THE BRINGING RECOVERY SUPPORTS TO SCALE TECHNICAL ASSISTANCE CENTER STRATEGY (BRSS TACS) DATA COLLECTION PROJECT TO IDENTIFY CORE COMPETENCIES FOR PEER WORKERS IN BEHAVIORAL HEALTH SERVICES

SUPPORTING STATEMENT

A. JUSTIFICATION

1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration's (SAMHSA) project, Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) is requesting the Office of Management and Budget's (OMB) approval for a new data collection entitled, "Identifying Core Competencies of Peer Workers in Behavioral Health Services." The BRSS TACS team intends to use two instruments to collect original data to inform the ongoing development of core competencies for peer workers in behavioral health care services. These instruments are:

- Core Competencies Survey with Peer Workers (Attachment 1)
- Telephone Interview of Peer Workers (Attachment 2)

Peer workers in behavioral health services go by many different job titles, work with different populations, and perform a range of recovery support services (SAMHSA, 2012). "Peer worker" is a generic term for a number of roles within the healthcare system. In behavioral health, peer workers all have lived experience of mental illness and/or substance use disorders and use their personal recovery stories to assist others who are struggling to recover. Common job titles of peer workers include: peer specialist, peer recovery coach, peer wellness coach, recovery support specialist, recovery partner, peer navigator, peer healthcare navigator, peer educator, peer bridger, and peer advocate (SAMHSA, 2012). The list of job titles and roles is expanding, as are the number and type of environments that employ peer workers.

Peer workers provide recovery support services within traditional behavioral healthcare programs, in community-based and hospital settings, primary healthcare settings, criminal justice programs, and within peer-run organizations and recovery community organizations (Salzer, Schwenk, & Brusilovskiy, 2010). Peer workers may be paid staff or volunteers. They work in hospitals, emergency rooms, detoxification clinics, outpatient treatment clinics, residential programs, employment support services, rehabilitation programs, jails and prisons, re-entry programs, home health services, court diversion programs, recovery community organizations, peer-run organizations, and increasingly in primary healthcare settings (SAMHSA, 2012). Increasingly, programs are hiring peer workers to provide a range of services and supports to people with behavioral health conditions (Canady, 2013). A growing body of evidence suggests that peer-provided, recovery-oriented behavioral health services produce outcomes as good as and, in some cases superior to, services from non-peer professionals (Cook, 2011; Davidson, Chin, Sell, & Rowe, 2006; Rogers, Farkas, Anthony, Kash, & Maru 2010; Solomon, 2010). Peer workers have positively affected outcomes such as social integration, hope, service engagement,

and reduced hospitalization across multiple randomized, quasi-experimental, and correlational studies (Doughty & Tse, 2011). Support provided by peer workers is considered an evidence-based practice by the Center for Medicare and Medicaid (Chinman, Salzer, & O'Brien-Mazza, 2012).

Peer workers deliver many services, but social support is the primary service. Across healthcare, peer support has been shown to be effective in supporting people who are living with chronic health conditions (Volkmann & Castanares, 2011). Overall, studies have found that social support decreases morbidity and mortality rates; increases life expectancy; increases knowledge of a disease; improves self-efficacy; improves self-reported health status; improves self-care skills, including medication adherence; and reduces use of emergency services (Berkman, Glass, Brissette, & Seeman, 2000; Gallant, 2003). Additionally, providers of social support report less depression, heightened self-esteem and self-efficacy, and improved quality of life (Umberson & Montez, 2010).

For people living with mental illness, connecting with peer support specialists leads to reduced hospitalizations, reduced use of crisis services, improved symptoms, increase in social support networks, and improved quality of life (Davidson et al., 2006; Doughty & Tse, 2011; Sledge, Lawless, Sells, Wieland, O'Connell, & Davidson, 2011), as well as strengthening the recovery of the people providing the peer support service (Moran, Russinova, Gidugu, Yim, & Sprague, 2011). For people in recovery from addiction, participating in a peer-run recovery community led to fewer relapses and higher levels of community participation (Boisvert, Martin, Grosek, & Claire, 2008; Laudet & Humphreys, 2013). In addition to the benefits experienced by individuals participating in peer support services, peer workers play a critical role in transforming behavioral healthcare services (Sells, Davidson, Jewell, Faizer, & Rowe, 2006; White, 2009).

Currently, peer workers perform their roles with a wide range of people across the age spectrum. They work with people living with addiction and/or mental illness and their family members. Family peer support has been demonstrated to be effective in helping family members cope with the behavioral health condition of another family member.

It is anticipated that the Affordable Care Act will lead to an increased demand for peer workers in behavioral health and primary health services. To respond effectively to this demand, states and other behavioral health authorities will need to provide clear guidelines about the roles of peer workers and the competencies that these roles require (SAMHSA, 2012). Peer workers from behavioral health are filling roles in primary care settings to assist people who have co-morbid behavioral and physical health conditions. Health reform holds the promise to allow states, tribes, and territories to address the longstanding health crisis among people with mental health and/or addiction conditions. Often cited is the high mortality rate of people with behavioral health conditions, leading to premature deaths 15-25 years earlier than the general population (National Association of State Mental Health Program Directors [NASMHPD], 2006). It has been recognized that 44% of all cigarette consumption is by people with behavioral health conditions. Peer support has been found to be effective in helping people stop smoking (Ford, Clifford, Gussy, & Gartner, 2013). People with behavioral health conditions are more likely to be living with multiple long-term health conditions (Townsend, Fricks, & Evans, 2010). One study reported that 70% of individuals with significant mental health and substance use conditions had

at least one chronic health condition, 45% had two, and almost 30% had three or more long-term health conditions (Anderson, 2005). Peer workers have assisted people with a variety of health conditions to change health behaviors, such as improving eating habits (Baird, Cooper, Margetts, Barker, & Inskip, 2009), increasing physical activity (Castro, Pruitt, Buman, & King, 2011), reducing smoking (Brothers & Borelli, 2011), improving self care (Chapin, Sergeant, Landry, Leedahl, Rachlin, Koenig, & Graham, 2013) and improving treatment adherence (Hunkeler, Meresman, Hargreaves, et al., 2000).

In anticipation of the increased demand for peer workers in behavioral health, states and other behavioral health authorities are training and certifying peers to fill these roles (SAMHSA, 2012). There is recognition that in order to realize the potential benefits of peer support, peer workers need training and ongoing supervision (Repper & Carter, 2011). Peer workers have expressed concern about the lack of clear job descriptions for peer roles in behavioral health care programs (Repper & Carter, 2011), and some peer workers have complained about being required to perform tasks that other staff find time-consuming or unrewarding and that have little to do with providing peer support such as driving, cleaning, cooking, or accompanying people to appointments (SAMHSA, 2012). While a peer may perform any or all of these tasks, they are done in partnership with the program participant and with the intent of strengthening the relationship, providing peer support and modeling recovery behaviors (White, 2009).

Although training programs for peer workers in the behavioral health system have existed for over a decade, there have been no attempts to standardize the content or the models of training. To date, no national consensus defines standards for peer worker training programs. Training programs differ in length, ranging from 30 to 105 hours of face-to-face training and vary widely in the knowledge and skills that they teach trainees (SAMHSA, 2012).

The Core Competency Project will describe the foundational knowledge, skills, and attitudes required by peer workers to perform their roles in a wide variety of behavioral health programs and services. Peer-provided recovery support services typically involve providing social support, linking people to community resources, assisting with decision-making activities, and a host of educational and recreational activities (CSAT, 2009; SAMHSA, 2012). In addition, peer workers facilitate educational and support groups and advocate for service improvements. SAMHSA defines peer-provided recovery support as, “a set of non-clinical, peer-based activities that engage, educate and support an individual successfully to make life changes necessary to recover from disabling mental illness and/or substance use disorder conditions” (CSAT, 2009). While some peer workers are performing advanced or specialized competencies within the behavioral health field, the core competencies described will include the foundational competencies required by all peer workers working in a variety of environments and with a diversity of people.

While many people view peer workers as critical components of recovery-oriented systems, paid peer positions and roles are relatively new additions to the behavioral health workforce. There are basic questions about how to define these roles. There are additional uncertainties about how best to prepare people in recovery for the role of peer worker and how to supervise and evaluate the job performance of peer workers. Developing a set of core competencies is an important step in responding to these questions and may be a valuable activity in expanding peer roles in behavioral health.

2. Purposes and Use of Information

The primary purpose for this information is to appraise the importance of specific competencies to the work of peer workers who are currently employed in behavioral health settings. The Core Competencies Survey will collect peer workers' ratings of the importance of different competencies to their work. The Telephone Interview of Peer Workers will collect peer workers' experiences with and opinions about the competencies on the survey. They will also be asked how they might use the competencies in their work. The Core Competencies Survey and the Telephone Interview are seen as critical to the development of core competencies for peer workers because they integrate the perspective of people who are currently employed as peer workers in the behavioral health care workforce and have been judged as competent by another colleague.

It is critical to communicate to the behavioral health field and behavioral health authorities about the foundational knowledge, skills, and attitudes needed by peer workers. Because of the anticipated continued demand for peers in the behavioral health workforce, SAMHSA has prioritized the development of peer-delivered recovery support services across mental health and substance use disorder services. In an effort to deliver services of uniformly high quality, the core competencies of peer workers will be described so that states and other credentialing bodies will be able to establish uniform standards for peer workers.

In addition, clear descriptions of core competencies will assist behavioral health authorities with their strategic workforce planning efforts. The description of core competencies will inform services and peer workforce training programs of the basic requirements needed by peer workers in behavioral health services. The competencies will provide guidance to behavioral health programs when writing job descriptions and performances evaluations. In many communities, job descriptions lack uniformity and specificity and do not reflect accurately the focus of peer-provided recovery support services.

This work will create competency descriptions that will provide guidance to organizations, programs, states, and regions to strengthen their peer workforce development efforts. These core competencies will inform training programs and state certification entities about the essential skills, knowledge, and attitudes needed by peer workers in a range of roles in behavioral health services. Currently, 33 states offer certification for their peer workers and a growing number of states use Medicaid funds to reimburse for peer support services (Daniels et al., 2014). Despite the growth of the behavioral health peer workforce, there are inconsistencies in the requirements for these certifications across different states.

For behavioral health organizations and programs, core competencies will provide guidance for job descriptions for peer workers and improve the recruitment of potential workers by providing fair and unbiased criteria for hiring and making sure everyone is assessed against the same framework. Core competency descriptions have the potential to strengthen the workforce through improved training and preparation of peer workers. Behavioral health programs and organizations can use the core competencies to improve performance evaluations by providing a framework to discuss and assess performance.

Core competencies have the potential to contribute to a "culture of competence" in which peer

workers could use the competencies to engage in accurate self-assessment and seek out experiences to improve their competencies. For peer workers, core competencies could help to clarify what is expected in their role and will assist them in assessing their own strengths and limitations as a provider of peer support.

Overview of Data Collection and Purposes

Data will be collected from two sources: 1) the Core Competencies Survey, an online survey of 100 expert peer workers, and 2) a telephone interview with a subgroup of 20 peer workers.

Core Competencies Survey

The Core Competencies Survey was developed through an extensive process of literature reviews, synthesis of the competencies, expert panel review, and consensus-building activities. The Core Competencies Survey has 61 items and uses a 5-point Likert scale from 1-unimportant to 5-very important. The items on the survey are specific competencies that were developed by the BRSS TACS team, their partners, and experts in peer-provided services in behavioral health. The competency development team was lead by Dr. Cheryl Gagne, deputy director of the BRSS TACS project, who directed several other BRSS TACS staff with the review of the literature to extract potential core competencies. Dr. Gagne had the guidance of Dr. Michael Hoge of the Annapolis coalition, an expert in competency development. In addition to this support, an 8-member advisory group participated in a series of virtual meetings to give input and feedback about the competencies. (Names of advisory group member are listed in section 8).

The development of these competencies began with a review of literature to gather descriptions of potential core competencies. The following sources were reviewed for lists or descriptions of the knowledge, skills, and attitudes needed by peer workers in behavioral health services:

- States' descriptions of training and credentialing programs for peers in behavioral health systems
- Descriptions of competencies for peers written by peer-run organizations and recovery community organizations
- Descriptions of competencies written by training programs for peer workers
- Competencies listed or described in literature collected using Google and Google Scholar with the following key search words: peer competencies, peer support skills, peer recovery coach competencies, peer recovery coach skills, recovery coach competencies and skills, peer support specialist, peer support mental health, peer support addiction, peer roles, peer job descriptions, training peer workers and certification of peer workers in behavioral health.

The BRSS TACS team conducted the review of the literature and extracted and synthesized descriptions of competencies with guidance from partners and experts, leading to an initial list of competencies believed to be foundational for peer workers across behavioral health services. This initial list was reviewed and revised numerous times before going out for review by peer workers through the Core Competencies Survey. Review and revisions were conducted by the BRSS TACS team with the guidance of an expert advisory group that participated in a series of virtual meetings to discuss the set accuracy and completeness of the core competencies required by peer workers in range of behavioral health settings.

The Core Competencies Survey is a web-based survey rating the importance of approximately 61 different competencies divided into in relation to the role of peer worker. The web-based survey will be conducted using Survey Monkey Gold, an easy-to-use and affordable survey platform compatible with most computers. C4 has an organizational subscription to Survey Monkey Gold. The survey will contain 61 items, each a competency to be rated, using a 5-point Likert scale, on the importance of each competency to the role of the peer worker. The scale will range from 1-not important to 5-very important. The survey will provide opportunities for respondents to write in comments about each competency, although they will not be required to do so. It will be also possible to print this survey, complete it manually, and mail to the Center for Social Innovation, if a person prefers, but it is not anticipated that printing and submitting the survey manually will be a popular option.

Respondents to the Core Competencies Survey will also complete the brief demographic section of the survey that will gather information about participant's gender, age, race/ethnicity, geographic location, level of education, monthly income, length of time as a peer worker, current field of employment, and certification status. Demographic data will be used to describe the survey respondents. The response to the current field of employment question will be used to categorize the respondent as working primarily in addiction services, mental health services, or services for people with co-occurring disorders, a variable that will be included in specific analyses of the data.

Peer Worker Interviews

Peer worker interviews will be conducted by telephone with 20 peer workers to gather descriptive details about the interviewees' use of the core competencies included in the quantitative surveys, their opinions about specific competencies, and their beliefs about the usefulness of articulating core competencies for their peer worker roles. Qualitative interviews may also produce examples of how peer workers use specific competencies. Before the interview, BRSS TACS staff will pre-test the interview questions and protocol over the telephone with three volunteer peer workers.

Participants in the telephone interviews will be a subsample of the respondents to the Core Competencies Survey.

Overview of Questions Related to Data Collection

The goal of the SAMHSA BRSS TACS project "Identifying Core Competencies of Peer Workers in Behavioral Health Services" is to achieve consensus among experts in peer support services in behavioral health about the core competencies needed for peer workers in the field of behavioral health. This data collection effort will endeavor to answer the following questions:

1. **What are the competencies that peer workers in behavioral health services rate as most important to their work?**
   Answering this question will assist state, county, and local government; peer-run/recovery community organizations; credentialing and accrediting bodies; and behavioral health agencies to write job descriptions, design training programs, develop performance standards, structure performance reviews, and set credentialing criteria. This

information will increase the behavioral health field's overall understanding about the role of peer support workers.

2. **How do peer workers from addiction services and peer workers from mental health services differ in their ratings of the importance of specific core competencies?**
   The 100 respondents are peer workers who are employed in behavioral health services, most of which can be categorized as providing services to people with mental illness, people with substance use disorders, or to people with co-occurring mental health and substance use disorders. It is unknown whether there will be differences in peer workers' opinions about the importance of specific competencies to their work, depending on whether they provide services and supports to be people in recovery from mental illness, addiction, or both. It is anticipated that the competencies most fundamental to peer workers in addiction recovery support services will be the same as for peer workers in mental health recovery support services, but the survey will allow for discovering any differences. It is important to understand differences in competency need and use between sub-groups of peer workers so that training programs and supervisors can focus on helping peer workers obtain the competencies more important for their specific role.

3. Use of Information Technology

The Web-Based Core Competencies Survey will be entirely web-based, thus eliminating paperwork. All web-based surveys will comply with the requirements of Section 508 of the Rehabilitation Act to permit accessibility to people with disabilities. All data collected will also be submitted and managed in secure electronic databases at the Center for Social Innovation.

Web-Based Core Competencies Survey
The single Core Competencies Survey will be administered using the software Survey Monkey Gold. It will be possible to print this survey and complete it manually and mail to the Center for Social Innovation, if a person prefers, but it is not anticipated that this will be a popular option. Data will be analyzed and stored in a secure database at the Center for Social Innovation.

Electronic Data Management
All survey data will be securely managed in electronic databases at the Center for Social Innovation. BRSS TACS staff will clean and enter the data in Microsoft Excel. The data will be stored in a secure file on the Center for Social Innovation's server for a minimum of five years.

4. Efforts to Identify Duplication

The data to be collected are unique and are not otherwise available. Information collected in literature reviews and from reports from the field suggests that there are no widely accepted lists of core competencies for peer workers in the behavioral health field. There is a need to collect the experiences and opinions of experts in peer-delivered services and supports to describe the core competencies of this emerging occupation.

5. Involvement of Small Entities

Data collection will not be a significant burden on small businesses, small entities, states, local governments, or on their workforces.

6. Consequences If Information Collected Less Frequently

Participation in this project is strictly voluntary. Participation in the telephone interviews and the web-based survey is voluntary and is a one-time survey.

7. Consistency with the Guidelines in 5 CFR 1320.5(d)(2)

This information collection fully complies with the guidelines in 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

The 60-day Federal Register notice was published on July 28, 2014 (79 FR 43759). No comments were received. The development of the Core Competencies Survey was aided by the work of an external consultant who has expertise in developing competencies for a range of professions in the behavioral health workforce.

Primary Consultant

Michael Hoge
Annapolis Coalition
3665 Erie Avenue
Cincinnati, OH, 45208

In addition to the paid consultant, an advisory group of experts participated in a series of virtual meetings to give feedback on the set of competencies. These experts consists people who work as peers in peer-run and traditional behavioral health settings, academicians, and other experts.

Sue Bergeson
Vice President of Consumer Affairs
OptumHealth Public Sector
6300 Olson Memorial Highway
Golden Valley, MN 55427

Pat Deegan
Pat Deegan, PhD & Associates, LLC
P.O. Box 208
Byfield, MA 01922

Marianne Farkas
Director of Training
Center for Psychiatric Rehabilitation
930 Commonwealth Avenue
Boston, MA 02115

Steve Harrington
Executive Director
International Association of Peer Specialists

700 Clarkson Drive
Sparta, MI 49345

Tom Hill
Senior Associate
Altarum
2000 M Street N.W.
Washington, DC 20036

Dan Fisher
Executive Director
National Empowerment Center
599 Canal Street
Lawrence, MA 01840

Clarence Jordan
Vice-president of Wellness and Recovery
Value Options Inc.
240 Corporate Blvd.
Norfolk, Virginia 23502

Ken Minkoff
Consultant
100 Powdermill Road
Box 319
Acton, MA 01720

9. Payment to Respondents

Participants in the Core Competencies Survey will receive a $25.00 gift card for their participation. People who participate in both the survey and the telephone interview will receive two $25.00 gift cards. Participants will receive gift cards because this is a hard-to-reach population and the information they provide cannot be acquired elsewhere.

10. Assurance of Confidentiality

Each survey response will have a unique identification code, which will allow respondents to be tracked and data to be sorted by region and specialization. The code will also protect identifying information. All data will be stored with its unique identification code in a password protect file. Only staff of the Core Competencies Project will have access to the data. Reports and articles will present only aggregate data.

11. Questions of a Sensitive Nature

It is possible that some questions will be considered sensitive by respondents. For example, the demographic questions of the Core Competency Survey inquire about person's experience of mental illness, addiction and whether or not they identify as transgender. The purpose of these questions is to describe the peers who participated in this project. It may be that these descriptions can be extrapolated to the wider peer workforce. Respondents will be informed that

they can skip over any question, for any reason. All data will be kept confidential and protected by unique identification code and in a password-protected file.

12. Estimates of Annualized Hour Burden

The total annualized burden to an estimated 120 total respondents for the “Core Competencies for Peer Workers in the Behavioral Health Services” data collection is estimated to be 220 hours. This estimated burden includes an estimated hour per telephone interview for 20 participants, and an estimated two hours per online survey for 100 participants. Respondents to the survey will be encouraged to take two hours to complete the survey so that they have adequate time for reflection. The estimated hour of time needed for the telephone interview is based on pilot interviews with two peer workers who are among the project consultants.

In a survey conducted by the National Association of Peer Specialists in 2007, the average hourly wage for peer workers was $12.13. Peer workers in this data collection effort, because they are expert peer workers, will have salaries closer to the top of the pay scale at an hourly wage of $21.00. This hourly wage was calculated based on an estimated annual salary of $42,000, the highest salary in a range of peer specialist job postings on the job search website of Indeed (http://www.indeed.com/salary/q-Certified-Peer-Specialist-l-Bethlehem,-PA.htm).

The annualized hourly costs to respondents are estimated to total $4,620.00.

Table 1: Annualized Burden Estimates

Type of Respondent	Number of Respondents	Responses per Respondent	Hours per Response	Total Annual Burden Hours	Hourly Wage Cost	Total Hour Cost
Peer workers for interview	20	1	1.0	20	$21.00	$420.00
Peer workers for survey	100	1	2.0	200	$21.00	$4,200.00
Total	**120**			**220**		**$4,620.00**

13. Estimates of Annualized Cost Burden to Respondents

There are neither capital nor startup costs, nor are there any operation and maintenance costs.

14. Estimates of Annualized Cost to the Government

The annual estimated cost to the government for the core competencies for “Core Competencies for Peer Workers in the Behavioral Health Services” data collection is $36,893.00. Approximately $16,697.00 represents BRSS TACS staff time to implement the survey, conduct the interviews, and analyze the data. The BRSS TACS project is funded entirely through a SAMHSA contract. Another approximately $9,000.00 represents the consulting fee to the Annapolis Coalition. These costs include C4’s Fringe Rate of $2,765.00 (35%), Overhead of $6,132.00 (57.7%), $3339.00 G&A (10.5%), $703.00 Base Fee (2%), and $1054.00 Award Fee

(3%). C4 covers the cost of the $300.00 annual subscription to Survey Monkey Gold that will be used by this project.

15. Changes in Burden

This is a new project.

16. Time Schedule, Publication and Analysis Plans

Time Schedule

Data collection is projected to take place from July 2014 through October 2014.

Table 2: Schedule of Key Activities

Task	Timeline
Prepare electronic survey and demographic questionnaire	**January 2015- February 2015**
• Finalize items on survey	January 2015
• Create e-surveys using Survey Monkey Gold	February 2015
• Pilot test e-survey	February 2015
Select survey respondents	**January 2015-May 2015**
• Develop criteria for survey respondents	January 2015
• Solicit nominations for survey respondents from BRSS TACS partners, advisors and behavioral health programs	February-May 2015
• Invite potential survey respondents to participate in the survey	March-May 2015
• Continue to solicit nominations for potential respondents from BRSS TACS partners, peer-run/recovery community organizations, and traditional behavioral health services that hire peer workers.	April-May 2015
Collect data	**April 2015 - June 2015**
• Prepare secure data base to store survey data	April 2015
• Monitor returns of surveys	April- June 2015
• Send reminders to potential respondents	April-June 2015
Conduct telephone interviews	**April 2015 - June 2015**
• Pilot telephone interview	April 2015
• Revise telephone interview	April 2015
• Invite subsample of survey respondents to participate in the telephone interview	April- May 2015
• Collect data from telephone interviews	May-June 2015
Analyze data	**June 2015**
• Calculate descriptive data from the demographic questionnaire	June 2015
• Calculate mean ratings for each competency and competency category	June 2015
• Perform correlation analyses to compare responses of subgroups	June 2015

• Analyze telephone interview data	June 2015
Write reports, articles, technical assistance products • Write report for SAMHSA • Develop outline for journal article • Create TA products	**July 2015** July 2015 July 2015 July 2015 and beyond

Publication Plan

Several publications will be developed based on these data:

- BRSS TACS will produce a report for SAMHSA that will outline the results from the quantitative survey and qualitative interviews.
- BRSS TACS will produce a list of core competencies for peer workers in the behavioral health workforce. This list will appear on the BRSS TACS pages of the SAMHSA website.
- BRSS TACS will produce technical assistance products for the core competencies of peer workers in the behavioral health workforce for states and other behavioral health authorities as directed by SAMHSA.
- BRSS TACS staff will submit at least one article to peer-reviewed journals for publication.

Analysis Plan

The analysis plan for the "Core Competencies for Peer Workers in the Behavioral Health Services" data collection uses a mixed methods approach and will focus on using the responses from the survey and from the telephone interviews to answer the two main questions:

1. What are the competencies that peer workers in behavioral health services rate as most important to their work?
2. How do peer workers from addiction services and peer workers from mental health services differ in their ratings of the importance of specific core competencies?

Quantitative Analysis

The purpose of the quantitative analysis is to provide feedback on the proposed core competencies by peer workers in the behavioral health workforce. Expert peer workers will respond to the survey by rating the importance of each competency on the survey. Mean ratings for each item (competency) will be calculated. The statistics presented will be descriptive and aggregated for the whole sample. These data will allow for comparisons between the national mean rating of each competency and disaggregated data to examine differences based on field of work (addiction or mental health), and organization employed (traditional or peer-run).

Qualitative Analysis

Peer worker telephone interviews, guided by a semi-structured interview format, will be used to gather qualitative data. Telephone interviews will query peer workers about their opinions of the proposed core competencies and their beliefs about the importance of describing competencies for their own work and for peer workforce development.

Peer worker telephone interviews will be conducted with an interviewer and a note taker, both of whom will record interviewees' responses to questions. Two BRSS TACS staff will code data to identify meaningful themes. The coding scheme will be emergent as information is collected

from the responses of peer workers. Research staff will also document stories told by interviewees that may exemplify beliefs and feelings about the core competencies.

Integration of Qualitative and Quantitative Data
The data from the survey and peer worker interviews will supplement each other to refine answers to the two main questions. The qualitative data will be used to aid in the interpretation of the quantitative data by providing a narrative and commentary to the findings. While the quantitative data predominantly focuses on peer workers' ratings of the importance of various competencies in their work, qualitative data will capture beliefs, attitudes, and opinions about individual competencies and about the use of competencies to strengthen the performance of individual peer workers and the peer workforce as a whole.

17. Display of Expiration Date

The expiration date for OMB approval will be displayed on all data collection instruments.

18. Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions.