMENT LOGIC MODEL

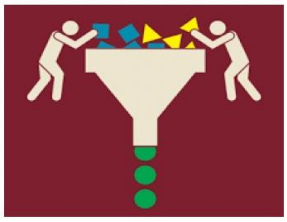
A Logic Model presents a visually intuitive pathway from the current state of affairs informed by available information (the INPUTS column) to a set of desired OUTCOMES, based on the mediating ACTIVITES and the OUTPUTS of those actions.

In the below Logic Model, the left column items are INPUTS (data) and INSIGHTS (from the engaged community and stakeholder experts) that have informed this document. ACTIVITIES and ACTIONS, are the specific recommendations. The hypothesized OUTPUTS presented are measurable results of the ACTION column items in the Logic Model to lead to the envisioned OUTCOMES/CHANGES.

The ACTIVITIES AND ACTIONS column of the Logic Model contains all of the "Recommendations" proposed in this document. The OUTCOMES envisioned here are connected with the community's vision for lived experience, specific goals articulated in the 10-Year Mental Health Plan, and long-term hopes identified by New Hampshire stakeholders and experts. Some of these may be quantifiable through research. In the end, changes to enhance the integration of people with lived experience in the mental health system will be most evident in the experience of those individuals, the programs and agencies that employ them, and, ideally, the quality of care that people encounter throughout New Hampshire when they access publicly funded mental health services. By their nature, systems-level outcomes are less simple to measure, but crucial in validating the logic of efforts to create enduring change. While it cannot be guaranteed that the ACTIONS in this Logic Model will produce the desired long-term OUTCOMES identified here, or that such changes will be measurable, it is reasonable to assume that change in some or all of them will result from the identified efforts.

The below Logic Model is presented as a foundational draft that outlines a framework for which to build a work plan that will guide implementation of New Hampshire's Peer Workforce Advancement Plan. It is recommended that the Peer Advisory Advancement Council lead implementation efforts and develop a more comprehensive and detailed work plan.

NH Lived Experience Advancement ***Logic Model***

INPUTS & INSIGHTS	ACTIVITIES & ACTIONS	OUTPUT ITEMS	OUTCOMES/CHANGE
			
•27 years state implementation of Peer Support •8 active PSA orgs •10-year Plan •Stakeholder Findings •State OCFA •10 CMHCs/Regions •PS positions in mutliple programs •New PS initiatives •Statewide PS Certification •PS training standards and CE •BRSS TAC program •Consumer Advocacy and org coalition •Consumer and Family Leadership •Activating Hope Process •Listening Sessions •LE Workforce Blueprint	•PS/LE Career ladder/tree •Lived Experience Services Advisory Council •Peer Services Orientation for CMHCs; •Peer Services Survey; •**Recovery-focused Supervision training** •Fundamentals of Peer Support training •Recovery-informed documentation and practices audit. •Peer Supporter / Specialist Survey •Medicaid billing code •Activating Hope Action Protocol •Peer Practices Co-Learning Community; •Wage and Compensation Standards; •Education, Equivalency and Training Standards. •Peer Support Provider Mentorship Network	•PS education, training and pay standards integrated at (5) CMHCS and 5 PSAs •(50%) increase in # of Certified PS statewide •50% of CMHC program staff and managers trained •100% increase in PS providers employed •PS/LE Career Pathways identified •LE educational equivalency and upskilling standards •Post-secondary degree /certificate program •PS wages increase to 'livable wage' standards •(40) new peer supporters receive fundamentals training •(25%) of PS active in mentorship support	•Welcoming and valuing culture for LE •Enhanced visibility and leadership of PLE •Understanding of values and practices of PS statewide •PSA orgs expand services and scope •PLE and PS engaged in all service settings •Multiple LE opportunities and multiple levels •All CMHCs/Regions promote PS services in mutliple programs •Increased job satisfaction for PS •Increased client service satisfaction •Enhanced recovery outcomes •Decreased urgent services, suicide, incarceration, unemployment