Peer Support Professionals Work Group

Report to the Legislative Research Commission

November 1, 2026

Prepared by the Peer Support Professionals Work Group

Co-Chairs: Billy O'Bryan and Phyllis Millspaugh

Table of Contents

1. Purpose Statement 3

2. Work Group Vision 3

3. Summary Recommendations 4

Primary Recommendation 4
Membership Continuation 4
Additional Time Needed 4
Transition and Implementation 4

4. Case for Support 4

5. Occupational Differences and Definitions 5

6. Current State 5

7. Kentucky's Challenge 7

8. Models: Efficacy Factors and Background 8

9. Eliminated Models 8

10. Models Recommended for Further Exploration 8

Independent Peer-Informed Certification Board 8
Hybrid Models 13
State Agency Housed Certification 15

Appendices 19

Appendix A: Work Group Members 19
Co-Chairs 19
Work Group Members 19
Appendix B: Alternative Models Considered 21
Appendix C: Public Meeting Update 22
Appendix D: Written Comments Received 22
Appendix E: Public Comments Summary 23
Appendix F: Model Efficacy References 24
Appendix G: Independent Peer Certification Board References 24
Appendix H: Office of Peer Support 25
Appendix I: State Agency-Housed Certification 25

1. Purpose Statement

The creation and purpose of the Peer Support Professionals Work Group are outlined in non-codified language, found in House Bill 470, Section 6 (https://apps.legislature.ky.gov/record/26rs/hb470.html).

Section 6 (1) establishes the Peer Support Professionals Work Group as an independent entity with two jobs:

1. Develop statewide requirements for licensed peer support professionals, and
2. Study whether establishing a professional board for peer support is an effective approach.

Section 6 (4) requires members of the work group to be appointed by the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) either directly or from recommendations from the Kentucky Board of Alcohol and Drug Counselors (KBADC) and the Division of Reentry Services, Department of Corrections, Justice and Public Safety Cabinet:

Appointed by DBHDID via	Members
Directly **(8)**	4 peer support professionals (mental health recovery, youth, family/community, behavioral health), 2 trainers from an approved training program, 1 recovery housing professional, 1 recovery community center professional
KBADC's submitted list **(6)**	1 peer support professional specializing in substance use recovery, 2 employers (residential/clinical treatment and recovery community centers), 2 supervisors (clinical and behavioral health, both overseeing peer programs), 1 public member who has received peer support services
DOC Re-Entry Services' submitted list **(2)**	1 certified peer support professional with incarceration-reentry experience, 1 Division of Reentry Services representative

2. Work Group Vision

The work group envisions a future in which peer support professionals in Kentucky are valued as competent, consistent, and ethical professionals with clear career pathways, effective supervision, and active voice in decision-making. Every person who engages with peer support can expect a trained, credentialed professional who practices ethically, maintains healthy boundaries, and walks alongside them in recovery using shared lived experience. Organizations employing peer support professionals will invest in their growth, provide effective supervision and educational opportunities, and include them as equal partners in integrated treatment

teams. The system will be characterized by consistency, clarity, accountability, and competency, with peer voices actively included in policy development and governance.

3. Summary Recommendations

Primary Recommendation

The work group does not recommend a licensure board because a 1) certification, 2) state-agency based, and a 3) hybrid model have greater potential to address the defined problems, reach ideal outcomes, and protect the public.

Membership Continuation

The work group recommends that this group's membership, plus identified missing voices (i.e., serious mental illness, Administrative Office of the Courts), continue the work.

Additional Time Needed

The work group emphasizes that additional time—through the next legislative period—is needed to fully explore and evaluate these models, including partner input, fiscal analysis, and infrastructure assessment, before final recommendations can be made.

Transition and Implementation

The work group recommends that current peer support services and infrastructure remain in place during any transition period, with DBHDID continuing its certifying authority for mental health peer support specialists and KBADC continuing its role as the registering authority for alcohol and drug peer support specialists until a new structure is fully operational. The work group would need to continue evaluating options with the goal of selecting a recommendation. Any new structure would likely need to be implemented during the upcoming legislative sessions.

4. Case for Support

The work group does not recommend a licensure board because the identified problems can be addressed through alternative models that better preserve the core values of peer support. A licensure board would require substantial infrastructure that does not currently exist, impose a significant financial burden on the profession, and risk eliminating lived experience as a primary qualification by imposing education and clinical requirements that conflict with peer support principles. Licensure also lacks an advocacy function, implies a clinical scope of practice, and faces a slow, complex start-up process that would reduce credibility under current time constraints.

The three recommended model alternatives—an independent certification board, hybrid agencies, and state agency-housed certification—offer greater flexibility to protect the public, incorporate peer voice, define scope of practice, and establish criteria for certification and

grandfathering. Additional review of these three recommended models would allow time for informed decision-making, ensure partners help create governing administrative regulations, and allow the profession to partner with the state and Medicaid while advocating for sustainable growth. The work group specifically noted that voices representing serious mental illness, the Administrative Office of the Courts, and assisted outpatient treatment need greater inclusion in the next phase of exploration.

5. Occupational Differences and Definitions

The work group discussed the range of titles, roles, and settings for peer support professionals in Kentucky to establish common understanding. The resulting occupational definition reflects the group consensus.

Who: Behavioral health peer support professionals. **What:** Use lived experience to help others cope with change, build trust, and engage in services, including substance use and mental health. **How:** Educate, share lived experience, and work with other specialists. **Why:** Engagement and retention in services; help people find their path to recovery; and because the work is healing.

Titles Used

Adult peer support specialist (APSS); behavioral health peer support professional; certified peer support specialist (CPSS); family peer support specialist (FPSS); registered alcohol and drug peer support specialist (RADPSS); youth peer support specialist (YPSS).

Populations Served

Adults with dual/co-occurring conditions; adults with mental health conditions; adults with substance use issues; individuals in crisis; families with cabinet involvement; individuals with lived experience of the justice system, community members; youth; vulnerable and at-risk populations (e.g., unhoused individuals, veterans).

Employer Setting

Alcohol and other drug entities (AODE); behavioral health service organizations (BHSO); certified community behavioral health clinics (CCBHC); community mental health centers (CMHC); emergency departments (ED); federally qualified health centers (FQHC); non-profits; health departments; jails; managed care organizations (MCO); psychiatric hospitals; and recovery community centers (RCC).

6. Current State

Kentucky's peer support professional framework operates through two distinct regulatory and credentialing systems.

The Department for Behavioral Health, Developmental and Intellectual Disabilities establishes certification requirements for adult, family, and youth peer support specialists under 908 KAR 2:220, 2:230, and 2:240. A proposed unified certified peer support specialist administrative regulation, 908 KAR 2:220, and the proposed repeal of the family- and youth-specific administrative regulations were filed with the Legislative Research Commission on July 13, 2026. The proposed changes are proceeding through the regulatory promulgation process and, if approved, are expected to become effective on or about January 1, 2027.

Separately, the Kentucky Board of Alcohol and Drug Counselors regulates registered alcohol and drug peer support specialists (RADPSS) under KRS 309.0831 and 201 KAR 35:050 and 35:055. Applicants for the RADPSS credential must meet board-established requirements related to training, supervised experience, examination, ethics, and renewal.

As a result, Kentucky has separate credentialing pathways for peer support professionals. DBHDID oversees certification for adult, family, and youth peer support specialists, while KBADC oversees registration of alcohol and drug peer support specialists. The two systems have different training, supervision, and credentialing requirements, including for professionals serving individuals with co-occurring mental health and substance use needs.

Both the cabinet and the KBADC perform important public-protection functions. However, peer support is a distinct, non-clinical service built upon lived experience, mutuality, self-determination, and recovery. Placing peer credentialing within a board primarily designed to regulate clinical alcohol and drug counseling may unintentionally apply a clinical framework to a workforce whose value in the recovery process depends partly on remaining distinct from clinical practice.

DBHDID requires peer support specialists to meet the following requirements:

- Be at least 18 years of age
- Possess a high school diploma or GED
- Maintain ongoing supervision (minimum two hours per month)
- Self-identify their lived experience
- Have an established pattern of recovery
- Successful completion of an approved training program
- Complete six hours of continuing education for recertification annually

DBHDID peer support specialists can bill Medicaid for services delivered, up to 30 hours of individual contact per week, if the services are medically necessary and coordinated within the context of a comprehensive, individualized plan of care developed in a person-centered planning process (907 KAR 15:010). DBHDID does not currently manage complaints or track active versus inactive certifications.

KBADC requires registered and temporary alcohol and drug peer support specialists to meet the following requirements:

- Be at least 18 years of age
- Possess a high school diploma or GED
- Successfully complete specific training hours in ethics, advocacy, mentoring, and recovery and wellness
- Maintain ongoing supervision (minimum four hours per month)
- Complete five hundred (500) hours of board-approved experience working with persons having a substance use disorder, twenty-five (25) hours of which shall have been under direct supervision
- Pass a proctored International Certification and Reciprocity Consortium (ICRC) assessment
- Provide a signed code of ethics form
- Provide a signed attestation of 12 consecutive months of recovery
- Submit two letters of reference signed by a board-approved certified alcohol and drug counselor (CADC) or licensed clinical alcohol and drug counselor (LCADC)
- Pay the required application fees

RADPSS can bill Medicaid for services delivered, up to 30 hours of individual contact per week, if the services are medically necessary and coordinated within the context of a comprehensive, individualized plan of care developed in a person-centered planning process (907 KAR 15:010). KBADC manages complaints and tracks active versus inactive registrants.

The differences between CPSS and RADPSS generate several points of confusion and interdependency: the evidence-based current recovery guideline is 12 consecutive months of recovery; there is no universal curriculum or code of ethics endorsed across all peer support roles; supervision capacity is limited, particularly for certified clinical supervisors; role confusion persists between peer support and clinical counseling; temporary credentials are not Medicaid billable, creating workforce barriers; and changes in one regulatory area inevitably impact others. The work group identified these complexities as central to the problem the legislature is attempting to address.

7. Kentucky's Challenge

Kentucky is attempting to establish a regulatory entity for peer support professionals that provides oversight and accountability while creating a path to help peers serve a diverse community consistently and safely, including through a universal curriculum, a code of ethics, qualified supervisors, and career pathing.

8. Models: Efficacy Factors and Background

The work group evaluated several governance models using efficacy factors that considered whether a professional framework exists (education, curriculum, national organizations, universities), whether the model addresses defined problems, includes peer voice, supports the envisioned future, protects the public, defines scope of practice, and reflects state and workforce readiness. The national landscape indicates that the majority of states use certification rather than licensure for peer support professionals; national bodies support certification and reciprocity; the Substance Abuse and Mental Health Services Administration (SAMHSA) encourages certification; and only one state (Montana) uses licensure. Impact data on quality and safety for any governance model is currently inconclusive or limited. These considerations informed the work group's evaluation of alternatives. (See Appendix F for references)

9. Eliminated Models

Licensure Board. A standalone licensure board was determined to be unnecessary to solve identified problems, too costly and complicated to implement, lacking existing infrastructure, and at risk of striking lived experience as a core qualification. A licensure board would also imply a clinical scope of practice that does not align with the peer support role. Placing peer support under an existing board (such as the Board of Alcohol and Drug Counselors) was eliminated because the current BADC arrangement is limited to substance use disorder, has an insufficient number of supervisors, and risks shifting the peer role toward clinical support tasks while deprioritizing peer-specific values and practices.

10. Models Recommended for Further Exploration

Independent Peer-Informed Certification Board

A certification model with reciprocity between states (i.e., state-to-state recognition of a credential issued by another state, allowing a qualified person to obtain the same or similar credential without repeating all requirements) and formal peer participation aligns with national emphasis and SAMHSA guidance. Under this model, an independent board would govern peer support professionals, restrict the official title to credentialed individuals, and create standardized certification processes, ethics standards, and disciplinary procedures specific to peer support. It would establish a dedicated peer-informed certification board with authority to approve curriculum, trainers, and continuing education. This model offers standardization with less administrative infrastructure than licensure and workforce entry requirements, while preserving the peer support values of lived experience. Limitations include the need for clear state recognition, coordination with Medicaid, defined accountability and appeals processes, and start-up funding, staffing, and administrative capacity.

Evidence for Peer-Informed Certification Board

Kentucky's current framework places peer support oversight across separate credentialing systems, each with established public-protection responsibilities.

Peer support, however, is a distinct, non-clinical service grounded in lived experience, mutuality, self-determination, and recovery. Locating peer credentialing within a board structured primarily to regulate clinical alcohol and drug counseling may introduce requirements or expectations based on a clinical model, potentially affecting the distinction between peer support and clinical practice.

An independent, peer-informed certification board would create a clearer division of responsibility. The cabinet would retain authority over Medicaid policy, covered services, reimbursement, provider participation, and regulatory compliance. DBHDID would continue to support the delivery of evidence-based services while the board handles the credentialing process and assists with the transition from its oversight. Until new statutory and regulatory requirements exist, DBHDID and KBADC would retain their authority and responsibilities.

The certification entity could concentrate on:

- Credentialing and renewal
- Core competency and examination standards
- Approval and monitoring of training providers
- Continuing education
- Peer supervisor qualifications and training
- A peer-specific code of ethics
- Complaint review and disciplinary procedures
- Reciprocity with other states
- Workforce data and specialty credentials

This separation would not diminish state accountability. Federal Medicaid guidance allows states to define peer certification requirements while maintaining state authority over service definitions, provider qualifications, supervision, utilization controls, and reimbursement. In other words, Kentucky could delegate certification administration without relinquishing responsibility for Medicaid integrity or public protection.

Ethics and Accountability

Peer support depends on trust, appropriate use of lived experience, confidentiality, boundaries, mutuality, and intentional self-disclosure. Kentucky would benefit from an ethics framework written specifically for the peer role.

SAMHSA recommends that certified peers participate directly in developing peer codes of ethics. It also recommends a publicly accessible complaint process and an impartial

review body that includes certified peer workers. A dedicated certification entity could establish clear procedures for receiving, investigating, and resolving complaints while providing due process to the peer and protection to the people receiving services.

This would give employers, peers, and service recipients a consistent statewide accountability mechanism, rather than relying primarily on individual organizations to interpret and address peer-specific concerns.

Peers Involvement in Decision-Making and Room for Greater Roles/Responsibilities

Peer representation must be foundational, not symbolic. Individuals with lived experience should hold meaningful voting representation on the certification board and serve on credentialing, ethics, training, and standards committees. The board should also reflect Kentucky's geographic and cultural diversity, including rural communities and individuals with mental health, addiction, family, youth, and other populations, such as veterans and individuals with lived experience of the justice system.

This structure aligns with SAMHSA's position that people with lived experience should be meaningfully involved in developing, adopting, and revising peer certification standards. Peer leadership would help Kentucky establish appropriate safeguards while protecting the values that make peer support effective.

Peer Support is Non-Clinical

Certification should demonstrate competence and accountability, but it should not transform peer support into another clinical discipline. Peer specialists are not entry-level therapists, and lived experience adds a new dimension to a person's recovery, bringing additional perspective and care. A lack of formal clinical education does not reduce the value added to the plan of care.

A dedicated board could define the peer role more precisely and protect it from role drift. Its standards should preserve the non-clinical nature of peer services and avoid unnecessary educational, financial, or administrative barriers, while ensuring providers do not harm the person they serve. This matters because overly restrictive requirements may exclude individuals whose lived experience is directly relevant to the populations Kentucky intends to serve.

An independent structure would not automatically prevent over-professionalization; that protection would depend on how the board is designed. Peer-majority or strong peer representation, explicit statutory language protecting the non-clinical scope of practice, and regular review against SAMHSA's standards would be essential.

Strengthening Fidelity to Peer Support Standards, Training and "Endorsements"

A dedicated entity could establish consistent qualifications for trainers through a standardized train-the-trainer process. This could include demonstrated peer support experience, knowledge of adult learning principles, fidelity to the peer model, and periodic renewal.

Kentucky could also create voluntary "endorsements" or advanced credentials for peers serving specialized populations, including:

- Veterans and military families
- Individuals with lived experience of the justice system
- People with co-occurring conditions
- Youth and young adults
- Families and caregivers
- Individuals experiencing homelessness
- Crisis-service participants
- Individuals experiencing problem gambling
- Peer supervisors

Florida offers one model for consideration. The Florida Certification Board administers more than 30 health and human service credentials, including recovery peer credentials, and maintains formal processes for applications, examinations, continuing education, ethics, discipline, and renewal. Its recovery peer credentials include lived-experience endorsements for adults, families, veterans, youth, and people involved with the criminal justice system.

Kentucky would not need to adopt Florida's requirements wholesale. Some may be more restrictive than Kentucky determines appropriate. However, the model demonstrates that a certification organization can administer multiple credentials and specialty pathways while clearly stating that a peer credential does not authorize clinical or independent practice.

Possible Considerations Exist

Kentucky already has much of the required infrastructure: an established peer workforce, approved training providers, curricula, certification requirements, continuing education processes, supervisors, participating provider organizations, and Medicaid reimbursement. DBHDID currently receives and stores training records and continuing education documentation that is submitted to a Training Records Information System (TRIS), and peer support is Medicaid-billable when applicable requirements are maintained.

Kentucky could consider two primary structural options:

1. Establish a new independent nonprofit certification board devoted to peer support.

2. Place peer certification within an existing independent credentialing organization, provided peers retain meaningful governance authority and the organization formally protects the peer role's non-clinical identity.

The Kentucky Certification Board for Prevention Professionals may also be worth evaluating as a potential certification structure. It already operates as a credentialing body, maintains certification and recertification processes, applies ethical and competency standards, and participates in the International Certification and Reciprocity Consortium (IC &RC). The Prevention Professionals Board demonstrates that Kentucky already uses a collaborative structure in which the state supports workforce standards while an external board administers a professional credential. This structure shows DBHDID's role in supporting evidence-based services while a board handles the credentialing process. This is very similar to other states and their peer governance structures.

Finances and Feasibility

Application, examination, certification, renewal, training-provider, and specialty or "endorsement" fees could contribute to ongoing operations. Kentucky should not assume that fees alone will make a new board self-supporting without first completing a formal feasibility analysis.

SAMHSA identifies certification costs as a potential workforce barrier and recommends using state, federal, or other resources to subsidize costs when possible. It also recommends scholarships and transparent publication of all fees. Peers should have some "skin in the game" and feel personally invested in earning and maintaining their certification. Reasonable application and renewal fees can create that sense of ownership while also supporting the certification board's sustainability. However, those fees should remain low enough not to become a barrier to entering or remaining in the peer workforce.

Kentucky could develop a plan based on:

- The verified number of active and prospective peer specialists
- Expected application and renewal volume
- Reasonable, transparent fee levels
- Start-up technology and staffing costs
- State or grant-supported start-up funding
- Scholarships and hardship waivers
- Revenue from training-provider approval and optional endorsements
- Administrative efficiencies available through an existing organization

Currently certified peers should have a simple, affordable transition pathway, with existing training and experience recognized when reasonably equivalent.

An independent certification board should not add another layer of bureaucracy or make peer support more clinical. It should create a structure that protects the integrity and fidelity of peer support. It should strengthen accountability and give peers a meaningful voice in the decisions that affect their profession. Kentucky already has a strong peer workforce and much of the infrastructure needed to build upon. The next step is determining whether an independent board can provide consistent standards, ethical oversight, and long-term sustainability while keeping certification accessible and affordable.

While the information on this model is more developed in the research, a transition would require additional steps, carefully communicated and thoroughly developed to prevent confusion in the field. The work group therefore recommends additional time to fully evaluate this certification model before Kentucky establishes a final governance structure for the peer support profession (See Appendix G for references).

Hybrid Models

The hybrid models combine existing state authority with formal peer participation. Under a potential hybrid model for Kentucky, DBHDID could retain the certifying authority in administrative regulation while delegating specific functions, such as certification standards, ethics, continuing education, and disciplinary recommendations, to a Peer Support Certification Commission composed of a majority of peers. This structure requires less structural change than a standalone board and leverages existing Medicaid and regulatory alignment. Another hybrid option involves a state agency-based model with an Office of Peer Support and a community health worker (CHW) model, which differs from an independent commission.

Peer Commission

Under the Peer Commission model, DBHDID could continue to handle the administrative functions associated with peer support certification, while the commission could exercise its delegated authority over standards and professional conduct. Administrative responsibilities could include certification and renewal processes, maintaining certification records, approving training standards and providers, and managing complaints, ethics, and certification status. The commission could oversee the substantive policy functions delegated to it — establishing certification standards, setting continuing education requirements, developing and enforcing ethics guidelines, and making disciplinary recommendations.

The Peer Support Certification Commission could provide a formal mechanism for certified peer support specialists and other key partners to participate in the ongoing development of Kentucky's peer support system. Through its majority-peer membership, the commission could inform recommendations related to certification standards, ethics, training, workforce development, role fidelity, quality improvement, regulatory changes, and other issues affecting the peer support profession. Its membership and governance structure should ensure meaningful representation across Kentucky's different peer support credentials and populations.

This approach could separate the day-to-day administrative responsibilities of certification from the broader policy and standards-setting functions that directly affect the profession. It could allow Kentucky to use existing governmental infrastructure for credential administration while establishing a formal, sustained mechanism for peer support professionals to have meaningful influence in decisions affecting their profession.

Office of Peer Support

Under another state agency-based hybrid model, DBHDID could serve as the certifying authority and would create a dedicated Office of Peer Support with identifiable staff, a discrete budget line, and a clear statutory mandate. This office would function similarly to the Kentucky Office of Certified Health Workers (KOCHW) but be tailored to the behavioral health context and peer movement values.

KOCHW operates within the Department for Public Health under CHFS as the official governing authority for CHW certification. Created through statute (KRS 309.462, KRS 309.464) and authorized by administrative regulation (902 KAR 21:040), KOCHW certifies CHWs, approves training organizations and instructors, manages continuing education requirements, maintains a public registry, and processes all applications through Certemy (a commercial online credentialing platform). When Medicaid reimbursement for CHW services launched in July 2023 under 907 KAR 3:310, KOCHW certification was the gatekeeper for billable eligibility.

What an Office of Peer Support Would Actually Do

Under this state agency-based model, DBHDID (or a designated state program) could remain the certifying authority. But rather than treating peer support certification as one of many regulatory functions scattered across divisions.

The office could consolidate functions that are currently fragmented or absent in the existing legislative guidance.

- **Certification and Renewal Administration:** Processing applications, verifying lived experience, tracking continuing education, and issuing credentials — replacing the current process.
- **Training Oversight and Approval:** Reviewing and approving training purveyors, curricula, and instructors across all peer support categories (adult, family, youth, substance use, mental health, co-occurring), rather than the dually independent current approval process.
- **Electronic Registry and Verification:** Transforming TRIS from a record repository into a real-time, searchable public registry like the CHW.
- **Complaint and Ethics Management:** Receiving, investigating, and adjudicating complaints — the gap most consistently raised by work group members and public commenters.
- **Supervision Standards and Approved Supervisor Registry:** Maintaining the list of approved peer support supervisors, tracking supervision hours, and ensuring quality rather than leaving supervision to employer discretion.
- **Specialization and Domain Add-Ons***:* Approving domain-specific training modules (perinatal, veterans, individuals with lived experience of the justice system, crisis, reentry) that build upon a core certification. This directly addresses the work group's preference for one centralized peer support certification with add-on domain-specific training.

The work group has not completed sufficient analysis to recommend a specific structure at this time. Additional analysis is needed to examine the appropriate statutory and regulatory authority, administrative placement, composition and authority of the commission, staffing and fiscal requirements, complaint and disciplinary processes, and the advantages and limitations of this approach compared with an independent certification board or other governance structures.

The work group therefore recommends additional time to fully evaluate this hybrid state-administered certification and peer-led commission model before Kentucky establishes a final governance structure for the peer support profession (See Appendix H for references).

State Agency Housed Certification

Under this model, DBHDID retains certifying authority while making targeted improvements to the existing framework. This approach allows consistent statewide implementation, direct alignment with Medicaid and regulatory requirements, and use of current infrastructure already partially in place through 908 KAR 2:220, 2:230, and 2:240.

Nationally, approximately 23 states use a direct state mental health agency certification model (including Ohio, Washington, and Massachusetts). These states have demonstrated that a well-structured agency program can protect peer role integrity, support Medicaid reimbursement, and maintain workforce access if the agency builds in formal peer governance safeguards.

The work group evaluated this model against the three problems identified: inconsistent standards, limited oversight, and workforce barriers. The state agency model scores highest on implementation speed and fiscal feasibility because it does not require standing up a new board, commission, or nonprofit entity. It also preserves the existing Medicaid billing pathway under 907 KAR 15:010 rather than requiring a complex transition of reimbursement authority to a new external body.

Current DBHDID infrastructure already includes the TRIS, a registry of certified supervisors, and established training purveyor relationships. The state agency model treats these as assets to be enhanced rather than replaced.

The following enhancements are being addressed through a proposed administrative regulation currently pending with the Legislative Research Commission: an amended 908 KAR 2:220 (combining all peer support categories under one administrative regulation) and the concurrent repeal of 908 KAR 2:311 (repealing 2:230 and 2:240). DBHDID filed these administrative regulations on July 13, 2026. The work group reviewed these proposed changes and determined they directly address the gaps identified below:

- Complaint and Disciplinary Pathway: The current administrative regulations contain no formal mechanism for DBHDID to receive, investigate, or adjudicate complaints against peer support specialists. This creates an accountability vacuum. The proposed 908 KAR 2:220 introduces a full enforcement framework that would include investigation procedures, denial and revocation standards, and appeal rights. If adopted as filed, the updated administrative regulation would establish the centralized complaint pathway with due process protections that the work group identified as essential.
- Co-Occurring Coverage: The current bifurcated system — DBHDID certifying mental health peers under 908 KAR 2:220 and KBADC registering substance use peers under KRS 309.0831 — leaves individuals with co-occurring conditions without a unified credential or training pathway. The proposed administrative regulation explicitly defines "co-occurring disorders" and "substance-related problem" within the peer support scope, making eligibility and training pathways available to individuals with lived experience in mental health, substance use, or both. This regulatory consolidation creates the structural space for a single co-occurring certified peer support specialist designation that does not exist today.
- Electronic Application and Improved TRIS: The current TRIS functions primarily as a record repository. The proposed administrative regulation mandates an electronic application process that tracks an applicant's progress from submission through testing, communicates required next steps, and manages renewals. A new web-based TRIS certification system is planned to launch alongside the administrative regulation,

providing real-time certification status lookup, automated renewal reminders, and supervisor linkage tracking. This was a specific requirement the work group noted as critical to reducing paperwork burden and processing delays that discourage workforce entry.

- Enhanced Training and Ethical Requirements: While DBHDID currently approves training programs, there is no universal code of ethics across peer support categories, and the existing family (908 KAR 2:230) and youth (908 KAR 2:240) administrative regulations lack formal training oversight aligned with current national standards. As the state mental health authority, DBHDID must ensure that behavioral health services, including peer support services, are delivered using an evidence-based mode and the proposed administrative regulation supports that responsibility. It introduces explicit professional conduct and disciplinary standards enforceable by DBHDID, adds a 50-hour core competency requirement plus 10 hours of training specific to the desired specialization (adult, family, youth), and establishes standardized exam and continuing education requirements for all three specializations. The work group noted that this directly addresses the absence of a unified code of ethics and the training gaps that prompted the revision to KRS 222.233 (https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=56831).
- Supervision Standards: Current supervision capacity with KBADC and its oversight of RADPSS is strained, with no formal criteria for who may supervise peer specialists beyond general employment requirements. The proposed administrative regulation strengthens supervision requirements, defining who may serve as an approved supervisor, establishing supervision frequency, and clarifying documentation standards. The work group viewed this as an essential step toward relieving the current burden on CADC supervisors and other staff who are informally pressed into peer supervision roles without clear authority or guidance.
- Specialization and Career Pathing: The work group heard public comment proposing tiered positions and specialization tracks. The proposed administrative regulation's structure, with its 50-hour core plus 10-hour specialization module, provides a regulatory vehicle for DBHDID to approve specializations (such as peer support services for veterans, people with lived experience of the justice system, or crisis-involved individuals) without requiring legislative amendment for each new category. This gives the state agency model built-in flexibility for workforce evolution that the work group identified as a key advantage over slower statutory alternatives.

Key distinction: Under the State Agency Housed model, these enhancements proceed through the existing regulatory process. The work group noted that because DBHDID has already

drafted and filed the consolidation administrative regulation, the timeline for addressing these gaps is substantially shorter than it would be for creating a new board or commission. If chosen, the regulatory improvements are already in progress; the remaining question is whether statutory or additional regulatory safeguards are needed to ensure peer voice, prevent bureaucratic drift, and protect the unique values of the peer movement within a state agency framework.

The work group therefore recommends additional time to fully evaluate this state agency-housed model before Kentucky establishes a final governance structure for the peer support profession (See Appendix I for references).

Appendices

Appendix A: Work Group Members

Co-Chairs

Billy O'Bryan and Phyllis Millspaugh were approved by unanimous vote as co-chairs for the work group on August 5, 2026.

Work Group Members

The following individuals serve as members of the Peer Support Professionals Work Group. Participants collectively bring 158 years of experience in peer support.

Member	Agency/Organization	Representation
Asia Tucker Barrett	Kentucky Partnership for Families and Children (KPFC)	Peer support professional with experience in youth recovery
Merideth Booth	Department of Corrections – Reentry Services	Certified peer support professional with experience in reentry from incarceration
Amber Collins	Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)	Department for Behavioral Health, Developmental & Intellectual Disabilities
Tara Dewees	Appalachian Regional Healthcare	Peer support professional with experience in behavioral health peer support
Arydian Eko	University of Kentucky	Peer support professional with experience in mental health recovery
Jessica Ellis	NorthKey Community Mental Health Center (CMHC), Certified Community Behavioral Health Clinic (CCBHC)	Behavioral health supervisor who oversees peer support programs
Mikeal Fannin	Mountain Comprehensive Care CMHC, Certified Community Behavioral Health Clinic (CCBHC)	Multidisciplinary educator/trainer from an approved peer support training program
Kathryn Green	Department of Corrections, Division of Reentry Services (DOC)	Representative from the Kentucky Division of Reentry Services
Brittany Herrington	Pathways Inc. (CMHC), Certified Community Behavioral Health Clinic (CCBHC)	Multidisciplinary educator/trainer from an approved peer support training program
Lindsey Lankswert	Louisville Metro Public Health and Wellness/MORE Program	Registered peer support professional with experience in residential or clinical treatment

Member	Agency/Organization	Representation
Danielle Matlock	Cumberland River Behavioral Health (CMHC), Certified Community Behavioral Health Clinic (CCBHC)	Clinical supervisor who oversees peer support programs / Kentucky Board of Alcohol and Drug Counselors
Phyllis Millspaugh	DBHDID	Department for Behavioral Health, Developmental & Intellectual Disabilities
Michelle Nobles	River Valley Behavioral Health CMHC, Certified Community Behavioral Health Clinic (CCBHC)	Employer of peer support professionals in recovery community centers
Billy O'Bryan	Louisville Recovery Community Connection	Recovery community center professional
Jamie Payne	Pennyroyal Community Mental Health Center, Certified Community Behavioral Health Clinic (CCBHC)	Member of the public who has received peer support services
Savvy Shabazz	Life Coach, Each One Teach One Reentry Fellowship/Savvy Shabazz Solutions, LLC & Young People in Recovery West Louisville Chapter Lead	Peer support professional with experience in family or community peer support
Sherri Staley	Department for Medicaid Services (DMS)	Department for Medicaid Services
Lynnsey Vandeventer	Revive Ministries, Inc.	Employer of peer support professionals with experience in residential or clinical treatment
Timothy Villafranca	River Valley Behavioral Health (RVBH) CMHC, Certified Community Behavioral Health Clinic (CCBHC)	Recovery housing professional
James Yarber	Shepherd's Shelter/Ross Rehab	Clinical supervisor who oversees peer support programs

Appendix B: Alternative Models Considered

During the August 4–5, 2026 retreat, the work group generated the following ideas as possible ways to achieve the desired state. Ideas marked with an asterisk were explored in more detail and are included in the body of this report.

- *Create a Certification board versus licensure board
- Change policy at local and state level
- Develop a universal curriculum for peer support services
- Create a complaint process
- Create a parallel mental health (MH) Board
- Create PSS website with trainings in one place
- Create tiered PSS roles
- *Retain DBHDID as the authority but improve credentialing
- *Develop a peer-led commission
- Develop a training consortium
- Develop partnership with existing peer networks
- *Establish an advisory council
- Establish code of ethics
- Integrate with national credentialing
- *Address membership, funding, staffing, appeals, and conflict of interest
- Allow only CMHCs to provide PSS training
- Create an organization responsible for training supervisor oversight
- Require proctored exams
- *Develop program specific peer-support
- *Promote advocacy within the current framework
- Establish one entity to govern PSS
- Maintain traditional PSS billing ability and expand board's definition of PSS
- *Turn TRIS into a working verification/registry

Appendix C: Public Meeting Update

The workgroup held a public comment period during its initial meeting on August 5, 2026, to increase public participation in the process. The public comment period started at 4:00 pm and included remarks from those attending in-person and online. Comments were limited to three minutes each. The initial workgroup meeting continued August 6, 2026, but due to a technical glitch with the state Zoom account deleted the original public meeting link and made it inactive. The meeting stopped as soon as organizers learned of the issue, which occurred at the beginning of Dr. Sheila Schuster's presentation. A new Zoom meeting link was created and announced via public channels, and the workgroup meeting resumed one hour later to allow time for distribution.

Appendix D: Written Comments Received

Participants were given the opportunity to submit written comments through August 7, 2026. The following comments were received and are presented as submitted by the commenters:

Comment One: Concept Versus Application

Related to the name, role, purpose, function, duties, etc. of a Board, Commission, or other entity as a next step. Sometimes thoughts in the form of ideas and language become unfunded (or under-funded) mandates when they reach the point of application for service delivery and service providers / employers. When this happens, they translate as barriers to organizations and government entities across KY's System of Care who typically receive very little or otherwise stringent funding for indirect and/or administrative overhead expenses. Thinking through all of the "true costs" involved (ex. people, processes, workloads, administrative overhead, etc.) is recommended for maximum effectiveness of the Peer Support Professionals Work Group.

Comment Two: Career Ladder for Peer Support Specialists

With regard to the career ladder/advance for Peer Support Specialists: It would be wonderful to see a career ladder incorporated into the peer support realm whereby peer support specialists could be placed into specific, tiered positions (ex. Peer Support Specialist I, II, III, etc.), where each level involves corresponding job duties (ex. supervisory responsibilities) that facilitate professional growth in the form of marketable, transferable skills that can be used both in and outside of the peer support field. Perhaps a structure of tiered positions, in which tenure, performance, career or personal leadership goals all play a part, could be helpful to peer support specialists seeking career advancement. The National Center for Family and Parent Leadership employs a tiered model of parent and family engagement using "Advise, Collaborate, Lead" tiers that may be used for reference.

Appendix E: Public Comments Summary

The following is a summary of public comments offered during the public comment period on August 5, 2026. Comments are listed in alphabetical order.

Comment One: A new board is not needed, since one already exists. Insist that the Board of Alcohol and Drug Counselors does what they are supposed to do. They have not been acting on the things they have supposed to have been doing for years, such as developing a code of ethics and a standard of practice. They also have no complaint or appeals procedure in place.

Comment Two: Clients are not getting complete wrap around services.

Comment Three**:** Consider consequences and unattended consequences in decision making.

Comment Four: Consider language use that may help with regard to funding, etc.

Comment Five: Give the opportunity for grandfathering in the Peer Support Specialist.

Comment Six: Lived experience with a son diagnosed with schizophrenia. He was supposed to get a peer support specialist, and it was highly anticipated, but it never materialized from Eastern State Hospital. Let's solve this problem. We need personal care homes.

Comment Seven: Opportunity to discuss how to shape career progression for Peer Support Professionals, how to monitor credentials, and ensure accountability of the role.

Comment Eight: Teens younger than 16 years old cannot get services.

Comment Nine: The history of peer support and how peer support came to be is informative and researching it should be part of this process.

Comment Ten: The real people with their boots on the ground doing this work and those they serve have to be considered in these discussions. Not all members of this group have a true picture of the reality for some of the individuals served.

Comment Eleven: There is therapeutic value in helping others become better people, it is not for billing/politics.

Comment Twelve: When someone ages out of family peer support services at 18, that family still needs support, but they aren't getting it because they transition to adult services.

Appendix F: Model Efficacy References

SAMHSA's National Model Standards for Peer Certification
https://library.samhsa.gov/product/samhsas-national-model-standards-peer-support-certification/pep23-10-01-001

2023 Update to the Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the U.S. https://www.carsrecovery.org/product-library/2023-update-to-the-comparative-analysis-of-state-requirements-for-peer-support-specialist-training-and-certification-in-the-us

Peer Specialists Working in State Behavioral Health Systems, 2023 - 2024
https://nri-inc.org/profiles

Appendix G: Independent Peer Certification Board References

Florida:
Certified Recovery Peer Specialist
(https://flcertificationboard.org/certifications/certified-recovery-peer-specialist-crps/)
Florida Certification Board Tax Status
(https://projects.propublica.org/nonprofits/organizations/592622949)

Pennsylvania:
Pennsylvania Certification Board (https://www.pacertboard.org/certifications)
Pennysylvania Certification Board Tax Status
(https://projects.propublica.org/nonprofits/organizations/232330432)

Virginia:
Virginia Certification Board
(https://projects.propublica.org/nonprofits/organizations/541458903)

Maryland:
Certifying Maryland's Behavioral Health Professionals (https://www.mabpcb.com/)

Rhode Island:
Rhode Island Certification Board (https://www.ricertboard.org/certifications)

Kentucky Certification Board for Prevention Professionals:
Kentucky Certification Board for Prevention Professionals
(https://www.kyprevention.org/)

Appendix H: Office of Peer Support

Kentucky Office of Community Health Workers (KOCHW)
(https://chfs.ky.gov/agencies/dph/dpqi/cdpb/Pages/chwp.aspx)

KOCHW authorizing statutes and administrative regulations:

KRS 309.462 (https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=52721)
KRS 309.464 (https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=52722)
902 KAR 21:040 (https://apps.legislature.ky.gov/law/kar/titles/902/021/040/)
907 KAR 3:310 (https://apps.legislature.ky.gov/law/kar/titles/907/003/310/)
CHW Registry (https://chfs.ky.gov/agencies/dph/dpqi/cdpb/Pages/chwp.aspx)

Appendix I: State Agency-Housed Certification

Ohio — State Agency Model

Ohio Department of Behavioral Health / Peer Supporters
(https://dbh.ohio.gov/community-partners/peer-supporters)

Ohio Department of Behavioral Health / Certified Peer Recovery Supporter (Adult)
(https://dbh.ohio.gov/wps/portal/gov/dbh/community-partners/peer-supporters/certified-peer-recovery-supporter-cprs-adult)

Washington — State Agency Model

KIVA Centers / Certified Peer Specialist
(https://www.hca.wa.gov/billers-providers-partners/program-information-providers/peer-specialists)

Washington State Health Care Authority / Peer Support
(https://www.hca.wa.gov/billers-providers-partners/program-information-providers/peer-support)

Massachusetts — State Agency Model (Contracted Training Delivery)

Massachusetts Department of Mental Health / Peer Support Training and Certification Program
(https://www.mass.gov/info-details/dmh-peer-support-training-and-certification-program)