State Board of Behavioral Health and Developmental Services
Office of Recovery Services
PUBLIC HEARING COMMENTS ON: PROPOSED STAGE REGULATION 12VAC35-250, Peer Recovery Specialists.

Stage	Proposed
VAC	Chapter 250 [Under Development]
Hearing:	**November 19, 2018**

#	Commenter Name	Commenter Organization	Comments	DBHDS Response – UPDATED 11/26/18 4:30 p.m.**
1	Becky Bowers-Lanier	Virginia Association of Addiction Providers (VAAP)	Ms. Bowers-Lanier stated she appreciated that in the development of the regulation, the agencies were mindful of the dual roles of the three agencies (DBHDS, DMAS, DHP's Board of Counseling, "BOC") in regulating the registry, education, and experience under supervision. The BOC regulations don't seem to address the nature of the supervision. VAAP asks that DBHDS detail the supervision of specialists, of the supervisor's training and education. Also, require content of ethical and boundary issues. The entire section of continuing education is not in the DBHDS proposed regulation. VAAP is very concerned of the boundary and ethical issues. (Comments submitted in writing)	Thank you for the comments on behalf of VAAP. The continuing education for supervisors is based upon their own credentials through certifying bodies (CPRS, CSAC, those licenses listed under LMHP, etc.). The continuing education for PRS is also based on their certifying body. DBHDS thinks this topic is well-covered through the following: The Code of Ethics is part of the regulation as a document incorporated by reference. Also, ethical and boundary training is part of the PRS and supervisor curricula. Subsection 50 B.10 includes a requirement for ethics and boundary training for PRS. There are requirements for supervision of PRS in the DMAS Peer Supplemental Manual.
2	Beth Tolley	Self	Request that 'family support partner' be added to definitions. 'an individual who has met all requirements of PRS and who is a parent or caregiver of a minor….. Broaden definition of 'individual' to include 'a caregiver….' Or, have 'family member/caregiver' added to the definition. (Comments submitted in writing.)	Thank you for your comments. **Update: DBHDS does not recommend adding "family support partner" (FSP) as a separate definition in the regulation for the following reasons: In the DMAS Peer Services Supplement Manual, DBHDS regulations are listed in the PRS definition, and not in the FSP definition. PRS is the umbrella term, and FSP is a type of PRS. DHBDS regulations must address (only needs to address) all PRS, and it is cleaner to use the umbrella term, with the explanation of FSP is included in Subsection 20 B 1-2. Listing both terms together throughout the regulation (as DMAS does, 'peer recovery specialist or family support partner') makes it sound like FSP is a different profession with different requirements when it is not. DBHDS does not recommend adding "caregiver" to the definition of PRS because the definition of "caregiver" is defined by DMAS regulation (12VAC30-130-5160) as someone who is "not being paid." Therefore, persons under that category could not be a PRS.
3	Laura May	Self, and as an employer	I would like to have the definition of 'parent' include 'or caregiver.' Even though in other places in the regulation it includes 'family member,' sometimes the person providing care is outside the realm of family.	Thank you for your comments. DBHDS does not recommend adding "caregiver" to the definition of PRS because the definition of "caregiver" is defined by DMAS regulation (12VAC30-130-5160) as someone who is "not being paid." Therefore, persons under that category could not be a PRS.
4	Kelvin Manurs	Arm and Arm, a nonprofit peer to peer re-entry organization that does counseling and support as well as training	The organization is part of a Prince William and George Mason project working on the opioid crisis. Mr. Manurs requested that some of the peer trainings be focused on smaller groups. These two different spectrums – individuals that have great talent and ability to work with other people, but the larger groups frighten them. He and the organization have been working in a couple different conduits to address, and some letters have come down the pike about this issue. Some individuals have stressed they have mental health issues in larger forums.	DBHDS appreciates the concern described; however, this does not pertain to the proposed regulation.
5	Cristy Corbin	Self	Ms. Corbin stated how great it is that this is the process now in place to recognize peer recovery specialists. She sees this time as a huge celebration for those of us working in the field. Some of the wording in the regulation is confusing. For instance, the title of the regulation versus the certification title. What are specialists being referred to as? In the definitions, there is 'PRS' definition, a 'registered' PRS, but not a 'certified' PRS. There is reference to certification further down in the regulation. Being that you don't have to be registered but must be certified, it might be helpful to add clarification to be supportive in what attempting to accomplish.	Thank you for your comments. 'Peer recovery specialist' is the main term. Those who qualify as a PRS in accordance with regulatory requirements, who then choose to register with the Board of Counseling (at the Department of Health Professions) are considered a 'registered peer recovery specialist.' However, the Board stated that registration is only required for the purposes of Medicaid billing. Conversely, if someone is registered, they can still provide non-Medicaid services. Before the regulations took effect, the term 'certified' was used for everyone who went through the DBHDS training and received a DBHDS-issued certificate. In the regulation,

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			Also, under PRS in subsection 20, 'shall provide such services of employee or contractor…..,' Change 'shall' 'may.' There needs to be more information about being a contractor or employee of DBHDS.	there is a definition of 'certifying body; which refers to 'an organization approved by DBHDS that has as one of its purposes the certification of peer recovery specialists.' This is referring to a nationally recognized, and for purposes of this regulation DBHDS-recognized (as listed in the regulation), professional accrediting body (that certifies successful completion of its requirements, and there upon awards a license or certificate. The most general type of certification is profession-wide. This type of certification is developed in various professions in order to apply professional standards, increase the level of practice, and protect the public. In regard to the reference to subsection 20, the language referring to being an 'employee or contractor' must be in the regulation as 'shall' because that is the scope of DBHDS authority.
6	Lynn Taylor		She was not sure if the hearing was the appropriate venue to discuss it, but a whole array of folks are training peers and she has found that it is very person-dependent, as there is no regulation of the trainer's skill set, how they are doing the training, what they are doing, no standardization. It is simply, 'Here's your 80 hours.' As a coach you're getting a whole mixed bag of tricks as an employer because you are not sure what training someone has, and sometimes have to retrain a new hire. She would like to know if there are reports of inconsistencies and not good training, and how that gets fed back to DBHDS to help train and educate more.	Thank you for your comments. The regulation states that everyone must take the 72-hour DBHDS training. This is to ensure that everyone has the same foundation of training. The trainers are to be teaching to the curriculum. Further, DBHDS performs random audits of trainings, monitors the class size, hours for the training (72), and content. Trainers must present training within those guidelines in order for the participants to receive a certificate of course completion. If this topic is considered for future action (meaning, if the current audit and monitoring are required to expand), additional resources would likely be required.
7	Bruce Cruser	Executive Director of Mental Health America-Virginia	He had stated he had nothing controversial to say. DBHDS and the other agencies are commended for what has been done with the regulations over the past year or so to address an amazing emergence of this new workforce. The regulations do a great job covering the ground of what will be a professional level. He pointed out that some of the folks present at the hearing were part of who worked on the curriculum. His complaints have to do with reimbursement rates, and that is beyond the scope of these DBHDS regulations. He thanked DBHDS for including the workforce in the developments to date, and ask that inclusion continue in whatever else is developed.	Thank you for your comments.
8	Elizabeth Sluder	Middle Peninsula-Northern Neck CSB PRS and coordinator, speaking for the CSB	The CSB is not billing due to the reimbursement rate because it is too low. It has gone from initially $66 to $26.50 and it does need to be raised considerably. PRS work not in just the ID population, but for the community as a whole, the workforce and reentry. It is not just for mentoring, but for the whole person. There is a lot of value delivered in that reimbursement.	DBHDS appreciates the concern described; however, this does not pertain to the proposed regulation.
9	Lyn Groover	MPNN CSB employee in the PRS division	I worked for two years as supportive employment specialist. Regarding the definitions of PRS, PRS services, and the definition of recovery, resiliency, wellness plan. Across the state we train PRS, and they come to me and want to be a PRS but they have a criminal background. I have to tell them 'sorry, you can't do direct care if barrier crime,' and then some break out in tears. It is demoralizing to them and to me. Employment was a stepping stone to recovery for me. I enjoy my job and enjoy helping people get past their illness…I don't have a criminal justice background. Who better to work with people with a criminal justice background than those who have one? The training is as far as they can currently go. I hope it will be addressed.	DBHDS appreciates the concern described; however, this does not pertain to the proposed regulation. A legislative change would have to occur to address concerns about current barrier crime restrictions.
10	Yaritza Ilarraza-Santos	Provides peer specialist services in the Veterans Health Administration Hunter Holmes McGuire Veterans Medical Center, speaking for herself	She stated that regarding the section on who may act as a PRS, it mentions a parent of a minor or adult child, or an adult with personal experience with a family member. She recommends adding a third type of person: a person who self-identifies as being in recovery from mental illness or substance use disorder or co-occurring, similar to the individuals to whom they are providing services.	Thank you for your comments. This is covered in the definitions of PRS and the recovery experience requirements. Also, the validation of lived experience is included in the Code of Ethics.

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11	Rick Gilbert	MPNN CSB	He is pleased that the date deadline portion was removed from the regulation, and that this topic area is being addressed and made permanent. There are two larger issues to qualify peers in the state to do this valuable work: 1) The barrier crime aspect of disqualification. Many of us have come to a better way of life in recovery, as a result of consequences from actions we took. I'm fortunate that my consequences and jail time were only for misdemeanors. Concerned we won't have enough people to qualify. More specifically, DBHDS needs to understand the likelihood of some of us having such consequences in our history, including jail time. 2) Also, address the 500 hour requirement. That is daunting for a number of people. Helping with a small department grant, group working with are daunted by the requirement as it is more than they can do in a year, for the most part, and should be something that is doable on a part-time basis.	DBHDS appreciates the concern described; however, this does not pertain to the proposed regulation. A legislative change would have to occur to address concerns about current barrier crime restrictions. Examples of how the 500 hours of peer support experience can be acquired are: • in three months at 40 hours per week, or • six months at 20 hours per week or • 50 weeks at 10 hours per week. Also, other states require as many as 1,000 hours. The 500 hour requirement was recommended in the December 2013 report of the DBHDS Creating Opportunities Peer Support Planning Committee, which was developed by the members listed below and vetted by other interested stakeholders. Excerpt from the committee's report listing participants: *The Creating Opportunities Team…was co-chaired by Becky Sterling of MPNN CSB and Susan Pauley of DBHDS Central Office. Upon learning that leaders in the peer and advocacy SA and MH communities had begun conversations about certification, the Creating Opportunities Team formed a sub-committee to focus specifically on certification. Becky Sterling, Susan Pauley, Mark Blackwell (from SAARA) and Bonnie Neighbour (from VOCAL) were Creating Opportunities team members who joined with Heather Peck (from VOCAL), Jan Brown (from SpiritWorks), Mike Newcomb (then Chair of the Virginia Peer Support Coalition), Rose Farber (from On Our Own in Charlottesville), Dee Jacobson (member of VOCAL, and of Virginia Peer Support Coalition, and Marjorie Yates (from SAARA) to research, debate, discuss, and develop the recommendations for standards and for administration of a certification process. Other members of the peer and advocacy community attended some meetings, were consulted with, and shared information with us they believed could inform the work. Staff in DBHDS Central Office (Michael Shank, Rhonda Thissen, Jim Martinez and Mellie Randall) who have worked with recovery oriented services and other peer support initiatives over the years also provided input and information that assisted the committee in their decisions.*