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**Certified Peer Specialist**

**Mental Health Recovery Peer**

**Role Delineation Study**

**Final Report**

**December 30, 2006**

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**Florida Certification Board**

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# **Mental Health Recovery Peer Specialist**

## **Role Delineation Study Final Report**

### **December 30, 2006**

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#### **I. Introduction**

The Florida Department of Children and Families (DCF) contracted with the Florida Certification Board (FCB) to conduct a Role Delineation Study (RDS) for the job classification of Certified Peer Specialist. Through discussion with the DCF, it was determined that there are three sub-specialties under the Certified Peer Specialist umbrella: MH Recovery Peer Specialist, Mental Health Family Peer Specialist, and Substance Abuse Recovery Peer Specialist. As such, the FCB conducted three separate Role Delineation Studies, each one particular to the sub-specialty.

For purposes of this report, the following terms are defined as follows:

1. **Certified Peer Specialist:** This is the title of the job classification. It represents the overarching profession of peer specialists.
2. **Mental Health Recovery Peer:** This is the title of the job position. It represents a peer specialist who has competency specific to working as an adult peer to adult mental health consumers.
3. **MH Recovery Peer Specialist:** This is the working title for the job position of Mental Health Recovery Peer. It indicates that the practitioner is a Certified Peer Specialist, specializing in mental health, peer-to-peer, recovery support.

The development of a credentialing program designed to measure an individual's competence in a particular area is a long and complex process. The RDS is the first step of the credential development process and is the most commonly applied and accepted validation strategy used in designing credentialing programs. The purpose of the RDS is to formally identify the domains of knowledge and specific tasks needed to be a competent Mental Health Recovery Peer Specialist (MH Recovery Peer Specialist).

FCB follows national standards when conducting RDS' to ensure that any resulting credentialing instruments are directly linked to the knowledge required to perform competently on the job.

## II. Compliance with Standards

Two widely accepted standards for the development of credentialing programs and certifying agencies are the *Standards for Accreditation of Certifying Agencies* (National Commission for Certifying Agencies, 2002) and the *Standards for Educational and Psychological Tests* (American Educational Research Association, American Psychological Association, and National Council on Measurement in Education, 1999).

For the purpose of this report, the Standards for Accreditation of Certifying Agencies will be referred to as the NCCA Standards and the Standards for Educational and Psychological Tests will be referred to as the Joint Standards.

The NCCA Standards specifically state that a RDS “must be conducted to clearly delineate performance domains and tasks, associated knowledge and/or skills, and sets of content/item specifications to be used as the basis for developing each type of assessment instruments.” In addition, “a report must be published linking the job/practice analysis to specifications for the assessment instruments.” The Joint Standards similarly state, “The test specifications should be documented, along with their rationale, and the process by which they were developed.” The Joint Standards also state that in credentialing tests, role delineation studies “usually provide the basis for defining the test specifications.”

The Florida Certification Board used the above standards to help guide the process used for the RDS and in the development of all reports that will serve as documentation for content validity for any resulting MH Peer Recovery Specialist credentialing program.

## III. The Role Delineation Study Process

As mentioned earlier, the RDS is the first step in developing a valid and reliable credentialing program. The RDS is a formal process conducted with selected subject matter experts (SMEs) and consists of two phases. Phase 1 consists of a workshop with SMEs in which the tasks, skills, and knowledge for competent performance are determined. Phase 2 revolves around the validation of the tasks identified by the SMEs in Phase 1. The validation effort includes a survey distributed to a larger group of SMEs and job incumbents. Survey respondents are asked to review the list of tasks and rate each task in terms of its importance to competent job performance and the frequency which each task is performed.

This section of the RDS Final Report details the process and results of the first phase of the RDS process. In summary, the following steps were conducted as part of the Phase 1 of the RDS:

1. The DCF convened a panel of Subject Matter Experts (SMEs) in the field of mental health peer recovery support to determine the scope of practice. These SMEs were led through the role delineation process by the Florida Certification Board. During the workshop, the SME panel defined the major performance domains and the associated tasks necessary for competent performance. Knowledge, skills and abilities (KSAs) associated with each task were then identified.
  
2. The FCB conducted an editorial and psychometric review of the listing of domains, tasks, and knowledge and prepared a survey to be distributed to a sample of MH Recovery Peer Specialist and those individuals who are knowledgeable of the profession and job role.

## **The Role Delineation Study Workshop**

The RDS workshop was held June 23 – 24, 2006, in Tallahassee, Florida. The workshop was conducted by Amy Peloquin, the Director of Certification with FCB. The following section will describe the workshop, including the list of participants, the agenda, and a description of the methods used during the workshop.

### ***A. List of Participants***

Table 1 provides the panel members who served as SMEs in the workshop. Panel members were recruited by the DCF. Panel members are listed in alphabetical order by surname.

**Table A-1: Subject Matter Experts Participating in Role Delineation Study Workshop**

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#### **Panel Member**

Letty Ballard  
 Toni Beard  
 Kris Butler  
 Diane Callender  
 Patrick Hendry  
 Cynthia Holland  
 Raymond Jacobs  
 Tom Lane  
 Susan Lang  
 Ellen Pepler  
 Clint Rayner  
 William “Bill” Schneider  
 Mike Stevenson  
 Carolyn Wilson

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## **B. Agenda**

The following agenda was used during the workshop:

### **June 23, 2006 (9:00 am to 4:30 pm)\***

9:00 – 9:30	Welcome and Introductions
9:30 – 9:45	Overview of the Role Delineation Study
9:45 – 10:00	Define the Target Audience
10:00 – 10:45	Define Performance Domains
10:45 – 11:00	Break
11:00 – 12:00	Instruction on Identifying Task Statements
12:00 – 1:00	Lunch (provided)
1:00 – 4:00	Write/Review Task Statements
4:00 – 4:30	Review Progress/Prepare for Day 2
4:30	Adjourn

### **June 24, 2006 (9:00 am to 3:00 pm)\***

9:00 – 9:15	Welcome/Introduction to Day 2
9:15 – 10:00	Validate Domains and Tasks
10:00 – 12:00	Write Knowledge/Skill Statements
12:00 – 1:00	Lunch (on your own)
1:00 – 2:30	Write/Review Knowledge/Skill Statements
2:30 – 3:00	Wrap-up and Discussion of Next Steps
3:00	Adjourn

\*Times are approximate. The agenda may change to meet the progress and needs of the group.

### ***C. Defining the Performance Domains***

After multiple large group, small group, and individual brainstorming sessions the panel members determined the major responsibilities or duties that define the MH Recovery Peer Specialist's job role. After identifying all possible major responsibilities, the panelists identified the following four domains of practice, which are:

Domain 1: Advocacy

Domain 2: Professional Responsibility

Domain 3: Mentoring

Domain 4: Recovery Support

### ***D. Determining the Task Statements***

Once the domains were finalized, the facilitator led the panel members through another brainstorming activity in which the tasks that a MH Recovery Peer Specialist needs to perform competently were identified for each domain. Once all the tasks were delineated, the panel members reviewed the tasks to ensure that the tasks provided full coverage of the job responsibilities, were independent of each other, and were appropriately categorized within each domain.

### ***E. Determining the Knowledge, Skill and Abilities (KSAs)***

The final step in the RDS workshop was to determine the knowledge, skills, and abilities necessary to perform the delineated tasks. As with the other steps, the facilitator led the group in a brainstorming session, as well as some group work, as the panel members determined the appropriate list of knowledge and skills necessary for a competent performance by a MH Recovery Peer Specialist.

### ***F. The Relationship between Domains, Job Tasks, and KSAs***

As stated previously, domains identify the major duties that define a job role. Under each of these performance domains are specific tasks that the MH Recovery Peer Specialist is expected to perform on-the-job. The knowledge, skill, and ability statements describe what the MH Recovery Peer Specialist must know or be able to do in order to carry out their job tasks in a competent manner.

Each of the knowledge, skill, and ability statements refers to the cognitive abilities of the MH Recovery Peer Specialist that will facilitate his or her ability to perform the job tasks in partnership with the consumer. As such, the knowledge, skill, and ability statements specifically do not refer to the consumer population that will receive support from the MH Recovery Peer Specialist. In addition, each statement is written to one of the following cognitive levels:

1. **Knowledge**, which refers to the MH Recovery Peer Specialist's ability to recall information. Knowledge statements frequently begin with action verbs such as *define, list, name, recall, state, etc.*
2. **Comprehension**, which refers to the MH Recovery Peer Specialist's ability to interpret information in their own words. Comprehension statements frequently begin with action verbs such as *describe, explain, identify, discuss, etc.*
3. **Application**, which refers to the MH Recovery Peer Specialist's ability to apply their knowledge or generalize it to a new situation. Application statements frequently begin with action verbs such as *demonstrate, apply, choose, interpret, etc.*

It is important to understand that in a role delineation study, the knowledge, skill, and ability statements are written at the highest cognitive level required to competently perform the job task. It can be assumed that all higher order cognitive levels require that the MH Recovery Peer Specialists also possess the lower level cognitive abilities required to perform at the highest level indicated. The next section identifies the job tasks, and associated knowledge, skill, and ability statements. These statements are grouped by domain.

#### **IV. Performance Domains, Job Tasks, and KSAs**

##### ***Domain 1: Advocacy***

**Job Tasks** that should be performed by the Mental Health Recovery Peer Specialist in the Advocacy domain are:

- 1.1. Serve as the consumer's individual advocate.
- 1.2. Advocate within systems to promote consumer centered recovery support services.
- 1.3. Assure that the consumer's choices define and drive their recovery planning process.
- 1.4. Promote consumer-driven recovery plans by serving on the consumer's recovery-oriented team.

**Knowledge, Skills and Abilities** that the Mental Health Recovery Peer Specialist should possess in order to perform the tasks identified in the Advocacy domain are:

- 1.1. Define system-level advocacy.
- 1.2. Explain why self-advocacy is the foundation of recovery.
- 1.3. Identify the consumer's individual support systems.
- 1.4. Promote the principles of individual choice and self-determination.
- 1.5. Explain how and why consumers should establish an Advanced Directive.
- 1.6. Explain how to advocate within the mental health system.
- 1.7. Define consumer-driven recovery.
- 1.8. Use "person-centered" language that focuses on the individual, not the diagnosis.
- 1.9. Demonstrate non-judgmental behavior.

## ***Domain 2: Professional Responsibility***

**Job Tasks** that should be performed by the Mental Health Recovery Peer Specialist in the Professional Responsibility domain are:

- 1.1. Respond appropriately to risk indicators to assure the consumers welfare and physical safety.
- 1.2. Immediately report suspicions that the consumer is being abused or neglected according to s. 415.1034(1)(a), F.S.
- 1.3. Maintain confidentiality.
- 1.4. Communicate personal issues that impact your ability to perform job duties.
- 1.5. Assure that interpersonal relationships, services, and supports reflect the consumer's individual differences and cultural diversity.
- 1.6. Document service provision as required by the employer.
- 1.7. Gather information regarding the consumer's personal satisfaction with their progress toward recovery goals.

**Knowledge, Skills and Abilities** that the Mental Health Recovery Peer Specialist should possess in order to perform the tasks identified in the Professional Responsibility domain are:

- 1.1. Explain the ten fundamental concepts of recovery as defined in the National Consensus Statement on Mental Health Recovery, which is published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).
- 1.2. Define the concept of a wellness-focused approach to consumer recovery.
- 1.3. Explain the fundamental concepts related to cultural competency.
- 1.4. Understand the concept of accountability.
- 1.5. Explain basic federal, state, employer regulations regarding confidentiality.
- 1.6. Explain what, where, when and how to accurately complete all required documentation activities.
- 1.7. Explain the concept of decompensation.
- 1.8. Identify the consumers risk indicators, including individual stressors, triggers and indicators of escalating symptoms
- 1.9. Explain basic de-escalation techniques.
- 1.10. Explain basic suicide prevention concepts and techniques.
- 1.11. Identify indicators that the consumer may be experiencing abuse and/or neglect.
- 1.12. Identify and respond appropriately to personal stressors, triggers, and indicators.

### ***Domain 3: Mentoring***

**Job Tasks** that should be performed by the Mental Health Recovery Peer Specialist in the Mentoring domain are:

- 1.1. Serve as a role model of a consumer in recovery.
- 1.2. Establish and maintain a “peer” relationship rather than a hierarchical relationship.
- 1.3. Promote social learning through shared experiences.
- 1.4. Teach consumers life skills.
- 1.5. Encourage consumers to develop independent behavior that is based on choice rather than compliance.
- 1.6. Assure that consumers know their rights and responsibilities.
- 1.7. Teach consumers how to self-advocate.

**Knowledge, Skills and Abilities** that the Mental Health Recovery Peer Specialist should possess in order to perform the tasks identified in the Mentoring domain are:

- 1.1. Explain the concept of mentoring.
- 1.2. Explain the concept of role-modeling behaviors.
- 1.3. Define social learning.
- 1.4. Define self-advocacy.
- 1.5. Define life skills.
- 1.6. Understand basic adult learning principles and techniques.
- 1.7. Use adult learning techniques to teach life skills.
- 1.8. Explain the concept of healthy, interdependent relationship.
- 1.9. Establish a respectful, trusting relationship.
- 1.10. Use active listening skills.
- 1.11. Use empathetic listening skills.
- 1.12. Demonstrate non-judgmental behavior.
- 1.13. Demonstrate consistency by supporting consumers during ordinary and extraordinary times.
- 1.14. Promote the development and use of Advanced Directives

#### ***Domain 4: Recovery Support***

**Job Tasks** that should be performed by the Mental Health Recovery Peer Specialist in the Recovery Support domain are:

- 1.1. Serve as an active member of the consumer's recovery-oriented team(s).
- 1.2. Assure that all recovery-oriented tasks and activities build on the consumer's strengths and resiliencies.
- 1.3. Help the consumer identify their options and participate in all decisions related to establishing and achieving recovery goals.
- 1.4. Help the consumer develop problem-solving skills so they can respond to challenges to their recovery.
- 1.5. Help the consumer access the services and supports that will help them attain their individual recovery goals.

**Knowledge, Skills and Abilities** that the Mental Health Recovery Peer Specialist should possess in order to perform the tasks identified in the Recovery Support domain are:

- 1.1. Explain the ten fundamental concepts of recovery as defined in the National Consensus Statement on Mental Health Recovery, which is published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).
- 1.2. Explain the concept of a strength-based approach to recovery.
- 1.3. Promote self-determination and consumer choice-driven recovery.
- 1.4. Use active and empathetic listening skills with the consumer.
- 1.5. Use *Motivational Interviewing* skills with the consumer.
- 1.6. State the stages of change.
- 1.7. State the stages of recovery.
- 1.8. Identify the consumer's current stage of change and/or recovery.
- 1.9. Help the consumer develop problem-solving skills by working together to identify and discuss options, alternatives, and possible consequences.
- 1.10. Explain the typical process that should be followed to access and/or participate in community mental health and related services.
- 1.11. Identify circumstances when it is appropriate to request assistance from other professionals to help meet the consumer's recovery goals.
- 1.12. Identify the consumer's strengths, resiliencies, and challenges to recovery.
- 1.13. Promote the consumer's empowerment by assuring that they are informed of their options and participate in all decision-making that will affect their lives.
- 1.14. Help the consumer request appropriate referrals and/or access needed resources.

## **V. The Role Delineation Study Validation Survey**

While the panel members of the RDS Workshop are considered subject matter experts, they represent only a small group of practitioners and their expert status may result in a perception of the profession that is different from many practitioners. It is for this reason that an RDS validation survey is developed and sent to a larger sample of practitioners. The responses from the survey respondents are then compared to the panelist's responses as a way to validate the panel's analysis of the profession.

### ***A. Developing the Survey***

After the Role Delineation Study Workshop, FCB conducted an editorial and psychometric review of the domains and task statements. All changes made were approved by members of the RDS Workshop panel. Using the final performance domains and task statements identified through the RDS workshop, FCB prepared a survey that enabled respondents to evaluate and provide feedback on the domains and task statements. FCB developed two parallel forms of the survey instrument: one version was web-based; the other version was a hard copy, which was returned to FCB for data entry and analysis.

Both versions of the survey provided an explanation of its purposes as well as clear instructions for its completion and, in the case of hard copy surveys, its return. Along with each domain and task listing, clear definitions of the rating scales were provided on each page. Based on the list of 23 tasks for the four domains, the survey asked the respondent to rate the importance and the frequency (amount of time spent) of each task in the 5-point Likert-type scale, where a higher value indicated more importance and higher frequency.

In addition to the domains and tasks, the survey collected confidential demographic information, such as gender, age, and level of education, used to document the respondents' qualifications and background. The demographic data was used to verify that the survey data was representative of the practice settings, experience level, and education level of the population of Certified Peer Specialists: MH Recovery Peer Specialist.

All survey data was captured in a common database, which was then analyzed by FCB. The web-based version of the survey captured survey responses as they were entered. For hard-copy surveys, FCB staff entered data into the web-based survey system.

A copy of the survey is provided in Appendix A.

## ***B. The Survey Sample***

The DCF estimated the incumbent population of individuals performing individuals practicing in job roles that would qualify them for the MH Recovery Peer Specialist at no more than 150 persons, statewide. The potential incumbent population is estimated at this level because the position is in the early stages of establishment and implementation. As such, there is a need to establish a common understanding of the position, so the FCB recommended that survey data be collected from persons performing the job, persons receiving services from MH Recovery Peer Specialists, and from potential employers of MH Recovery Peer Specialists. In identifying targets for the survey, the FCB worked with the DCF and the Florida Peer Network to identify service providers, treatment facilities, and members and non-members of Florida's mental health associations.

Because there were two options for responding to the survey, a two-prong strategy was developed to request participation. A Survey Participation Request Letter was developed by FCB and provided to the DCF for distribution to a statewide providers, associations, and individuals practicing in job roles that would qualify them for the MH Recovery Peer Specialist. The letter provided a statement of purpose, a brief overview of the survey, the internet link to the survey itself, and the timeframe for completion. If the respondent did not have ready access to the internet, respondents were encouraged to contact the FCB for a hard copy of the survey if necessary. The FCB provided eight hard copy surveys to respondents who contacted the FCB directly.

In addition, the FCB and the Florida Peer Network distributed hard copies of the survey at the Florida Council for Community Mental Health's annual conference. Twenty-two surveys were completed and returned to the FCB because of the conference. In total, 52 people responded to the survey, representing 35% of the target population. The demographic characteristics of the sample are summarized in Tables C-1 through C-8.

In some cases, not all respondents answered every question, so the total number for respondents for each demographic questions may not equal the total number of surveys analyzed. In addition, for some questions, respondents had the opportunity to select more than one option, so the total value would be larger than the total number of surveys returned.

## ***C. Analysis of Demographic Data***

Eight demographic questions were asked in the survey. This section provides a summary of the demographic results and confirms that the survey sample represents practitioners from a variety of practicing settings with varying levels of education and experience and background. Note that some of the percents will not add to 100% due to rounding.

Of those responding to the survey, 29% (n=14) of the respondents were male and 71% (n=35) of the respondents were female. Three respondents did not indicate gender. Table C-1 below summarizes the gender variable.

**Table C-1: Summary of the Gender Demographic Responses**

<b>Gender Categories</b>	<b>N</b>	<b>Percent</b>
Male	14	28.6%
Female	35	71.4

All levels of age were represented in the survey. The majority of the respondents (55.1%) were over the age of 50 years. Twenty percent were between 41 – 50 years of age. Eighteen percent were between 31 – 40 years of age. The remaining six percent were under 30 years of age. The age variable is summarized below in Table C-2.

**Table C-2: Summary of the Age Demographic Responses**

<b>Age Categories</b>	<b>N</b>	<b>Percent</b>
Under 30 years old	3	6.1%
31 – 40 years	9	18.4%
41 – 50 years	10	20.4%
Over 50 years	27	55.1%
No Response	3	N/A

The vast majority of the survey respondents, 77.6%, hold a formal degree higher than a BA or BS Degree. Approximately 14% have some college (4.1%), an AA/AS degree (2.0%), or a BS/BA degree (8.2). Four respondents held a High School Diploma or GED and no respondents held less than a GED. The summary of the respondents' highest education level is provided in table C-3 below.

**Table C-3: Summary of the Highest Level of Education Demographic Responses**

<b>Highest Level of Education Categories</b>	<b>N</b>	<b>Percent</b>
No GED or High School Diploma	0	0%
GED	1	2.0%
High School Diploma	3	6.1%
Some College	2	4.1%
AA/AS Degree	1	2.0%
BA/BS Degree	4	8.2%
Higher than BA/BS	38	77.6%
No Response	3	N/A

The majority of respondents (68.1%) indicated over ten years of experience in a MH Recovery Peer Specialist role. The remainder of the respondents indicated anywhere from one to nine years of experience: none of the respondents indicated less than one year of experience. Table C-4 below provides the summary of the number of years of practice by survey respondents.

**Table C-4: Summary of the Years of Experience Demographic Responses**

<b>Years of Experience Categories</b>	<b>N</b>	<b>Percent</b>
Less than 1 year	0	0%
1 – 3 years	5	10.6%
4 – 6 years	4	8.5%
7 – 9 years	6	12.8%
Over 10 years	32	68.1%
No Response	5	N/A

A variety of practice settings were represented by the survey respondents as shown below in Table C-5. Although respondents may work in multiple settings, respondents were asked to select their *primary* work setting.

**Table C-5: Summary of the Work Setting Demographic Responses**

<b>Work Setting Categories</b>	<b>N</b>	<b>Percent</b>
In-patient Mental Health Center	11	22.9%
Residential Substance Abuse Program	0	0%
Community Rehabilitation Program	6	12.5%
Supportive Housing	1	2.1%
Recovery Support	4	8.3%
Drop-In Center	2	4.2%
Out-patient Mental Health Program	24	50.0%
Out-patient Substance Abuse Program	4	8.3%
Other	16	33.3%
No Response	4	N/A

In addition to the variety of work settings, the populations served by the respondents were collected. Respondents were asked to select the age (child/adolescent or adult) and setting (mental health or substance abuse programs). Respondents were able to select all age groups that they serve, so the values shown in Table C-6 will not equal the number of survey respondents since many of the respondents selected more than one age group.

Responses indicate all age groups (children, adolescents, and adults) and all programs (mental health and substance abuse). As can be seen in Table C-6, almost all of the respondents (87.5%) work with adults in mental health programs and a significant number of respondents also work with children/adolescents in mental health programs (33.3%). Almost 27% of respondents work in substance abuse programs serving adults (16.7%) and serving children/adolescents (10.4%). A summary of the population served is follows in Table C-6.

**Table C-6: Summary of the Populations Served Demographic Responses**

<b>Population Served Categories*</b>	<b>N</b>	<b>Percent</b>
Children/Adolescents (under 18 years) – Mental Health Program	16	33.3%
Children/Adolescents (under 18 years) – Substance Abuse Program	5	10.4%
Adult (over 18 years) – Mental Health Program	42	87.5%
Adult (over 18 years) – Substance Abuse Program	8	16.7%
No Response	4	N/A

\*multiple responses were allowed.

Fully 95% of the survey respondents are working in a full-time capacity. Table C-7 below provides the summary of the work hours of the survey respondents.

**Table C-7: Summary of the Work Hours Responses**

<b>Work Hours Categories</b>	<b>N</b>	<b>Percent</b>
Part-time	2	4.1%
Full-time	47	95.9%
No Response	3	N/A

The final survey demographic question asked information regarding the ethnicity of the respondents. As shown in Table C-8 below, a wide range of ethnicities was represented.

**Table C-8: Summary of the Ethnicity Responses**

<b>Ethnicity Categories</b>	<b>N</b>	<b>Percent</b>
American Indian or Alaska Native	1	1.2%
Asian	0	0%
Black or African American	4	8.5%
Caucasian or White	31	66.0%
Hispanic or Latino	11	23.4%
Native Hawaiian or other Pacific Islander	0	0%
Other	0	0%
No Response	5	N/A

## VI. Determining the Domain Percentages

The responses from the survey were analyzed and compared to the responses of the panel members. In particular, the domains are compared to ensure that the coverage on the examination at the domain level is not significantly different between panel members and the survey respondents. If the responses for the domain ratings are similar between the two groups, then one can assume that the work produced by the panel members is a valid assessment of the profession.

The survey respondents and the panel members were asked to evaluate the four domains in terms of importance and frequency, using the same five-point scale. In addition, survey respondents and panel members were asked to estimate the percentage of time a MH Recovery Peer Specialist spends performing duties in these domains.

### A. Importance Ratings

Respondents were asked to use the five-point scale (see table A-1, below) to respond to the following question, “How important is the domain, relative to the other domains, to the job performance of a MH Recovery Peer Specialist?”

**Table A-1: Importance Rating Scale**

Rating	Description
1	Not Important
2	Somewhat Important
3	Important
4	Very Important
5	Extremely Important

As shown in Table A-2, all four domains were evaluated as being important by both panel members and survey respondents, as the lowest rating was 4.3.

**Table A-2: Comparison of Importance Ratings – Survey Respondents vs. Panelists**

Performance Domains	Survey Respondents' Importance Ratings	Panelists' Importance Ratings
Advocacy	4.325	4.552
Professional Responsibility	4.440	4.421
Mentoring	4.548	4.548
Recovery Support	4.496	4.321

While the panelists felt that Advocacy was the most important domain, the survey respondents rated Advocacy as the least important domain. However, the difference is less than half a percentage point and the survey respondents and the panelists consistently rated each of the four domains as Very Important.

## **B. Frequency Ratings**

Respondents were asked to use the five-point scale (see table B-1, below) to respond to the following question, “How much time does a MH Recovery Peer Specialist spend performing duties in these domains, relative to the other domains?”

**Table B-1: Frequency Rating Scale**

<b>Rating</b>	<b>Description</b>
1	Not Much Time
2	A Little Bit of Time
3	An Average Amount of Time
4	A Fair Amount of Time
5	A Large Amount of Time

As shown in Table B-2, all four domains were evaluated as being performed an average or fair amount of time, with the lowest rating at 3.7.

**Table B-2: Comparison of Frequency Ratings – Survey Respondents vs. Panelists**

<b>Ethnicity Categories</b>	<b>Survey Respondents’ Frequency Ratings</b>	<b>Panelists’ Frequency Ratings</b>
Advocacy	3.890	3.874
Professional Responsibility	3.794	4.132
Mentoring	4.162	4.878
Recovery Support	4.080	3.922

The survey respondents and the panelists agreed that the majority of time is spent performing mentoring duties. However, there were some differences between the survey respondents’ frequency ratings and those of the panelists for the other domains.

The survey respondents felt that the second most frequently performed tasks are in the Recovery Support domain, followed by Advocacy and Professional Responsibility. Conversely, the panelists felt that the second most frequently performed duties fall under the Professional Responsibility domain, followed by Recovery Support and then, Advocacy. The difference in ratings may be attributed to the low (n=7) number of panel

members providing ratings. However, the differences in the means are not significant: the responses for each domain are within no more than 3/10<sup>th</sup> of a point.

### ***C. Summary of Findings Regarding Domains***

As shown in the tables in the preceding pages, the perception of the profession by the survey respondents is consistent with the perception of the panelists. Both groups found all four domains “important” to “extremely important.” In addition, while there were some differences in the frequency and estimated percentages, the differences were not by significant values. In fact, the minor differences between the panelists and survey respondents in terms of the frequency and estimated percentage of time spent in the domains may be attributed to the small number of panel members per the workshop design. The small number of panel members needed to conduct the RDS Workshop (Phase 1) is one reason why a validation survey (Phase 2) is sent to a larger audience.

In accordance to standard practice, the test blueprint is computed based on the survey responses rather than the panelists’ ratings. However, in the final acceptance of the test blueprint, the data from the workshop panelists may also be considered.

## **VII. The Test Blueprint**

The final phase of the Role Delineation Study was to develop the test blueprint. The test blueprint provides the exact number of items from each domain and task that should appear on the examination. Exam items should be developed to assess the knowledge and skills in each domain and task according to the determined percentages.

Appendix B contains a summary test blueprint, which contains the number of items for each domain and task. Appendix C contains a detailed test blueprint, which adds to the Summary Test Blueprint by including the knowledge and skill statements associated with each performance domain. The detailed test blueprint is typically found helpful to item writers as examination items are developed and to curriculum developers designing competency-based instruction. In addition, the detailed blueprint provides the candidates with considerably more information regarding the scope of knowledge the examination will be measuring.

### ***A. Testing Format***

A variety of testing formats exist for appropriately assessing a candidate’s knowledge. Typically, multiple-choice examinations are used to measure knowledge, while performance-based examinations are used to assess skills and actual job performance.

Each testing format has its advantages and its disadvantages. Ultimately, it is the decision of the certifying agency as to which examination format they prefer to use.

The Florida Certification Board recommends that the MH Recovery Peer Specialist certification examination be in multiple-choice format. This format can be scored objectively, allows for the most thorough content coverage, and is the least expensive to administer. In addition, FCB evaluated the tasks and associated knowledge statements outlined in the role delineation and concluded that the use of a written, multiple-choice examination format is appropriate to assess candidate performance for the MH Recovery Peer Specialist.

FCB recommends that no fewer than 100 items be used on the examination, as 100 items are needed to ensure adequate reliability. As a result, the test blueprint in this report was calculated using 100 items.

## ***B. Overview of Statistical Analysis***

To develop the test blueprint for the MH Recovery Peer Specialist examination, the first consideration was given to the mean percentage assigned to each domain. The mean value was used to (1) identify any task statements that should be eliminated from the test blueprint and (2) determine the percentage of the examination that should be allocated for the domain.

First, the mean rating was calculated for “Importance” and “Frequency” by task. Tasks with a mean rating of less than 2.5 would be flagged as “not important” or “not frequently performed.” Ideally, none of the tasks identified by the panelists in the Role Delineation Study Workshop would be eliminated as these panelists have delineated these tasks as critical for competent performance of a MH Recovery Peer Specialist. The data analysis indicated that all tasks are important and are frequently performed, as the lowest survey mean rating was 3.40. Therefore, all tasks identified by the panelists were used in the development of the test blueprint.

To calculate the percentage allocated per domain, the weight of each task was determined in the following way. First, the average ratings for “Importance” and “Frequency” were calculated for each task. Then, the mean of the two ratings was calculated, establishing the Mean Combined Rating. Then, the mean combined rating for each of the 23 tasks was summed to establish the Total Rating Score, which is 97.18 in this case. Finally, the weight for each task (exam proportion) was computed by dividing the Mean Combined Rating by the Total Rating Score. The results of these calculations are summarized below in Table D2-b.

The proportion of each task to the entire task inventory within each domain was then calculated. This proportion was directly used to determine the number of items that should be allocated to each task. The differences in exam proportions between tasks were rather small; the lowest was 3.54% (Task 2.4), and the highest was 4.76% (Task 2.3).

Therefore, each task should be allocated essentially the same number of items. By allocating four items per task, the total number of items will be 92 items. In order to achieve the total number of items of 100, 8 tasks should be chosen to allocate five items. The following procedure was employed to choose eight tasks.

1. First, the number of items for each domain was determined based on the sum of the exam proportions of items within each domain. The results were 17, 30, 31, and 22 items for the 4 domains, respectively.
2. Then, the number of tasks to be assigned five items, rather than four items, was determined by (# of items for the domain) – (4 x # of tasks in the domain). For example, there were four tasks in Domain 1, while 17 items should be assigned to the domain. Since  $17 - (4 \times 4) = 1$ , one task should be assigned five items. Among the tasks in Domain 1, task 1.3 had the highest exam proportion. Therefore, five items were assigned for task 1.3, while four items were assigned for the other tasks in Domain 1.
3. The same procedure was applied for the other three domains, and tasks 2.2, 2.3, 3.1, 3.2, 3.5, 4.4, and 4.5 were chosen to assign five items. All other items were assigned four items. The detailed test blueprint is presented in Appendix C.

### ***C. Reliability of Task Ratings***

Since the mean task ratings for importance and frequency are directly used to determine the number of exam items, it is important that the data be reliable. The reliability of the task ratings can be described as the consistency of the score/ratings that are obtained on the observed scales.

One of the most common methods used to determine the reliability of a measurement instrument is the Cronbach Coefficient Alpha (Cronbach, 1951). This statistic measures the internal consistency of responses made within a survey. A widely used rule of thumb is that the reliability coefficient should be at least .70 (Nunnally, 1978). However, it is noted that this is just a rule of thumb and there have been many studies published in the social science literature with coefficient alpha reliabilities under .70.

The coefficient reliability of each scale (importance and frequency) was calculated across all tasks. The results (see Table C-1, below) support the use of the survey respondents' ratings to determine exam proportions of each task.

**Table C-1: Reliability Estimates of the Task Ratings**

Variable	Reliability Estimate
Importance	.822
Frequency	.893

With reliability estimate values greater than .80, we can assume that the respondents responded to the survey in a consistent manner with thoughtful consideration to each rating provided and that the questions relating to those tasks were appropriately interpreted by respondents.

#### ***D. Summary Statistics for the Domains and Tasks***

To determine the proportion of the examination to be allocated to each domain, the mean percentage values per the survey respondents was computed. Table D-1 provides a listing of the calculated percentage (adjusted/rounded to yield 100%). The importance and frequency mean ratings for the tasks, and the calculated exam proportions, are provided in table D-2.

**Table D-1: Percent of Exam Items per Domain**

Domain	Percent of Exam Item
Advocacy	16.9% (17 items)
Professional Responsibility	29.7% (30 items)
Mentoring	31.4% (31 items)
Recovery Support	22.1% (22 items)

**Table D-2a: Summary of Ratings with Calculated Exam Proportions by Domain**

Domain	Importance Rating	Frequency Rating	Exam Proportion
Domain 1: Advocacy	4.325	3.890	16.9%
Domain 2: Professional Responsibility	4.440	3.794	29.7%
Domain 3: Mentoring	4.548	4.162	31.4%
Domain 4: Recovery Support	4.496	4.080	22.1%

**Table D-2b: Summary of Ratings with Calculated Exam Proportions by Domain and Task**

<b>Domain/Task</b>	<b>Importance Rating</b>	<b>Frequency Rating</b>	<b>Exam Proportion</b>
Domain 1: Advocacy	4.325	3.890	16.9%
Task 1.1	4.37	3.82	4.21%
Task 1.2	4.29	3.84	4.18%
Task 1.3	4.35	3.96	4.28%
Task 1.4	4.29	3.94	4.23%
Domain 2: Professional Responsibility	4.440	3.794	29.7%
Task 2.1	4.72	3.84	4.40%
Task 2.2	4.88	3.86	4.50%
Task 2.3	4.86	4.40	4.76%
Task 2.4	3.74	3.14	3.54%
Task 2.5	4.32	3.78	4.17%
Task 2.6	4.18	3.88	4.15%
Task 2.7	4.38	3.66	4.14%
Domain 3: Mentoring	4.548	4.162	31.4%
Task 3.1	4.72	4.44	4.71%
Task 3.2	4.56	4.26	4.54%
Task 3.3	4.18	3.78	4.10%
Task 3.4	4.36	4.04	4.32%
Task 3.5	4.80	4.26	4.66%
Task 3.6	4.62	4.18	4.53%
Task 3.7	4.60	4.18	4.52%
Domain 4: Recovery Support	4.496	4.080	22.1%
Task 4.1	4.30	4.02	4.28%
Task 4.2	4.52	4.14	4.46%
Task 4.3	4.48	4.00	4.36%
Task 4.4	4.58	4.08	4.46%
Task 4.5	4.60	4.16	4.51%

## **VIII. Conclusion**

FCB's contract with the Department of Children and Families (DCF) to conduct a Role Delineation Study Workshop and Validation Survey effort is indicative of DCF's commitment to developing valid and reliable certification programs. In addition, the efforts engaged by the FCB in conducting the RDS comply with the NCCA and Joint Standards. With the domains and tasks finalized, the next phases of the credential development process can begin.

Upon completion of the Role Delineation Study Final Report, the test blueprint is final and should not be changed until an updated Role Delineation Study is completed. In particular, the domains, tasks, and assigned percentages cannot be modified. The associated knowledge and skill statements can be modified, if necessary. However, this modification can in no way change the percentage values for the domains and tasks.

The lifespan of the Role Delineation Study and test blueprint is five years. After five years, it is recommended that the DCF conduct another Role Delineation Study to update the domains and tasks and to assess any changes to the importance and frequency ratings. As this is a relatively new profession, the DCF may consider updating the Role Delineation Study in three years, or in keeping with evidence-based practice in the field.

## **Appendices**

- A: Validation Survey Instrument
- B: Summary Test Blueprint
- C: Detailed Test Blueprint

## **Appendix A: Validation Survey Instrument**

### **MH Recovery Peer Specialist RDS Validation Survey**

This document is the validation survey for the MH Recovery Peer Specialist credential. All responses are anonymous: data is pulled into a single file for analysis.

There are three sections to the survey: each section begins with detailed instructions.

In **Section A**, you are asked to complete a demographic survey with will provide FCB with the demographic information necessary to ensure that professionals working in various settings with differing backgrounds are represented in the data collection.

In **Section B**, you are asked to evaluate the task statements required for competent performance as a MH Recovery Peer Specialist.

In **Section C**, you are asked to rate the performance domains that have been identified as defining the profession of the MH Recovery Peer Specialist.

Please mark your responses directly on the survey.

**If you complete your survey while at the conference**, please return the completed survey to either the FCB Booth or the Florida Peer Network booth.

**If you complete your survey after the conference**, please mail the completed survey to the FCB no later than October 20, 2006. Mail surveys to:

Amy Peloquin  
Director of Certification  
Florida Certification Board  
1715 South Gadsden Street  
Tallahassee, Florida 32301

If you have any questions regarding this survey, please stop by the FCB Booth or feel free to contact Ms. Amy Peloquin at [apeloquin@fcertificationboard.org](mailto:apeloquin@fcertificationboard.org) or at 850-222-6314 at your convenience.

***Thank you for your time and participation!***

**MH Recovery Peer Specialist Validation Survey Directions:**

Please provide your demographic information. This information is used to ensure that a representative sample of professionals working in the field responded to the survey.

1. Gender:	<input type="checkbox"/> Female	<input type="checkbox"/> Male
2. Age:	<input type="checkbox"/> Under 30 years old	<input type="checkbox"/> 41 – 50 years old
	<input type="checkbox"/> 31 – 40 years old	<input type="checkbox"/> Over 50 years old
3. How long have you worked in a field related to the MH Recovery Peer Specialist?	<input type="checkbox"/> Less than 1 year	<input type="checkbox"/> 7 – 9 years
	<input type="checkbox"/> 1 – 3 years	<input type="checkbox"/> More than 10 years
	<input type="checkbox"/> 4 – 6 years	
4. Which of the following best describes your current work setting? Check all that apply.	<input type="checkbox"/> Inpatient Mental Health Center	<input type="checkbox"/> Residential Substance Abuse Program
	<input type="checkbox"/> Community Rehabilitation Program	<input type="checkbox"/> Supportive Housing
	<input type="checkbox"/> Recovery Support	<input type="checkbox"/> Drop-in Center
	<input type="checkbox"/> Outpatient Mental Health Program	<input type="checkbox"/> Outpatient Substance Abuse Center
	<input type="checkbox"/> Other: _____	
5. What is your highest level of education completed? Select only one.	<input type="checkbox"/> No GED or High School Diploma	<input type="checkbox"/> AA/AS Degree
	<input type="checkbox"/> GED	<input type="checkbox"/> BA/BS Degree
	<input type="checkbox"/> High School Diploma	<input type="checkbox"/> Higher than BA/BS Degree
6. Which populations do you currently serve in your job? Check all that apply.	<input type="checkbox"/> Children/Adolescents (under 18 years old) in a mental health program.	
	<input type="checkbox"/> Children/Adolescents (under 18 years old) in a substance abuse program.	
	<input type="checkbox"/> Adults (18 and older) in a mental health program.	
	<input type="checkbox"/> Adults (18 and older) in a substance abuse program.	
7. Which of the following best describes your work hours?	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time
8. <b>Optional Question:</b> Which of the following best describes your ethnicity/race? Select one.	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Hispanic or Latino
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander
	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Caucasian/White
	<input type="checkbox"/> Other: _____	

**Section B Introduction:**

The following domains of knowledge have been identified for MH Recovery Peer Specialists:

- Domain 1: Advocacy
- Domain 2: Professional Responsibility
- Domain 3: Mentoring
- Domain 4: Recovery Support

Within each domain, there are a set of tasks that are performed by a MH Recovery Peer Specialist. The purpose of this section is to differentiate between the importance and frequency of the tasks *relative to each other* within each domain. The ratings you provide will be used in determining the percentage of items that each task will have on the examination. That is, tasks that are more important and are more frequently performed will have more questions on the exam.

**Directions:**

Each domain area and its associated tasks will appear on the following pages. Please rate each task statement according to the rating scale below.

**Rating for Importance** ~ For each task statement, ask yourself, “How important is the task, compared to all the other tasks in this domain, to the job of the MH Recovery Peer Specialist?”

Rate each statement according to this scale:

1	Not Important
2	Somewhat Important
3	Important
4	Very Important
5	Extremely Important

**Rating for Frequency** ~ For each task statement, ask yourself, “How much time does a MH Recovery Peer Specialist spend performing this task, as compared to the other tasks in the domain?”

Rate each statement according to this scale:

1	Not Much Time
2	A Little Bit of Time
3	An Average Amount of Time
4	A Fair Amount of Time
5	A Large Amount of Time

**Review of Rating Scales**

Importance Ratings		Frequency Ratings	
1	Not Important	1	Not Much Time
2	Somewhat Important	2	A Little Bit of Time
3	Important	3	An Average Amount of Time
4	Very Important	4	A Fair Amount of Time
5	Extremely Important	5	A Large Amount of Time

**Please Circle Your Responses**

**Domain 1: Advocacy**

Task Statement	Importance	Frequency
1.1 Serve as the consumer's individual advocate.	1 2 3 4 5	1 2 3 4 5
1.2 Advocate within systems to promote consumer centered recovery support services.	1 2 3 4 5	1 2 3 4 5
1.3 Assure that the consumer's choices define and drive their recovery planning process.	1 2 3 4 5	1 2 3 4 5
1.4 Promote consumer-driven recovery plans by serving on the consumer's recovery-oriented team.	1 2 3 4 5	1 2 3 4 5

**Domain 2: Professional Responsibility**

Task Statement	Importance	Frequency
2.1 Respond appropriately to risk indicators to assure the consumers welfare and physical safety.	1 2 3 4 5	1 2 3 4 5
2.2 Immediately report suspicions that the consumer is being abused or neglected according to Florida Statutes.	1 2 3 4 5	1 2 3 4 5
2.3 Maintain confidentiality.	1 2 3 4 5	1 2 3 4 5
2.4 Communicate personal issues that affect your ability to perform job duties.	1 2 3 4 5	1 2 3 4 5
2.5 Assure that interpersonal relationships, services, and supports reflect the consumer's individual differences and cultural diversity.	1 2 3 4 5	1 2 3 4 5
2.6 Document service provision as required by the employer.	1 2 3 4 5	1 2 3 4 5
2.7 Gather information regarding the consumer's personal satisfaction with their progress toward recovery goals.	1 2 3 4 5	1 2 3 4 5

**Review of Rating Scales**

<b>Importance Ratings</b>		<b>Frequency Ratings</b>	
1	Not Important	1	Not Much Time
2	Somewhat Important	2	A Little Bit of Time
3	Important	3	An Average Amount of Time
4	Very Important	4	A Fair Amount of Time
5	Extremely Important	5	A Large Amount of Time

**Please Circle Your Responses**

**Domain 3: Mentoring**

<b>Task Statement</b>	<b>Importance</b>	<b>Frequency</b>
3.1 Serve as a role model of a consumer in recovery.	1 2 3 4 5	1 2 3 4 5
3.2 Establish and maintain a "peer" relationship rather than a hierarchical relationship.	1 2 3 4 5	1 2 3 4 5
3.3 Promote social learning through shared experiences.	1 2 3 4 5	1 2 3 4 5
3.4 Teach consumers life skills.	1 2 3 4 5	1 2 3 4 5
3.5 Encourage consumers to develop independent behavior that is based on choice rather than compliance.	1 2 3 4 5	1 2 3 4 5
3.6 Assure that consumers know their rights and responsibilities.	1 2 3 4 5	1 2 3 4 5
3.7 Teach consumers how to self-advocate.	1 2 3 4 5	1 2 3 4 5

**Domain 4: Recovery Support**

<b>Task Statement</b>	<b>Importance</b>	<b>Frequency</b>
4.1 Serve as an active member of the consumer's recovery support team.	1 2 3 4 5	1 2 3 4 5
4.2 Assure that all recovery-oriented tasks and activities build on the consumer's strengths and resiliencies.	1 2 3 4 5	1 2 3 4 5
4.3 Help the consumer identify their options and participate in all decisions related to establishing and achieving recovery goals.	1 2 3 4 5	1 2 3 4 5
4.4 Help the consumer develop problem-solving skills so they can respond to challenges to their recovery.	1 2 3 4 5	1 2 3 4 5
4.5 Help the consumer access the services and supports that will help them attain their individual recovery goals.	1 2 3 4 5	1 2 3 4 5

**Section C Introduction:**

The purpose of this section is to differentiate the percentage of time a MH Recovery Peer Specialist spends performing these duties, relative to the other domains (the last section compared frequency relative to other task statements per domain).

**Directions:**

Assign the percentage of time you spend *OR* the percentage of time you believe a MH Recovery Peer Specialist would spend performing duties in these domains.

The total percentage must equal 100%.

**Please Circle Your Responses**

Domain	Percentage
Domain 1: Advocacy	_____
Domain 2: Professional Responsibility	_____
Domain 3: Mentoring	_____
Domain 4: Recovery Support	_____
	<b>100%</b>

**This concludes the Survey.**

**Thank you for your time and input.**

**Appendix B: Summary Test Blueprint**

**MH Recovery Peer Specialist  
Summary Test Blueprint  
(based on 100 multiple-choice items)**

Domain/Task		Items per Task	Items per Domain
Domain 1: Advocacy			17
1.1	Serve as the consumer’s individual advocate.	4	
1.2	Advocate within systems to promote consumer centered recovery support services.	4	
1.3	Assure that the consumer’s choices define and drive their recovery planning process.	5	
1.4	Promote consumer-driven recovery plans by serving on the consumer’s recovery-oriented team.	4	
Domain 2: Professional Responsibility			30
2.1	Respond appropriately to risk indicators to assure the consumers welfare and physical safety.	4	
2.2	Immediately report suspicions that the consumer is being abused or neglected according to s. 415.1034(1)(a), F.S.	5	
2.3	Maintain confidentiality.	5	
2.4	Communicate personal issues that impact your ability to perform job duties.	4	
2.5	Assure that interpersonal relationships, services, and supports reflect the consumer’s individual differences and cultural diversity.	4	
2.6	Document service provision as required by the employer.	4	
2.7	Gather information regarding the consumer’s personal satisfaction with their progress toward recovery goals.	4	
Domain 3: Mentoring			31
3.1	Serve as a role model of a consumer in recovery.	5	
3.2	Establish and maintain a “peer” relationship rather than a hierarchical relationship.	5	
3.3	Promote social learning through shared experiences.	4	
3.4	Teach consumers life skills.	4	

Appendix B: Summary Test Blueprint

3.5	Encourage consumers to develop independent behavior that is based on choice rather than compliance.	5	
3.6	Assure that consumers know their rights and responsibilities.	4	
3.7	Teach consumers how to self-advocate.	4	
Domain 4: Recovery Support			22
4.1	Serve as an active member of the consumer's recovery-oriented team(s).	4	
4.2	Assure that all recovery-oriented tasks and activities build on the consumer's strengths and resiliencies.	4	
4.3	Help the consumer identify their options and participate in all decisions related to establishing and achieving recovery goals.	4	
4.4	Help the consumer develop problem-solving skills so they can respond to challenges to their recovery.	5	
4.5	Help the consumer access the services and supports that will help them attain their individual recovery goals.	5	

**Appendix C: Detailed Test Blueprint**

**MH Recovery Peer Specialist  
Detailed Test Blueprint  
(based on 100 multiple-choice items)**

Domain/Task		Items per Task	Items per Domain
Domain 1: Advocacy			17
1.1	Serve as the consumer’s individual advocate.	4	
1.2	Advocate within systems to promote consumer centered recovery support services.	4	
1.3	Assure that the consumer’s choices define and drive their recovery planning process.	5	
1.4	Promote consumer-driven recovery plans by serving on the consumer’s recovery-oriented team.	4	
<p><b>Knowledge, Skills and Abilities</b> that the MH Recovery Peer Specialist should possess in order to perform the tasks identified in the Advocacy domain:</p> <ul style="list-style-type: none"> <li>1.1. Define system-level advocacy.</li> <li>1.2. Explain why self-advocacy is the foundation of recovery.</li> <li>1.3. Identify the consumer’s individual support systems.</li> <li>1.4. Promote the principles of individual choice and self-determination.</li> <li>1.5. Explain how and why consumers should establish an Advanced Directive.</li> <li>1.6. Explain how to advocate within the mental health system.</li> <li>1.7. Define consumer-driven recovery.</li> <li>1.8. Use “person-centered” language that focuses on the individual, not the diagnosis.</li> <li>1.9. Demonstrate non-judgmental behavior.</li> </ul>			
Domain 2: Professional Responsibility			30
2.1	Respond appropriately to risk indicators to assure the consumers welfare and physical safety.	4	
2.2	Immediately report suspicions that the consumer is being abused or neglected according to s. 415.1034(1)(a), F.S.	5	
2.3	Maintain confidentiality.	5	
2.4	Communicate personal issues that impact your ability to perform job duties.	4	

Appendix C: Detailed Test Blueprint

2.5	Assure that interpersonal relationships, services, and supports reflect the consumer’s individual differences and cultural diversity.	4	
2.6	Document service provision as required by the employer.	4	
2.7	Gather information regarding the consumer’s personal satisfaction with their progress toward recovery goals.	4	
<p><b>Knowledge, Skills and Abilities</b> that the MH Recovery Peer Specialist should possess in order to perform the tasks identified in the Professional Responsibility domain:</p> <ol style="list-style-type: none"> <li>2.1. Explain the ten fundamental concepts of recovery as defined in the National Consensus Statement on Mental Health Recovery, which is published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).</li> <li>2.2. Define the concept of a wellness-focused approach to consumer recovery.</li> <li>2.3. Explain the fundamental concepts related to cultural competency.</li> <li>2.4. Understand the concept of accountability.</li> <li>2.5. Explain basic federal, state, employer regulations regarding confidentiality.</li> <li>2.6. Explain what, where, when and how to accurately complete all required documentation activities.</li> <li>2.7. Explain the concept of decompensation.</li> <li>2.8. Identify the consumers risk indicators, including individual stressors, triggers and indicators of escalating symptoms</li> <li>2.9. Explain basic de-escalation techniques.</li> <li>2.10. Explain basic suicide prevention concepts and techniques.</li> <li>2.11. Identify indicators that the consumer may be experiencing abuse and/or neglect.</li> <li>2.12. Identify and respond appropriately to personal stressors, triggers, and indicators.</li> </ol>			
Domain 3: Mentoring			31
3.1	Serve as a role model of a consumer in recovery.	5	
3.2	Establish and maintain a “peer” relationship rather than a hierarchical relationship.	5	
3.3	Promote social learning through shared experiences.	4	
3.4	Teach consumers life skills.	4	
3.5	Encourage consumers to develop independent behavior that is based on choice rather than compliance.	5	
3.6	Assure that consumers know their rights and responsibilities.	4	

Appendix C: Detailed Test Blueprint

3.7	Teach consumers how to self-advocate.	4	
<p><b>Knowledge, Skills and Abilities</b> that the MH Recovery Peer Specialist should possess in order to perform the tasks identified in the Mentoring domain:</p> <ul style="list-style-type: none"> <li>3.1. Explain the concept of mentoring.</li> <li>3.2. Explain the concept of role-modeling behaviors.</li> <li>3.3. Define social learning.</li> <li>3.4. Define self-advocacy.</li> <li>3.5. Define life skills.</li> <li>3.6. Understand basic adult learning principles and techniques.</li> <li>3.7. Use adult learning techniques to teach life skills.</li> <li>3.8. Explain the concept of healthy, interdependent relationship.</li> <li>3.9. Establish a respectful, trusting relationship.</li> <li>3.10. Use active listening skills.</li> <li>3.11. Use empathetic listening skills.</li> <li>3.12. Demonstrate non-judgmental behavior.</li> <li>3.13. Demonstrate consistency by supporting consumers during ordinary and extraordinary times.</li> <li>3.14. Promote the development and use of Advanced Directives.</li> </ul>			
Domain 4: Recovery Support			22
4.1	Serve as an active member of the consumer's recovery-oriented team(s).	4	
4.2	Assure that all recovery-oriented tasks and activities build on the consumer's strengths and resiliencies.	4	
4.3	Help the consumer identify their options and participate in all decisions related to establishing and achieving recovery goals.	4	
4.4	Help the consumer develop problem-solving skills so they can respond to challenges to their recovery.	5	
4.5	Help the consumer access the services and supports that will help them attain their individual recovery goals.	5	
<p><b>Knowledge, Skills and Abilities</b> that the MH Recovery Peer Specialist should possess in order to perform the tasks identified in the Recovery Support domain:</p> <ul style="list-style-type: none"> <li>4.1. Explain the ten fundamental concepts of recovery as defined in the National Consensus Statement on Mental Health Recovery, which is published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).</li> <li>4.2. Explain the concept of a strength-based approach to recovery.</li> </ul>			

## Appendix C: Detailed Test Blueprint

- 4.3. Promote self-determination and consumer choice-driven recovery.
- 4.4. Use active and empathetic listening skills with the consumer.
- 4.5. Use *Motivational Interviewing* skills with the consumer.
- 4.6. State the stages of change.
- 4.7. State the stages of recovery.
- 4.8. Identify the consumer's current stage of change and/or recovery.
- 4.9. Help the consumer develop problem-solving skills by working together to identify and discuss options, alternatives, and possible consequences.
- 4.10. Explain the typical process that should be followed to access and/or participate in community mental health and related services.
- 4.11. Identify circumstances when it is appropriate to request assistance from other professionals to help meet the consumer's recovery goals.
- 4.12. Identify the consumer's strengths, resiliencies, and challenges to recovery.
- 4.13. Promote the consumer's empowerment by assuring that they are informed of their options and participate in all decision-making that will affect their lives.
- 4.14. Help the consumer request appropriate referrals and/or access needed resources.